

CAREPATH

CarePath Diagnosis List

Patient needs nursing diagnoses for care planning. First Edition, 2026

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238 original problem statements in 20 need groups, with plain-language descriptions, worked care plans, and an index.

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*To every patient who trusted a nurse on their hardest day, and to the families who waited beside them.
And to nurses everywhere, who show up, listen, and care.*

Acknowledgments

I thank the patients and families who taught me, more than any book, what good care feels like.

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How to use this book

This book is a working list of problem statements that describe common patient needs in plain language. Each statement has a code (a letter for the need group and a number), a short title, a type, and a one-sentence description. Use Part 1 to scan and choose; use Part 2 to read a full entry.

Types

- **A (Actual):** the problem is present now and can be seen or measured. The evidence is the signs and symptoms you observe.
- **R (Risk):** the problem has *not* happened yet, but risk factors are present. A risk statement is supported by risk factors, never by signs of the problem. If the signs are already present, choose the matching actual statement instead (for example, S4 Broken or damaged skin rather than S5 Likely to develop pressure sores).

The nursing process in five steps

1. **Assess.** Collect subjective data (what the patient or family says) and objective data (what you observe and measure).
2. **Diagnose.** Group the cues, find the need, and choose a statement. Check that the type (actual or risk) matches your data.
3. **Plan.** Set goals that are measurable: who, what change, how much, by when.
4. **Implement.** Carry out interventions in priority order: dangerous problems first, then comfort and teaching.
5. **Evaluate.** Compare findings with the goal. Was it met, partly met, or not met? Revise the plan.

Choosing between similar statements

- **Nausea or vomiting:** C3 (feeling sick) when there is no vomiting; F7 (vomiting) when there is, with fluid loss as the main concern.
- **Pain:** C1 short-term, C2 long-lasting, C8 pain near the end of life (see also D4).
- **Bowel problems:** E1 hard stools, E2 loose stools, E6 leakage.
- **Skin:** S4 damaged skin, S5 risk of pressure sores, W3 pressure sore already present.
- **Falls:** S1 likely to fall (the main risk statement), with M16 and B12 as contributing causes.
- **Seizures:** Z3 risk of seizures (the condition), S26 injury during a seizure (the safety focus).

How each Part 2 entry is arranged

Definition; causes or risk factors; signs or warning signs; a short fictional scenario in its own box with subjective (S) and objective (O) data; the CarePath diagnosis; interventions, each with a rationale (why it is done); expected outcomes; and a closing paragraph that links the data to the diagnosis. Interventions are listed in priority order. For urgent statements the first action is always to get help.

Important. All scenarios are fictional and for teaching. Vital signs, laboratory values, and targets are examples only. Real care must follow the doctor's orders, local protocols, and the patient's actual assessment.

Writing a CarePath diagnosis

A CarePath diagnosis uses the problem, cause, evidence (PES) pattern.

Actual problem: *Problem* related to *cause*, as evidenced by *signs and symptoms*. Example: C1 Short-term pain, related to a surgical incision, as evidenced by a pain score of 7/10 and guarding.

Risk problem: *Problem* related to *risk factors*; no signs of the problem are present yet. Example: S1 Likely to fall, related to weakness, a sleeping tablet, and past falls (risk factors).

Common mistakes to avoid

- Writing a medical diagnosis as the cause when a nursing cause is more useful for nursing action.
- Using a risk statement when the signs are already present. Choose the actual statement.
- Putting the treatment in the statement ("needs oxygen"). The statement names the problem; the plan names the treatment.
- Goals with no number or time ("pain improves"). Write "pain 3/10 or lower within 1 hour".
- Listing interventions in the order they came to mind. Put the most urgent first.

A good goal answers four questions: who (the patient), what change (behavior or measurement), how much (the target), by when (the time frame).

Three worked care plans

C1 Short-term pain (actual problem)

Mr. Hassan, 58, day 1 after open appendectomy.

- **Assessment:** S: "It hurts when I cough or move." O: pain 7/10 at the incision; grimacing; guarding the abdomen; pulse 104/min; blood pressure 138/84; reluctant to turn.

Assessment tools for this scenario: **CP-PAIN** Pain & Comfort Score (p. 268) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-BREATH** Breathing & Circulation Check (p. 265)

Validated scales to consider: NRS 0–10, FLACC, PAINAD, Braden Scale, TIME wound chart, NEWS2, SpO₂, ECG

- **Diagnosis:** Short-term pain related to a surgical incision, as evidenced by a pain score of 7/10, guarding, and a pulse of 104/min.
- **Goal:** Pain 3/10 or lower within 1 hour of pain relief; turns in bed without grimacing by the end of the shift.

Intervention	Rationale
Assess pain with the same scale each time, including location and what makes it worse	A consistent score shows whether the plan is working
Give pain relief on time as ordered, before moving or coughing exercises	Treating early keeps pain from building and lets him move
Teach him to splint the incision with a pillow when coughing	Reduces pull on the wound and pain
Reposition and offer cold or heat only if ordered	Comfort measures add to, not replace, medicine
Re-check pain, sedation, and breathing 30 to 60 minutes after each dose	Confirms relief and catches side effects early

Evaluation: At 1 hour pain was 3/10; he turned himself without grimacing. Goal met.

S1 Likely to fall (risk problem)

Mrs. Nasser, 81, admitted with a chest infection.

- **Assessment:** S: "I get up at night to use the bathroom and I am a bit wobbly." O: fell last year; unsteady gait; takes a sleeping tablet; high fall-risk score; wears loose slippers; no fall in hospital so far.

Assessment tools for this scenario: **CP-SAFE** Safety & Falls Score (p. 269)

Validated scales to consider: Morse Fall Scale

- **Diagnosis:** Likely to fall related to weakness, a sleeping tablet, and a past fall (risk factors); no fall has occurred.
- **Goal:** No falls during the stay; calls for help before getting up; names three fall-prevention steps by discharge.

Intervention	Rationale
Keep the bed low, brakes on, and the call bell in reach	Reduces injury and makes help easy to reach
Offer the toilet before the sleeping tablet and at set night times	Stops hurried, unassisted night trips
Provide non-slip footwear; clear the path and light the way	Removes common hazards
Assist with walking and use a walking aid if prescribed	Matches support to her real ability

Intervention	Rationale
Ask the doctor or pharmacist to review the sleeping tablet	Sedatives raise fall risk, especially in older adults

Evaluation: No fall by day 6; she called for help each time and named three steps at discharge. Goal met.

F5 Unsteady blood sugar (urgent risk problem)

Ms. Rahim, 44, with insulin-treated diabetes; lunch is late.

- **Assessment:** S: "I took my insulin but lunch has not come yet." O: blood sugar 5.2 mmol/L before lunch; insulin given 30 minutes ago; recent infection; no sweating or shaking.

Assessment tools for this scenario: CP-FLUID Fluid Balance & Nutrition Score (p. 266) · CP-INFECT Infection Check (p. 281)

Validated scales to consider: MUST, fluid chart, glucose, qSOFA / sepsis screen

- **Diagnosis:** Unsteady blood sugar related to insulin, a delayed meal, and infection (risk factors); no signs of the problem are present yet.
- **Goal:** Blood sugar at or above 4 mmol/L through the stay; states the warning signs of low sugar and what to do before discharge.

Intervention	Rationale
Call the kitchen and give a safe snack now	Fast-acting insulin without food can drop sugar quickly
Recheck blood sugar before the meal and if symptoms appear	Early checks catch a fall before symptoms
If sugar is below 4 mmol/L: treat at once per protocol and recheck in 15 minutes	Low sugar is an emergency and the treatment is time-critical
Teach warning signs: shaking, sweating, hunger, confusion	Lets her act before an emergency develops

Evaluation: She ate 20 minutes later, sugar 6.8 mmol/L; no symptoms. Goal met.

Urgent statements

Some statements describe a danger to life or limb. On these entries the first intervention is to call for help or start emergency steps. Treat airway, breathing, and circulation first, then work through other statements in this order: safety, then comfort, then teaching and support.

- **B7** Fluid in the lungs
- **B8** Low blood oxygen needing support
- **B13** Poor blood flow to the brain
- **B14** Very low blood circulation (shock)
- **F5** Unsteady blood sugar
- **E9** Very little urine being made
- **C7** Side effects of pain medicine
- **S7** Body temperature too high or too low
- **S10** Reaction to medicine or allergen
- **S12** Likely to bleed heavily after surgery
- **S17** Choking
- **S18** Poisoning risk
- **S26** Injury during seizure
- **P9** Risk of self-harm (needs urgent response)
- **P18** Sudden confusion
- **N5** Risk of heavy bleeding after birth
- **N10** Newborn breathing difficulty
- **K4** Child cannot express pain
- **O2** Breathing problems after anaesthesia
- **O3** Risk of internal bleeding after surgery
- **Z3** Risk of seizures
- **Z7** Raised pressure in the brain

Part 1: The list

A = actual, R = risk. Urgent statements are marked.

B - Breathing and circulation (14)

Recommended assessment tools

CarePath tool: **CP-BREATH** Breathing & Circulation Check (p. 265)

Validated scales: NEWS2, SpO₂, ECG

Code	Problem statement	Type	Description
B1	Struggling to breathe comfortably	A	Breathing feels hard, shallow, too fast, or too slow, so the person cannot get comfortable air in and out.
B2	Poor oxygen exchange in the lungs	A	The lungs are not moving enough oxygen into the blood or carbon dioxide out, which may show as low oxygen readings, drowsiness, or confusion.
B3	Airway blocked by secretions	A	Mucus or fluid in the airway cannot be coughed up, making breathing noisy or difficult.
B4	Weak heart pumping	A	The heart is not moving enough blood to meet body needs, which may cause tiredness, swelling, or low blood pressure.
B5	Poor blood flow to hands or feet	A	The limbs receive too little blood and may look pale or blue, feel cold, or have weak pulses.
B6	Unstable blood pressure	R	Blood pressure may swing too high or too low because of illness, medicine, or fluid changes.
B7	Fluid in the lungs URGENT	A	Extra fluid collects in the lungs, causing breathlessness, cough, or crackling breath sounds.
B8	Low blood oxygen needing support URGENT	A	Oxygen levels stay below a safe level unless extra oxygen or other support is given.
B9	Needs breathing machine support	A	The person cannot breathe well alone and relies on a ventilator or similar device.
B10	Swollen legs or feet	A	Fluid builds up in the lower limbs, causing puffiness, tightness, or heaviness.
B11	Irregular heartbeat	A	The heart rhythm is too fast, too slow, or uneven, which may cause palpitations, dizziness, or weakness.
B12	Dizzy when standing up	R	Blood pressure drops on standing, so the person may feel faint or fall.
B13	Poor blood flow to the brain URGENT	R	Reduced blood supply to the brain may cause confusion, weakness, or changes in speech or vision.
B14	Very low blood circulation (shock) URGENT	R	Circulation may become too weak to supply vital organs, which is an emergency needing rapid action.

F - Food and fluids (13)

Recommended assessment tools

CarePath tool: **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales: MUST, fluid chart, glucose

Code	Problem statement	Type	Description
F1	Not eating enough to meet body needs	A	Food intake is too low to supply the energy and nutrients needed for health and healing.
F2	Eating more than the body needs	A	Intake is higher than the body uses, leading to unhealthy weight gain.
F3	Dehydration	A	The body has too little water, shown by thirst, dry mouth, dark urine, or low blood pressure.
F4	Fluid build-up in the body	A	The body holds too much fluid, causing swelling, quick weight gain, or breathlessness.
F5	Unsteady blood sugar URGENT	R	Blood sugar may swing too high or too low because of illness, diet, or medicine.
F6	Trouble chewing or swallowing	A	Chewing or swallowing is painful or unsafe, with coughing or choking at meals.
F7	Vomiting	A	Repeated throwing up that may lead to fluid loss, weakness, and poor intake.
F8	Needs tube feeding	A	Food and fluids must be given through a tube, which needs careful care and monitoring.
F9	Breastfeeding difficulty	A	The mother or baby struggles with latch, milk flow, or comfort during breastfeeding.
F10	Body salts out of balance	R	Levels of salts such as sodium or potassium may become unsafe.
F11	Poor appetite	A	The person has little desire to eat, so intake falls.
F12	Sore or damaged mouth	A	The lining of the mouth or gums is painful, dry, or ulcerated, making eating and speaking hard.
F13	Unplanned weight loss	A	The person is losing weight without trying, which may signal poor intake or illness.

E - Elimination (9)

Recommended assessment tools

CarePath tool: **CP-ELIM** Elimination Check (p. 267)

Validated scales: Bristol Stool Chart, bladder scan

Code	Problem statement	Type	Description
E1	Hard or infrequent bowel movements	A	Stools are hard, dry, or rare, with straining or discomfort.
E2	Frequent loose stools	A	Watery or frequent stools that risk fluid loss, weakness, and skin damage.
E3	Unable to empty the bladder	A	Urine stays in the bladder, causing fullness, discomfort, or overflow leaking.

Code	Problem statement	Type	Description
E4	Leaking urine	A	Urine escapes without control, for example with coughing, urgency, or at other times.
E5	Unable to reach the toilet in time	A	Bladder control is present but mobility, distance, or timing leads to accidents.
E6	Bowel leakage	A	Stool passes without control, risking skin damage and embarrassment.
E7	Burning or pain passing urine	A	Urinating hurts or burns, which may signal infection or irritation.
E8	Likely to get urine infection from a catheter	R	A urinary catheter gives germs a path into the bladder.
E9	Very little urine being made URGENT	A	Urine output is lower than expected, which may signal dehydration or kidney trouble.

C - Comfort and rest (12)

Recommended assessment tools

CarePath tool: **CP-PAIN Pain & Comfort Score** (p. 268)

Validated scales: NRS 0–10, FLACC, PAINAD

Code	Problem statement	Type	Description
C1	Short-term pain	A	Pain of recent onset from injury, surgery, or illness that is expected to ease with healing.
C2	Long-lasting pain	A	Pain that continues for months or longer and affects daily life and mood.
C3	Feeling sick to the stomach	A	An unpleasant urge to vomit, with or without actual vomiting.
C4	Unable to sleep well	A	Trouble falling or staying asleep leaves the person unrefreshed.
C5	Constant tiredness	A	Ongoing exhaustion that rest does not fix and that limits activity.
C6	Itching or skin discomfort	A	Skin itch, burning, or irritation that disturbs rest and may lead to scratching damage.
C7	Side effects of pain medicine URGENT	A	Drowsiness, nausea, constipation, or slowed breathing caused by pain medicines.
C8	Pain near end of life	A	Pain during advanced illness that needs prompt and frequent comfort measures.
C9	Muscle cramps or spasms	A	Sudden, painful tightening of muscles.
C10	Headache	A	Pain in the head that may limit rest and activity.
C11	Dry mouth or thirst	A	The mouth feels dry or sticky and the person is uncomfortably thirsty.
C12	Noise or light disturbing rest	A	The surroundings are too noisy or bright for the person to rest.

S - Safety and protection (26)

Recommended assessment tools

CarePath tool: **CP-SAFE Safety & Falls Score** (p. 269)

Validated scales: Morse Fall Scale

Code	Problem statement	Type	Description
S1	Likely to fall	R	Weakness, medicine, poor balance, or hazards raise the chance of a fall.
S2	Likely to catch an infection	R	Wounds, lines, weak defenses, or exposure raise the chance of infection.
S3	Likely to get hurt	R	The person's condition or surroundings raise the chance of accidental harm.
S4	Broken or damaged skin	A	Skin is cut, torn, blistered, or broken down.
S5	Likely to develop pressure sores	R	Staying in one position, moisture, or poor nutrition raise the chance of skin breakdown over bony areas.
S6	Likely to bleed easily	R	Blood-thinning medicine, low platelets, or illness raise the chance of bleeding.
S7	Body temperature too high or too low URGENT	A	Body temperature is outside the safe range because of illness, surroundings, or medicine.
S8	Likely to inhale food or fluid	R	Weak swallowing or reduced alertness raise the chance of food or fluid entering the lungs.
S9	Slow wound or surgical healing	R	Poor nutrition, infection, or illness may slow healing.
S10	Reaction to medicine or allergen URGENT	R	The person may react to a medicine, food, latex, or other trigger.
S11	Likely to develop blood clots	R	Limited movement, surgery, or illness raise the chance of clots in the veins.
S12	Likely to bleed heavily after surgery URGENT	R	The surgical site may bleed more than expected.
S13	Wrong medicine or dose	R	Errors in drug, dose, time, route, or patient may cause harm.
S14	Harm from restraints	R	Physical or chemical restraints can cause injury, distress, and loss of dignity.
S15	Likely to wander or get lost	R	Confusion or memory loss may lead the person to leave a safe place.
S16	Burn or scald risk	R	Hot water, heat packs, or equipment may burn skin, especially where feeling is reduced.
S17	Choking URGENT	R	Food or objects may block the airway.
S18	Poisoning risk URGENT	R	Access to harmful substances or medicine overdose raises the chance of poisoning.
S19	Unsafe home	R	Hazards such as clutter, poor lighting, or loose rugs raise the chance of injury.
S20	Abuse or violence exposure	R	The person may be exposed to harm from others or be recovering from it.
S21	Likely to harm others	R	Anger, confusion, or illness may lead to violence toward other people.
S22	Staff exposure to needles or body fluids (workplace safety)	R	Healthcare workers may be exposed to blood-borne infection through sharps or splashes.
S23	Nerve or limb damage from positioning	R	Pressure or poor positioning may damage nerves or reduce blood flow to a limb.

Code	Problem statement	Type	Description
S24	Likely to spread infection to others	R	An infectious person may pass germs to other patients, staff, or family.
S25	Eye damage in unconscious patients	R	Eyes that do not blink or close may dry out or be scratched.
S26	Injury during seizure URGENT	R	Falls, tongue bites, or a blocked airway may occur during a seizure.

M - Movement and self-care (19)

Recommended assessment tools

CarePath tool: **CP-MOVE** Movement & Self-Care Score (p. 271)

Validated scales: Barthel Index, Katz ADL

Code	Problem statement	Type	Description
M1	Limited ability to move	A	Pain, weakness, or restrictions reduce the ability to move the body or parts of it.
M2	Tires quickly during activity	A	Ordinary activity causes breathlessness, fast heart rate, or exhaustion.
M3	Cannot turn or change position in bed	A	The person cannot reposition without help.
M4	Difficulty walking	A	Walking is slow, unsteady, painful, or not possible without help.
M5	Needs help to wash	A	The person cannot bathe or wash alone.
M6	Needs help to dress	A	The person cannot choose, put on, or remove clothing alone.
M7	Needs help to eat	A	The person cannot bring food to the mouth or manage meals alone.
M8	Needs help to use the toilet	A	The person cannot get to, use, or clean up after the toilet alone.
M9	Too little physical activity	A	Daily movement is below what is needed for good health.
M10	Difficulty using a walking aid	A	The person struggles with a frame, crutches, stick, or wheelchair.
M11	Muscle weakness	A	Muscles lack the strength needed for normal tasks.
M12	Stiff joints or shortened muscles	A	Joints move poorly or muscles tighten, limiting range of motion.
M13	Cannot groom or care for appearance	A	The person cannot manage hair, teeth, nails, shaving, or similar personal care.
M14	Unsafe wheelchair or transfer	A	Moving between bed, chair, and toilet is unsafe for the person or the helper.
M15	Cannot do household tasks	A	Cooking, cleaning, shopping, or laundry are beyond the person's current ability.
M16	Poor balance	A	Unsteady standing or walking raises the chance of falling.
M17	Loss of limb movement	A	One or more limbs cannot move or move only weakly.
M18	Muscle wasting from bed rest	R	Long inactivity may cause weakness, stiffness, and loss of muscle.

Code	Problem statement	Type	Description
M19	Poor body positioning	A	The body is held in a position that is uncomfortable or harmful.

P - Emotions and mind (29)

Recommended assessment tools

CarePath tool: **CP-MIND Mood & Mind Screen** (p. 272)

Validated scales: PHQ-9, GAD-7, C-SSRS

Code	Problem statement	Type	Description
P1	Worry or nervousness	A	An uneasy feeling with tension, restlessness, fast heartbeat, or trouble focusing.
P2	Fear of a specific thing	A	Fear directed at a clear threat such as a procedure, pain, or situation.
P3	Difficulty handling stress	A	The person's usual ways of coping are not working.
P4	Loss of hope	A	The person sees little chance of improvement and loses motivation.
P5	Feeling no control over one's situation	A	The person feels unable to influence events or decisions about their care.
P6	Low self-worth	A	A negative view of oneself, often after illness, loss, or change.
P7	Unhappy with body appearance	A	Distress about body changes from surgery, injury, illness, or aging.
P8	Sadness after a loss	A	A natural grief reaction to death, loss of health, or another loss.
P9	Risk of self-harm (needs urgent response) URGENT	R	Thoughts or signs of wanting to end life or cause harm. Needs immediate safety steps and urgent specialist support.
P10	Distress after a frightening event	A	Flashbacks, nightmares, or feeling constantly on edge after trauma.
P11	Confusion or memory problems	A	Ongoing trouble thinking clearly, remembering, or knowing time and place.
P12	Low mood	A	Persistent sadness, loss of interest, or tearfulness.
P13	Anger or aggression	A	Irritability or hostility that may escalate to harmful words or actions.
P14	Extreme mood swings	A	Rapid or intense changes in mood that are hard to control.
P15	Hearing or seeing things others do not	A	The person perceives voices or images that are not there.
P16	Suspicious or distorted thinking	A	Strong false beliefs or mistrust that do not match reality.
P17	Poor concentration	A	Difficulty keeping attention on tasks, conversations, or instructions.
P18	Sudden confusion URGENT	A	An abrupt change in awareness or thinking, often from infection, medicine, or acute illness.
P19	Difficulty making decisions	A	The person is unsure which care option to choose or is torn between choices.

Code	Problem statement	Type	Description
P20	Trouble controlling impulses	A	The person acts without thinking in ways that risk harm.
P21	Dependence on alcohol or drugs	A	Regular substance use that harms health or daily life.
P22	Withdrawal symptoms	A	Shaking, sweating, agitation, or cravings after stopping a substance.
P23	Harmful eating behaviors	A	Eating patterns such as severe restriction, bingeing, or purging that harm health.
P24	Self-injury	A	Deliberately hurting oneself. Needs safe, nonjudgmental care and specialist support.
P25	Guilt or shame	A	Painful feelings of blame or inadequacy about illness or past events.
P26	Long-lasting grief	A	Grief that stays intense for a long time and blocks daily functioning.
P27	Stress from illness or hospital stay	A	Strain from illness, an unfamiliar setting, and loss of routine.
P28	Loss of sense of identity	A	The person feels they no longer know who they are after illness, injury, or a change of role.
P29	Ready for better coping	A	The person wants to build stronger coping skills.

R - Communication and relationships (16)

Recommended assessment tools

CarePath tool: **CP-TALK Communication Check** (p. 273)

Validated scales: Communication barrier checklist

Code	Problem statement	Type	Description
R1	Difficulty speaking or being understood	A	Speech is unclear, limited, or absent, so needs are hard to communicate.
R2	Difficulty hearing or seeing	A	Hearing or vision loss limits communication, safety, or understanding.
R3	Feeling alone or cut off from others	A	The person has little contact or connection with other people and feels isolated.
R4	Struggling with family or work roles	A	Illness prevents the person from carrying out usual roles.
R5	Family caregiver overwhelmed	A	Tiredness, stress, or strain in the person who gives unpaid care.
R6	Conflict or breakdown in family support	A	The family cannot work together or support the patient.
R7	Difficulty trusting or cooperating with care	A	The person resists or distrusts treatment, staff, or advice.
R8	Not enough help at home	A	Home support is too little for the person's needs.
R9	Language barrier	A	The person and staff do not share a common language.
R10	Trouble understanding health information	A	Low reading ability or health literacy makes instructions hard to follow.

Code	Problem statement	Type	Description
R11	Relationship or intimacy difficulty	A	Illness or treatment strains close relationships.
R12	Abuse or neglect in the family	A	Signs that a family member is being harmed or not properly cared for.
R13	Parenting difficulty	A	A parent struggles to meet a child's physical, emotional, or safety needs.
R14	Weak bond between parent and baby	R	Early bonding may be delayed by separation, illness, or stress.
R15	Loss of privacy or dignity	R	Care may expose the person or treat them with less respect than they deserve.
R16	Care conflicts with culture	A	Care routines clash with the person's cultural practices or values.

L - Learning and self-management (13)

Recommended assessment tools

CarePath tool: **CP-LEARN Learning Readiness Check** (p. 274)

Validated scales: Teach-back

Code	Problem statement	Type	Description
L1	Not enough knowledge about the condition	A	The person lacks information about their illness, treatment, or recovery.
L2	Not following the treatment plan	A	The person does not take medicines, attend visits, or follow advice as agreed.
L3	Difficulty managing medicines	A	The person has trouble with doses, timing, or side effects.
L4	Difficulty managing the illness at home	A	The person cannot carry out the daily tasks needed to stay well at home.
L5	Ready to learn and improve health	A	The person is motivated to learn and take more control of their health.
L6	Unsure how to use equipment or devices	A	The person cannot safely use devices such as inhalers, monitors, or dressings.
L7	Unsafe medicine use at home	A	Mixing, missing, or double-dosing medicines may cause harm.
L8	Struggling to manage long-term illness	A	The daily demands of a chronic condition are hard to keep up with.
L9	Unhealthy habits (smoking, inactivity)	A	Habits that harm health continue despite risk.
L10	Cannot reach health services	A	Distance, cost, transport, or other barriers block access to care.
L11	Cannot afford care or medicines	A	Money problems prevent the person from getting treatment.
L12	Not ready for discharge	A	The person or home situation is not yet prepared for safe discharge.
L13	Believes wrong health information	A	The person holds beliefs about health that are inaccurate and may lead to harm.

V - Spiritual and values (6)

Recommended assessment tools

CarePath tool: **CP-SPIRIT** Spiritual & Values Check (p. 275)

Validated scales: FICA spiritual screen

Code	Problem statement	Type	Description
V1	Struggling with meaning, faith, or purpose	A	The person questions meaning, belief, or purpose during illness or loss.
V2	Conflict between care and personal beliefs	A	Treatment options clash with the person's values or beliefs.
V3	Ready to grow spiritually	A	The person wishes to deepen peace, meaning, or connection.
V4	Wishes about end of life unclear	A	The person has not decided or shared their wishes about end-of-life care.
V5	Fear of dying	A	Strong fear or distress about death or the dying process.
V6	Cannot practice faith or rituals	A	Illness or the care setting prevents religious or spiritual practice.

N - Maternal and newborn (14)

Recommended assessment tools

CarePath tool: **CP-MOTHER** Mother & Newborn Check (p. 276)

Validated scales: MEOWS, APGAR

Code	Problem statement	Type	Description
N1	Pregnancy discomfort	A	Physical discomfort during pregnancy such as backache, nausea, or swelling.
N2	High-risk pregnancy	R	Pregnancy conditions that raise the chance of harm to mother or baby.
N3	Fear of labor	A	Worry or fear about childbirth, pain, or outcomes.
N4	Labor pain	A	Pain during contractions and birth that needs comfort support.
N5	Risk of heavy bleeding after birth URGENT	R	Blood loss after delivery may be higher than expected.
N6	Slow recovery after birth	A	Healing, energy, or comfort after birth is slower than expected.
N7	Baby feeding poorly	A	The baby has weak sucking, poor latch, or takes too little milk.
N8	Baby's temperature unstable	A	The newborn cannot keep a safe body temperature.
N9	Newborn jaundice	A	Yellow skin or eyes in a newborn from high bilirubin.
N10	Newborn breathing difficulty URGENT	A	The baby breathes fast, grunts, or struggles to get enough air.
N11	Difficulty adjusting to new parenthood	R	Stress, exhaustion, or lack of support may make adjusting to a baby hard.
N12	Sadness after childbirth	A	Low mood, tearfulness, or anxiety in the weeks after delivery.

Code	Problem statement	Type	Description
N13	Grief after pregnancy loss	A	Sorrow after miscarriage, stillbirth, or loss of a newborn.
N14	Family planning questions	A	The person wants information on contraception or spacing pregnancies.

K - Child and teen (12)

Recommended assessment tools

CarePath tool: **CP-CHILD** Child & Teen Check (p. 277)

Validated scales: PEWS, FLACC

Code	Problem statement	Type	Description
K1	Slow growth	A	Height or weight is below what is expected for age.
K2	Delayed development	A	The child may be slower in movement, speech, or social skills than expected.
K3	Fear of hospital or procedures	A	The child is frightened of staff, needles, or unfamiliar surroundings.
K4	Child cannot express pain URGENT	A	The child is too young or unable to say where or how much they hurt.
K5	Accident risk at home	R	Hazards such as stairs, water, or hot items raise injury risk.
K6	Distress when separated from parents	A	The child is upset or anxious when caregivers are away.
K7	Behavior problems	A	Ongoing tantrums, defiance, or aggression that disrupt care and family life.
K8	Missing school due to illness	A	Illness or treatment interrupts schooling and learning.
K9	Risk-taking behavior in teens	A	Teens may take risks with substances, sex, or safety.
K10	Infant dehydration risk	R	Infants can lose body water quickly through vomiting, diarrhea, or poor feeding.
K11	Unsafe infant sleep	R	Sleep position or setting may raise the chance of suffocation or sudden infant death.
K12	Missed vaccinations	A	Recommended vaccines have not been given on schedule.

A - Older adult (8)

Recommended assessment tools

CarePath tool: **CP-OLDER** Older Adult Check (p. 278)

Validated scales: 4AT / CAM, Mini-Cog

Code	Problem statement	Type	Description
A1	Frailty	A	General weakness, low energy, and slow recovery that raise the chance of falls and illness.
A2	Memory loss	A	Noticeable forgetfulness that affects daily life.
A3	Too many medicines	R	Many medicines at once raise the chance of interactions and side effects.
A4	Loneliness at home	R	Living alone with little contact may lead to loneliness and low mood.

Code	Problem statement	Type	Description
A5	Neglect or money exploitation risk	R	The older person may be neglected or taken advantage of by others.
A6	Unsafe to live alone	A	Health or memory problems make independent living risky.
A7	Difficulty adjusting to a care home	A	Moving to a new setting causes stress, confusion, or sadness.
A8	Loss of independence	A	The person can no longer do tasks they once managed alone and feels reduced control.

W - Wounds and skin (7)

Recommended assessment tools

CarePath tool: **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales: Braden Scale, TIME wound chart

Code	Problem statement	Type	Description
W1	Wound not healing	A	A wound stays open or shows little progress over the expected time.
W2	Heavy wound drainage	A	A wound leaks large amounts of fluid and needs frequent dressing care.
W3	Pressure sore present	A	Skin and tissue over a bony area has broken down from pressure.
W4	Difficulty caring for a stoma	A	The person or carer struggles to manage a stoma and its appliance.
W5	Fragile skin or skin tears	R	Thin or dry skin tears or bruises easily.
W6	Skin reaction to cancer treatment	A	Radiation or drugs cause redness, peeling, or soreness of the skin.
W7	Rash or skin infection	A	Skin shows rash, redness, warmth, or pus from irritation or infection.

O - Surgery and intensive care (10)

Recommended assessment tools

CarePath tool: **CP-SURG** Post-op & Critical Care Check (p. 279)

Validated scales: RASS, CPOT, Aldrete

Code	Problem statement	Type	Description
O1	Fear before surgery	A	Worry about pain, anaesthesia, outcomes, or loss of control before an operation.
O2	Breathing problems after anaesthesia URGENT	A	Shallow breathing, low oxygen, or airway problems after an operation.
O3	Risk of internal bleeding after surgery URGENT	R	Hidden bleeding may occur and show as low blood pressure, fast pulse, or pain.
O4	Drain, tube, or line problems	R	Tubes and lines may block, slip out, kink, or be pulled.
O5	Infection from lines	R	Intravenous lines and other devices can carry germs into the body.

Code	Problem statement	Type	Description
06	Slow gut recovery after surgery	A	Bowel movement is slow to return, causing bloating, nausea, or constipation.
07	Needs of sedated or unconscious patient	R	The person cannot protect their own airway, skin, eyes, or position.
08	Discomfort from tubes	A	Tubes and devices cause soreness, irritation, or restlessness.
09	Sleep loss in ICU	A	Noise, light, and care routines prevent restful sleep.
010	Family distress in ICU	A	Relatives feel fear, shock, or helplessness while the patient is critically ill.

Z - Brain and senses (7)

Recommended assessment tools

CarePath tool: **CP-NEURO Brain & Senses Check** (p. 280)

Validated scales: GCS, pupils, NIHSS

Code	Problem statement	Type	Description
Z1	Difficulty understanding speech	A	The person hears but struggles to make sense of spoken language.
Z2	Ignoring one side of the body	A	After brain injury the person may not notice one side of the body or space.
Z3	Risk of seizures URGENT	R	Sudden bursts of abnormal brain activity that may cause injury.
Z4	Adjusting to vision loss	A	The person struggles with safety, independence, or feelings after losing sight.
Z5	Adjusting to hearing loss	A	The person struggles with communication, safety, or feelings after losing hearing.
Z6	Risk of injury from numbness	R	Loss of feeling raises the chance of unnoticed injury.
Z7	Raised pressure in the brain URGENT	A	Increasing pressure inside the skull may cause headache, vomiting, confusion, or drowsiness.

H - Infection and community health (6)

Recommended assessment tools

CarePath tool: **CP-INFECT Infection Check** (p. 281)

Validated scales: qSOFA / sepsis screen

Code	Problem statement	Type	Description
H1	Exposed to an infectious disease	R	The person has had contact with someone who has a contagious illness.
H2	Distress from isolation	A	Isolation for infection control leaves the person lonely or anxious.
H3	Outbreak risk in community	R	Conditions in the community raise the chance of a disease spreading.
H4	Unsafe water or sanitation	R	Poor water or waste disposal raises the chance of illness.

Code	Problem statement	Type	Description
H5	Crowded living conditions	R	Overcrowding raises the chance of spreading infection and stress.
H6	Poor hygiene practices	A	Handwashing, bathing, or food handling habits put health at risk.

D - End of life (5)

Recommended assessment tools

CarePath tool: **CP-END** End-of-Life Comfort Check (p. 282)

Validated scales: ESAS

Code	Problem statement	Type	Description
D1	Needs comfort near death	A	The dying person needs relief of symptoms and calm, dignified care.
D2	Family grief before death	A	Relatives are grieving while the person is still alive.
D3	Unfinished affairs or wishes	A	The person has legal, family, or personal matters to settle.
D4	Distressing symptoms near death	A	Breathlessness, agitation, pain, or secretions cause distress near the end.
D5	Needs bereavement support	A	Family members need support after a death.

T - Long-term illness (8)

Recommended assessment tools

CarePath tool: **CP-LONG** Long-Term Condition Check (p. 283)

Validated scales: Self-management review

Code	Problem statement	Type	Description
T1	Uncontrolled high blood pressure	A	Blood pressure stays high despite treatment, raising the risk of stroke and heart disease.
T2	Foot problems in diabetes	R	Reduced feeling and blood flow raise the chance of ulcers and infection.
T3	Lung disease flare-ups	A	Breathing worsens suddenly in chronic lung disease.
T4	Difficulty following fluid limits	A	The person struggles to keep to fluid restrictions set for heart or kidney problems.
T5	Dialysis access care	R	The dialysis access site may become infected, blocked, or damaged.
T6	Cancer treatment side effects	A	Nausea, tiredness, sore mouth, or hair loss from treatment.
T7	Difficulty accepting long-term illness	A	The person struggles emotionally with a permanent condition.
T8	Weak immune system	R	Illness or treatment lowers the body's defenses against infection.

X - Sexual and reproductive health (4)

Recommended assessment tools

CarePath tool: **CP-SEX** Sexual & Reproductive Health Check (p. 284)

Validated scales: PLISSIT

Code	Problem statement	Type	Description
X1	Concern about sexual function	A	The person is worried about changes in sexual ability or desire.
X2	Concern about fertility	A	The person is worried about the ability to have children.
X3	Needs safe-sex knowledge	A	The person needs information on preventing infection and unplanned pregnancy.
X4	Menopause symptoms	A	Hot flushes, sleep trouble, mood changes, or other symptoms linked to menopause.

Part 2: Detailed explanations

B - Breathing and circulation

Recommended assessment tools

CarePath tool: **CP-BREATH Breathing & Circulation Check** (p. 265)

Validated scales: NEWS2, SpO₂, ECG

B1 Struggling to breathe comfortably

Group: Breathing and circulation | Type: Actual problem

- **Definition:** Breathing feels hard, shallow, too fast, or too slow, so the person cannot get comfortable air in and out.
- **Possible causes:** Lung disease; pain; anxiety; fluid or air in the chest; weak breathing muscles; obesity
- **Signs and symptoms:** Fast, slow, or shallow breathing; using neck muscles; flaring nostrils; sitting upright to breathe; low oxygen readings

Scenario

A man with COPD breathes 30 times a minute and can say only three words at a time.

Subjective (S): "I can't catch my breath, even sitting still."

Objective (O): Respiratory rate 30/min; oxygen saturation 89% on room air; uses neck muscles; speaks only 3 words at a time; sits upright leaning forward.

Assessment tools for this scenario: **CP-BREATH Breathing & Circulation Check** (p. 265)

Validated scales to consider: NEWS2, SpO₂, ECG

CarePath diagnosis: Struggling to breathe comfortably related to lung disease, as evidenced by fast, slow, or shallow breathing and using neck muscles.

Interventions and rationale

Intervention	Rationale
Sit him upright.	Sitting upright lets the diaphragm drop and the lungs expand more fully, which lowers the work of breathing. Leaning forward also eases airflow in COPD.
Check breathing rate and oxygen level.	Regular checks show whether breathing and oxygen are improving or worsening, so treatment can be adjusted before he tires out.
Give oxygen or medicine as ordered.	Extra oxygen raises the low blood oxygen and bronchodilator medicines open narrowed airways. The amount is ordered because too much oxygen can be harmful in some lung disease.
Coach slow breathing.	Slow, controlled breathing keeps airways open longer and reduces trapped air, so each breath works better and costs less effort.
Stay calm.	A calm nurse lowers anxiety, which otherwise speeds breathing and raises oxygen need, feeding a cycle of worsening breathlessness.
Report worsening.	Early reporting lets the team act before tiring breathing muscles lead to breathing failure.

Expected outcomes

- Within 1 hour: breathing rate 12-20/min and oxygen saturation at the doctor's target.
- Within 24 hours: speaks in full sentences and says breathing feels easier.

Linking the data to the diagnosis

The patient has COPD and is breathing 30 times a minute, with oxygen saturation 89% on room air, neck muscle use, speech limited to three words at a time and an upright, forward-leaning posture. He says he cannot catch his breath even sitting still. This is an actual problem because difficult breathing is already present, so a risk statement would be wrong. Poor oxygen exchange in the lungs could be confused with it, but here the main issue is the effort and discomfort of breathing itself. The plan aims for a rate of 12-20/min with oxygen at the doctor's target within 1 hour, then full sentences and easier breathing within 24 hours.

B2 Poor oxygen exchange in the lungs

Group: Breathing and circulation | Type: Actual problem

- **Definition:** The lungs are not moving enough oxygen into the blood or carbon dioxide out, which may show as low oxygen readings, drowsiness, or confusion.
- **Possible causes:** Pneumonia; fluid in the lungs; lung scarring; shallow breathing after surgery
- **Signs and symptoms:** Low oxygen readings; fast breathing; restlessness or confusion; blue lips; abnormal blood gas results

Scenario

A woman with pneumonia has an oxygen saturation of 88% and is restless at night.

Subjective (S): "I feel like I'm not getting enough air, and I'm so tired."

Objective (O): Oxygen saturation 88% on room air; respiratory rate 26/min; restless at night; crackling sounds in the right lung; temperature 38.4 C.

Assessment tools for this scenario: **CP-BREATH** Breathing & Circulation Check (p. 265) · **CP-INFECT** Infection Check (p. 281)

Validated scales to consider: NEWS2, SpO₂, ECG, qSOFA / sepsis screen

CarePath diagnosis: Poor oxygen exchange in the lungs related to pneumonia, as evidenced by low oxygen readings and fast breathing.

Interventions and rationale

Intervention	Rationale
Raise the head of the bed.	Raising the head lets the diaphragm move down and the lungs expand, so more air reaches the air sacs where oxygen passes into the blood.
Give oxygen as ordered.	Extra oxygen raises the blood oxygen level when infected lungs cannot move enough oxygen across on their own.
Check oxygen and breathing often.	Frequent checks catch falling oxygen or rising breathing rate early. Restlessness can be an early sign that the brain is short of oxygen.
Encourage deep breathing and coughing.	Deep breathing opens collapsed air sacs and coughing clears mucus, so more of the lung can take part in gas exchange.
Report falling oxygen.	Prompt reporting lets the doctor change oxygen or treatment before the patient becomes exhausted or seriously short of oxygen.

Expected outcomes

- Within 24 hours: oxygen saturation at or above 94% (or the doctor's target), breathing rate 12-20/min, calm and oriented.
- By discharge: clear breath sounds.

Linking the data to the diagnosis

The patient has pneumonia, with oxygen saturation 88% on room air, breathing rate 26/min, crackling sounds in the right lung, temperature 38.4 C and restlessness at night. She says she is not getting enough air and feels very tired. This is an actual problem because the low oxygen is already measured,

not just possible. Struggling to breathe comfortably could be confused with it, but the key finding here is the failure to move oxygen into the blood, not the feeling of effort. The plan aims for saturation at or above 94% (or the doctor's target), a normal breathing rate and calm orientation within 24 hours, and clear breath sounds by discharge.

B3 Airway blocked by secretions

Group: Breathing and circulation | Type: Actual problem

- **Definition:** Mucus or fluid in the airway cannot be coughed up, making breathing noisy or difficult.
- **Possible causes:** Thick mucus; weak cough; infection; smoking; sedation
- **Signs and symptoms:** Wet or rattling breath sounds; weak cough; mucus that cannot be cleared; noisy breathing

Scenario

A patient after surgery cannot cough up thick mucus and sounds wet when breathing.

Subjective (S): "I can feel the mucus but I can't cough it up."

Objective (O): Wet gurgling breath sounds; weak ineffective cough; thick yellow secretions in the mouth; oxygen saturation 92%.

Assessment tools for this scenario: CP-BREATH Breathing & Circulation Check (p. 265)

Validated scales to consider: NEWS2, SpO₂, ECG

CarePath diagnosis: Airway blocked by secretions related to thick mucus, as evidenced by wet or rattling breath sounds and weak cough.

Interventions and rationale

Intervention	Rationale
Position upright.	An upright position lets the lungs expand and makes coughing stronger, which helps move mucus out of the airway.
Teach deep breathing and supported coughing.	Deep breaths open airways behind the mucus, and holding a pillow over the wound lessens pain so the cough is strong enough to clear secretions.
Give fluids and humidified air if ordered.	Fluids and moist air thin thick mucus, making it easier to cough up. These are ordered because fluid limits or oxygen settings may apply.
Suction if needed.	Suction removes mucus the patient cannot clear alone, reopening the airway and improving oxygen levels. It is used only when needed because it is uncomfortable and can irritate the airway.
Give prescribed medicines.	Prescribed medicines can thin mucus, open airways and relieve pain, all of which help the patient cough effectively.

Expected outcomes

- Within 24 hours: coughs up secretions effectively, breath sounds clearer, oxygen saturation at target.
- Patient demonstrates supported coughing correctly.

Linking the data to the diagnosis

The patient is recovering from surgery and cannot cough up thick mucus. The nurse notes wet gurgling breath sounds, a weak ineffective cough, thick yellow secretions in the mouth and oxygen saturation 92%. He says he can feel the mucus but cannot cough it up. This is an actual problem because the airway is already partly blocked. Poor oxygen exchange in the lungs may follow if it continues, but the cause here is the mucus itself, so this statement is the better fit. The plan aims for effective coughing, clearer breath sounds and oxygen at target within 24 hours, with correct supported coughing shown by the patient.

B4 Weak heart pumping

Group: Breathing and circulation | Type: Actual problem

- **Definition:** The heart is not moving enough blood to meet body needs, which may cause tiredness, swelling, or low blood pressure.
- **Possible causes:** Heart failure; heart attack; weak heart muscle; rhythm problems
- **Signs and symptoms:** Tiredness; swollen legs; fast pulse; low blood pressure; breathless lying flat; weight gain

Scenario

A man with heart failure gains 2 kg in 3 days and cannot lie flat.

Subjective (S): "I'm so tired and my ankles are swollen. I need three pillows to sleep."

Objective (O): Weight up 2 kg in 3 days; pulse 110/min; blood pressure 92/60; pitting swelling in both ankles; crackles at the lung bases.

Assessment tools for this scenario: **CP-BREATH** Breathing & Circulation Check (p. 265) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: NEWS2, SpO₂, ECG, Braden Scale, TIME wound chart, MUST, fluid chart, glucose

CarePath diagnosis: Weak heart pumping related to heart failure, as evidenced by tiredness and swollen legs.

Interventions and rationale

Intervention	Rationale
Check pulse, blood pressure, and weight daily.	Daily pulse, blood pressure and weight show how well the heart is pumping. Quick weight gain signals fluid build-up before it becomes severe.
Give heart medicines as ordered.	Heart medicines strengthen the pumping, slow the heart rate or remove extra fluid, which lowers the heart's workload.
Limit fluid and salt if ordered.	Less salt and fluid means less water held in the body, which reduces swelling, lung congestion and strain on the heart.
Plan rest.	Rest lowers the heart's oxygen demand and workload, and planning it between activities saves energy for what matters.
Report sudden changes.	Sudden changes such as fast weight gain or worse breathlessness may mean heart failure is getting worse and needs prompt treatment.

Expected outcomes

- Within 3 days: weight stable or falling toward target, pulse 60-100/min, no new swelling.
- Sleeps with no more than two pillows.
- Patient lists 3 warning signs to report.

Linking the data to the diagnosis

The patient has heart failure and is gaining weight fast: 2 kg in 3 days. He has a pulse of 110/min, blood pressure 92/60, pitting swelling in both ankles and crackles at the lung bases. He says he is very tired and needs three pillows to sleep. This is an actual problem because the heart is already failing to move enough blood. Fluid build-up in the body describes the extra water, but this statement names the cause, the weak pump, and so fits better. The plan aims for stable or falling weight, a pulse of 60-100/min, no new swelling, sleep on two pillows or fewer, and three warning signs named within 3 days.

B5 Poor blood flow to hands or feet

Group: Breathing and circulation | Type: Actual problem

- **Definition:** The limbs receive too little blood and may look pale or blue, feel cold, or have weak pulses.
- **Possible causes:** Narrowed arteries; diabetes; smoking; blood clot; tight dressings
- **Signs and symptoms:** Cold, pale, or blue hands or feet; weak pulses; slow wound healing; leg pain when walking

Scenario

A diabetic patient has a cold, pale left foot with a weak pulse and a slow-healing toe sore.

Subjective (S): "My left foot always feels cold and my toe sore will not heal."

Objective (O): Left foot cold and pale; weak foot pulse; capillary refill 5 seconds; toe sore 1 cm and not healing for 3 weeks; blood sugar 12 mmol/L.

Assessment tools for this scenario: **CP-BREATH** Breathing & Circulation Check (p. 265) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: NEWS2, SpO₂, ECG, Braden Scale, TIME wound chart, MUST, fluid chart, glucose

CarePath diagnosis: Poor blood flow to hands or feet related to narrowed arteries, as evidenced by cold, pale, or blue hands or feet and weak pulses.

Interventions and rationale

Intervention	Rationale
Check pulses, color, and warmth.	Checking pulses, color and warmth shows how well blood reaches the foot and picks up worsening supply early.
Keep limbs warm but avoid heat pads.	Gentle warmth helps keep vessels open, but heat pads can burn skin that has poor blood flow and reduced feeling, and cannot carry the heat away.
Avoid tight clothing.	Tight clothing can squeeze vessels and further reduce blood flow that is already poor.
Encourage no smoking.	Smoking narrows blood vessels and lowers the oxygen carried by blood, so stopping improves flow and wound healing.
Report sudden pain or color change.	Sudden pain or color change may mean a clot has blocked the artery, which threatens the limb and needs urgent treatment.

Expected outcomes

- During the stay: foot stays warm and pink with a felt pulse.
- Within 2 weeks: wound smaller.
- Patient states foot care steps and accepts support to stop smoking.

Linking the data to the diagnosis

The patient is diabetic and has a cold, pale left foot with a weak pulse, capillary refill of 5 seconds and a 1 cm toe sore that has not healed for 3 weeks. She says the foot always feels cold. Blood sugar is 12 mmol/L. This is an actual problem because the poor circulation is already visible in color, temperature and slow healing. A skin or wound statement would miss the underlying cause, which is too little blood reaching the foot. The plan aims for a warm, pink foot with a felt pulse during the stay, a smaller wound within 2 weeks, and the patient stating foot care steps and accepting help to stop smoking.

B6 Unstable blood pressure

Group: Breathing and circulation | Type: Risk problem

- **Definition:** Blood pressure may swing too high or too low because of illness, medicine, or fluid changes.
- **Risk factors:** Stroke; bleeding; fluid loss; blood pressure medicine; infection
- **Warning signs to watch for:** Large swings in readings; dizziness; headache; fainting

Scenario

A patient with a past stroke starts new blood pressure tablets while recovering from a stomach bug with fluid loss.

Subjective (S): "I have been vomiting and I started new tablets for my blood pressure."

Objective (O): Blood pressure 148/90 on admission; vomiting for 2 days with poor fluid intake; new blood pressure tablets started today; past stroke; no dizziness or fainting.

Assessment tools for this scenario: **CP-BREATH** Breathing & Circulation Check (p. 265) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: NEWS2, SpO₂, ECG, Braden Scale, TIME wound chart, MUST, fluid chart, glucose

CarePath diagnosis: Unstable blood pressure related to new blood pressure medicine, fluid loss and past stroke (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Check blood pressure at ordered times with the right cuff size, lying and standing.	A correct cuff size gives accurate readings, and comparing lying and standing values reveals drops on standing caused by fluid loss or tablets.
Give medicines as ordered and note the time of each dose.	Giving medicines on time and noting dose times lets the team link pressure changes to the medicine and avoid missed or doubled doses.
Encourage fluids as allowed and record intake.	Vomiting has lowered body fluid, which can drop blood pressure. Drinking replaces it, and recording intake shows whether enough is taken.
Teach to sit up slowly.	Rising slowly gives blood pressure time to adjust, lowering the chance of dizziness, fainting and falls.
Report readings outside the ordered range, dizziness, headache or fainting at once.	Readings out of range may mean pressure is too high, raising stroke risk after a past stroke, or too low, reducing blood to the brain. Prompt action prevents harm.

Expected outcomes

- Within 24 hours: blood pressure stays within the doctor's range with no symptom-causing readings.
- No fainting or falls during the stay.
- Patient names her medicines and when to take them.

Linking the data to the diagnosis

This is a risk statement: the problem has not happened yet. The patient had a past stroke, has been vomiting for 2 days with poor fluid intake, and started new blood pressure tablets today. Blood pressure was 148/90 on admission, and there is no dizziness or fainting. The diagnosis rests on these risk factors, not on any swings in readings. A statement about dizziness on standing would be wrong because no drop has been found. The plan aims to keep pressure within the doctor's range with no symptom-causing readings in 24 hours, no fainting or falls, and the patient naming her medicines and when to take them.

B7 Fluid in the lungs **URGENT**

Group: Breathing and circulation | Type: Actual problem

- **Definition:** Extra fluid collects in the lungs, causing breathlessness, cough, or crackling breath sounds.
- **Possible causes:** Heart failure; kidney failure; too much intravenous fluid
- **Signs and symptoms:** Crackling breath sounds; cough with frothy mucus; breathlessness; low oxygen

Scenario

A patient with heart failure coughs up pink frothy mucus and cannot lie flat.

Subjective (S): "I can't breathe lying flat and I keep coughing."

Objective (O): Frothy pink sputum; crackles in both lungs; oxygen saturation 86%; respiratory rate 32/min; swollen legs.

Assessment tools for this scenario: CP-BREATH Breathing & Circulation Check (p. 265)

Validated scales to consider: NEWS2, SpO₂, ECG

CarePath diagnosis: Fluid in the lungs related to heart failure, as evidenced by crackling breath sounds and cough with frothy mucus.

Interventions and rationale

Intervention	Rationale
Sit upright.	An upright position lets fluid settle lower in the lungs and gives the diaphragm room to move, so breathing is easier.
Give oxygen and diuretics as ordered.	Oxygen treats the low blood oxygen, and diuretics make the kidneys remove extra fluid, reducing the fluid in the lungs.
Monitor fluid balance and weight.	Fluid balance and weight show whether fluid is leaving the body and whether treatment is working.
Call for urgent help if severe.	Severe fluid in the lungs can quickly lead to respiratory failure, so urgent help brings faster, stronger treatment.

Expected outcomes

- Within 6 hours: comfortable breathing at rest, oxygen saturation at target, clearer lungs.
- Within 48 hours: weight and fluid balance moving toward the doctor's targets.

Linking the data to the diagnosis

The patient has heart failure and is coughing up pink frothy mucus, with crackles in both lungs, oxygen saturation 86%, breathing rate 32/min and swollen legs. He cannot breathe lying flat. This is an actual, urgent problem, so help is called first, then the nurse sits him upright and starts oxygen as ordered. Weak heart pumping describes the heart cause, but the frothy sputum and very low oxygen show fluid is already in the lungs, so this statement is the right one. The plan aims for comfortable breathing at rest, oxygen at target and clearer lungs within 6 hours, with weight and fluid balance moving toward targets by 48 hours.

B8 Low blood oxygen needing support **URGENT**

Group: Breathing and circulation | Type: Actual problem

- **Definition:** Oxygen levels stay below a safe level unless extra oxygen or other support is given.
- **Possible causes:** Pneumonia; lung disease; shallow breathing; opioid overdose
- **Signs and symptoms:** Oxygen readings below target; fast breathing; blue lips; restlessness

Scenario

A patient with COPD drops to 85% oxygen when walking to the bathroom.

Subjective (S): "I get so short of breath just walking to the bathroom."

Objective (O): Oxygen saturation 85% after walking, 93% at rest on oxygen; respiratory rate 28/min; lips slightly blue.

Assessment tools for this scenario: CP-BREATH Breathing & Circulation Check (p. 265)

Validated scales to consider: NEWS2, SpO₂, ECG

CarePath diagnosis: Low blood oxygen needing support related to COPD (chronic lung disease), as evidenced by oxygen readings below target and fast breathing.

Interventions and rationale

Intervention	Rationale
Give oxygen at the ordered flow.	Oxygen at the ordered flow raises the blood oxygen level. The amount is ordered because too much or too little can harm, especially in lung disease.
Check equipment and tubing.	Leaks, kinks or a disconnected tube can stop oxygen reaching the patient, so checking makes sure the treatment is actually delivered.
Position upright.	An upright position helps the lungs expand and reduces the effort of breathing.
Limit exertion.	Activity raises oxygen demand, and his level fell to 85% on walking. Limiting exertion and resting between tasks prevents these drops.
Report persistent low readings.	Persistent low readings despite oxygen mean the current support is not enough and the doctor needs to adjust treatment.

Expected outcomes

- Within 48 hours: oxygen saturation stays at the doctor's target at rest and with activity.
- No blue lips.
- Completes bathroom trips with rest pauses and no distress.

Linking the data to the diagnosis

The patient has COPD and his oxygen saturation drops to 85% after walking to the bathroom, compared with 93% at rest on oxygen. His breathing rate is 28/min and his lips are slightly blue. He says he gets very short of breath just walking. This is an actual, urgent problem, so help is called first if readings stay low. Poor oxygen exchange in the lungs is a similar statement, but this one focuses on the need for oxygen support to keep levels safe. The plan aims to keep saturation at the doctor's target at rest and with activity within 48 hours, with no blue lips and bathroom trips done with rest pauses.

B9 Needs breathing machine support

Group: Breathing and circulation | Type: Actual problem

- **Definition:** The person cannot breathe well alone and relies on a ventilator or similar device.
- **Possible causes:** Respiratory failure; surgery; brain injury; severe weakness
- **Signs and symptoms:** Connected to a ventilator; unable to breathe alone; sedated; breathing tube in place

Scenario

A sedated ICU patient after a head injury relies fully on a ventilator.

Subjective (S): (Sedated and unable to speak.) Family: "He couldn't breathe on his own after the accident."

Objective (O): On a ventilator with ordered settings; sedated; oxygen saturation 96%; secretions suctioned every 2 hours; head of bed raised 30 degrees.

Assessment tools for this scenario: **CP-BREATH** Breathing & Circulation Check (p. 265)

Validated scales to consider: NEWS2, SpO₂, ECG

CarePath diagnosis: Needs breathing machine support related to respiratory failure, as evidenced by connected to a ventilator and unable to breathe alone.

Interventions and rationale

Intervention	Rationale
Check tube position and ventilator settings.	Correct tube position ensures air reaches both lungs, and checking settings confirms the machine delivers the ordered breaths and oxygen.
Suction as needed.	Suction removes secretions that a sedated patient cannot cough up, keeping the tube and airways open.
Give mouth care.	Mouth care reduces germs that could be breathed into the lungs and cause ventilator-related pneumonia.
Keep head raised.	A raised head lowers the chance that stomach contents or mouth secretions run into the lungs.
Prevent tube pulling.	Pulling out the breathing tube can cause sudden loss of the airway and injury, so securing it and preventing tugging is vital.
Keep talking to the patient.	Hearing is often kept during sedation, so talking reassures the patient, reduces distress and respects dignity.

Expected outcomes

- Oxygen saturation stays at target.
- No accidental tube removal.
- No ventilator-related pneumonia.
- Weaning begins when the doctor orders.
- Mouth care done every 4 hours.

Linking the data to the diagnosis

The patient is sedated in intensive care after a head injury and relies fully on a ventilator. Family say he could not breathe on his own after the accident. The nurse records oxygen saturation 96%, secretions suctioned every 2 hours and the head of the bed raised 30 degrees. This is an actual problem because he cannot breathe alone now. Poor oxygen exchange in the lungs would describe lung failure in general, but this statement fits because the care centers on the machine and the breathing tube. The plan aims to keep oxygen at target, prevent tube removal and ventilator-related pneumonia, start weaning when ordered, and give mouth care every 4 hours.

B10 Swollen legs or feet

Group: Breathing and circulation | Type: Actual problem

- **Definition:** Fluid builds up in the lower limbs, causing puffiness, tightness, or heaviness.
- **Possible causes:** Heart failure; kidney problems; long sitting; low protein; vein problems

- **Signs and symptoms:** Puffy or tight skin; a dent that stays when pressed; shoes feel tight; heavy legs

Scenario

An older woman's ankles are swollen and leave a dent when pressed.

Subjective (S): "My shoes don't fit and my legs feel heavy."

Objective (O): Both ankles swollen with pitting 2+; weight up 1.5 kg in a week; skin tight and shiny; blood pressure 140/85.

Assessment tools for this scenario: **CP-BREATH** Breathing & Circulation Check (p. 265) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: NEWS2, SpO₂, ECG, Braden Scale, TIME wound chart, MUST, fluid chart, glucose

CarePath diagnosis: Swollen legs or feet related to fluid retention, as evidenced by 2+ pitting swelling of both ankles, weight up 1.5 kg in a week, and tight, shiny skin.

Interventions and rationale

Intervention	Rationale
Raise legs when sitting.	Raising the legs uses gravity to help fluid drain back toward the heart, which lowers swelling.
Weigh daily.	Daily weight is a reliable way to see fluid gain or loss, since about 1 kg of weight is roughly 1 liter of fluid.
Follow salt and fluid advice.	Less salt and controlled fluids reduce the water held in the body and so the swelling.
Check skin for breakdown.	Swollen, tight skin is fragile and has less blood supply, so it breaks down easily. Checking finds early damage.
Give diuretics as ordered.	Diuretics help the kidneys remove extra fluid and salt, which reduces swelling.

Expected outcomes

- Within 3 days: swelling reduced and weight moving toward target.
- Skin stays intact.
- Patient raises legs correctly and states salt and fluid advice.

Linking the data to the diagnosis

The older woman has both ankles swollen with 2+ pitting, tight shiny skin, weight up 1.5 kg in a week and blood pressure 140/85. She says her shoes do not fit and her legs feel heavy. This is an actual problem because the swelling is already present and leaves a dent when pressed. Fluid build-up in the body is a wider statement about total body fluid, while this one is limited to the legs and feet and so fits the local findings. The plan aims for less swelling and weight moving toward target within 3 days, intact skin, and the patient raising her legs correctly and stating the salt and fluid advice.

B11 Irregular heartbeat

Group: Breathing and circulation | Type: Actual problem

- **Definition:** The heart rhythm is too fast, too slow, or uneven, which may cause palpitations, dizziness, or weakness.
- **Possible causes:** Heart disease; electrolyte imbalance; stimulants; stress
- **Signs and symptoms:** Pounding or skipping heartbeat; uneven pulse; dizziness; fainting; chest discomfort

Scenario

A patient says "my heart is skipping" and the monitor shows an uneven rhythm.

Subjective (S): "My heart is skipping and I feel dizzy."

Objective (O): Pulse irregular at 120/min; monitor shows uneven rhythm; blood pressure 105/68; oxygen saturation 96%.

Assessment tools for this scenario: CP-BREATH Breathing & Circulation Check (p. 265) · CP-SKIN

Skin & Wound Score (p. 270)

Validated scales to consider: NEWS2, SpO₂, ECG, Braden Scale, TIME wound chart

CarePath diagnosis: Irregular heartbeat related to heart disease, as evidenced by pounding or skipping heartbeat and uneven pulse.

Interventions and rationale

Intervention	Rationale
Check pulse and blood pressure.	Pulse and blood pressure show how the uneven rhythm is affecting blood flow, since a fast irregular rhythm can lower the heart's output.
Connect to monitor if ordered.	A monitor shows the exact rhythm continuously, so changes are seen promptly and the doctor can identify the type.
Report symptoms.	Reporting symptoms such as dizziness or chest pain gives the doctor the information needed to judge urgency and treat.
Give heart rhythm medicine as ordered.	Rhythm medicines help control the heart rate or restore a steady rhythm, which improves pumping.
Keep the patient calm.	Anxiety releases stress hormones that can speed the heart and worsen palpitations, so staying calm helps.

Expected outcomes

- Heart rate and rhythm within the doctor's range.
- No dizziness or fainting.
- Patient names when to report palpitations or chest pain.

Linking the data to the diagnosis

The patient says his heart is skipping and he feels dizzy. The nurse finds an irregular pulse of 120/min, an uneven rhythm on the monitor, blood pressure 105/68 and oxygen saturation 96%. This is an actual problem because the abnormal rhythm is already present and measured. Weak heart pumping could follow if the rhythm lowers blood flow, but the finding here is the rhythm itself, so this statement is the better fit. The plan aims for heart rate and rhythm within the doctor's range, no dizziness or fainting, and the patient naming when to report palpitations or chest pain.

B12 Dizzy when standing up

Group: Breathing and circulation | Type: Risk problem

- **Definition:** Blood pressure drops on standing, so the person may feel faint or fall.
- **Risk factors:** Dehydration; blood pressure medicine; long bed rest; older age
- **Warning signs to watch for:** Light-headedness or darkening vision on standing; holding on to furniture; falls

Scenario

An older man on a water tablet and a blood pressure tablet has been drinking little and has spent two days in bed.

Subjective (S): "I have not been drinking much and I have been in bed a lot."

Objective (O): Blood pressure 138/82 lying and 128/76 standing; pulse 76/min lying; dry lips; on blood pressure tablets; 2 days in bed; no dizziness reported.

Assessment tools for this scenario: **CP-BREATH** Breathing & Circulation Check (p. 265) · **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: NEWS2, SpO₂, ECG, Braden Scale, TIME wound chart

CarePath diagnosis: Dizzy when standing up related to dehydration, blood pressure medicine and long bed rest (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Check lying and standing blood pressure.	Comparing lying and standing blood pressure detects a drop on standing, the early sign of this problem, before symptoms appear.
Have him sit on the bed edge before standing.	Sitting first lets blood pressure adjust gradually, since blood pools in the legs on standing after time in bed.
Rise slowly.	Rising slowly gives vessels time to tighten, preventing a sudden drop in blood flow to the brain.
Encourage fluids.	Drinking restores blood volume lost through poor intake and the water tablet, which supports a stable pressure.
Assist when walking.	Helping him walk prevents a fall if he becomes light-headed.

Expected outcomes

- Within 48 hours: no fainting or falls and standing blood pressure within 20 mmHg of lying.
- Patient demonstrates slow position changes and says why.

Linking the data to the diagnosis

This is a risk statement: the problem has not occurred yet. The older man takes a water tablet and a blood pressure tablet, has been drinking little and has spent two days in bed. He has dry lips and reports no dizziness. Blood pressure is 138/82 lying and 128/76 standing, a fall of 10 mmHg, so the drop is not yet significant. The diagnosis rests on risk factors, not on found signs. The plan aims for no fainting or falls in 48 hours, standing pressure within 20 mmHg of lying, and the patient showing slow position changes and saying why.

B13 Poor blood flow to the brain **URGENT**

Group: Breathing and circulation | Type: Risk problem

- **Definition:** Reduced blood supply to the brain may cause confusion, weakness, or changes in speech or vision.
- **Risk factors:** Stroke; narrowed neck arteries; low blood pressure; clots
- **Warning signs to watch for:** Sudden weakness on one side; slurred speech; vision loss; severe headache; confusion

Scenario

A 74-year-old with an irregular heartbeat and narrowed neck arteries is not taking her blood thinner regularly.

Subjective (S): "I forget my blood thinner some days."

Objective (O): Irregular pulse 92/min; blood pressure 168/96; known narrowing of neck arteries; missed blood-thinner doses; no weakness, speech or vision change.

Assessment tools for this scenario: **CP-BREATH** Breathing & Circulation Check (p. 265) · **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: NEWS2, SpO₂, ECG, Braden Scale, TIME wound chart

CarePath diagnosis: Poor blood flow to the brain related to narrowed neck arteries, irregular heartbeat and missed blood thinner (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Check blood pressure and pulse, and do a quick brain check (face, arm, speech) each shift.	Blood pressure, pulse and a quick face, arm and speech check find early changes. High pressure and an irregular rhythm both raise stroke risk.
Give the blood thinner as ordered and explain why every dose matters.	The blood thinner lowers clot formation caused by the irregular heartbeat. Skipped doses remove that protection, so understanding why helps her take every dose.
Teach the signs of stroke: face drooping, arm weakness, slurred speech.	Knowing the signs lets the patient and others recognize a stroke fast, because earlier treatment saves more brain tissue.
If any sign appears: note the time it began, call the emergency team at once and give nothing by mouth.	The onset time decides which clot treatments are possible and the emergency team gives the fastest care. Nothing by mouth because swallowing may be impaired and she could choke.
Support the patient to stop smoking and follow a pill routine.	Smoking damages arteries and raises clotting risk, and a pill routine helps her remember doses.

Expected outcomes

- No new weakness, speech change or vision loss during the stay.
- Patient names the warning signs of stroke and whom to call.
- Patient takes the blood thinner on time and states why it matters.
- If a sign appears: onset time recorded and emergency team called within minutes.

Linking the data to the diagnosis

This is a risk statement: no stroke or brain symptoms have occurred. The 74-year-old has an irregular pulse of 92/min, blood pressure 168/96, known narrowing of the neck arteries and missed blood thinner doses. She says she forgets it some days, and there is no weakness, speech or vision change. The diagnosis rests on these risk factors. The problem is urgent if a sign appears, so help is called first. The plan aims for no new weakness, speech change or vision loss, the patient naming warning signs and whom to call, taking the thinner on time, and onset time recorded with the emergency team called within minutes if needed.

B14 Very low blood circulation (shock) URGENT

Group: Breathing and circulation | Type: Risk problem

- **Definition:** Circulation may become too weak to supply vital organs, which is an emergency needing rapid action.
- **Risk factors:** Severe bleeding; infection; heart failure; severe allergy

- **Warning signs to watch for:** Fast weak pulse; very low blood pressure; cold clammy skin; confusion; little urine

Scenario

A trauma patient with a pelvic fracture is stable but has lost a large amount of blood at the scene.

Subjective (S): "I feel a little light-headed."

Objective (O): Pulse 104/min; blood pressure 112/70; respiratory rate 20/min; skin pale but warm; urine output 40 mL in the last hour; pelvic fracture; estimated blood loss 600 mL.

Assessment tools for this scenario: **CP-BREATH** Breathing & Circulation Check (p. 265) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-ELIM** Elimination Check (p. 267)

Validated scales to consider: NEWS2, SpO₂, ECG, Braden Scale, TIME wound chart, Bristol Stool Chart, bladder scan

CarePath diagnosis: Very low blood circulation (shock) related to severe bleeding (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Check pulse, blood pressure, breathing, skin and mental state every 15 minutes.	Frequent checks catch early signs of shock, such as a rising pulse or falling pressure, in time to act, since bleeding can worsen quickly.
Control any bleeding and keep the patient warm.	Controlling bleeding stops further loss of blood volume, and warmth prevents chilling, which worsens circulation and clotting.
Give oxygen and fluids or blood as ordered.	Oxygen helps the remaining red cells deliver oxygen to organs, and fluids or blood restore the volume that keeps organs supplied.
Record urine output every hour.	Urine output reflects blood flow to the kidneys, so falling output is an early sign that organs are not getting enough blood.
Call emergency help at once if pulse is above 120/min, systolic pressure below 90, skin cold and clammy, or the patient is confused.	These signs mean shock is developing, which can quickly become fatal, so immediate expert help is needed.

Expected outcomes

- Pulse and blood pressure stay within the doctor's targets during treatment.
- Urine output stays at or above 30 mL/hour.
- Skin stays warm and the patient stays alert.
- No signs of shock develop; if they do, help is called within minutes.

Linking the data to the diagnosis

This is a risk statement: shock has not developed yet. The trauma patient has a pelvic fracture and an estimated blood loss of 600 mL. He says he feels a little light-headed. Pulse is 104/min, blood pressure 112/70, respiratory rate 20/min, skin pale but warm, and urine output 40 mL in the last hour. These findings are not shock, so the diagnosis rests on the risk from severe bleeding. It is urgent: if the listed warning signs appear, help is called first. The plan aims to keep pulse, pressure and urine output (30 mL/hour or more) in target, with warm skin and an alert patient.

F - Food and fluids

Recommended assessment tools

CarePath tool: **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales: MUST, fluid chart, glucose

F1 Not eating enough to meet body needs

Group: Food and fluids | Type: Actual problem

- **Definition:** Food intake is too low to supply the energy and nutrients needed for health and healing.
- **Possible causes:** Illness; poor appetite; mouth pain; poverty; nausea; depression
- **Signs and symptoms:** Weight loss; eating less than half of meals; weakness; hair or skin changes

Scenario

A patient with cancer eats only a few bites and has lost 5 kg in a month.

Subjective (S): "I just don't feel like eating."

Objective (O): Eats only 2-3 bites per meal; weight down 5 kg in one month; BMI 17.8; dry skin.

Assessment tools for this scenario: **CP-FLUID** Fluid Balance & Nutrition Score (p. 266) · **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: MUST, fluid chart, glucose, Braden Scale, TIME wound chart

CarePath diagnosis: Not eating enough to meet body needs related to illness, as evidenced by weight loss and eating less than half of meals.

Interventions and rationale

Intervention	Rationale
Weigh weekly.	Weekly weight shows the trend and tells whether the nutrition plan is working.
Offer small frequent meals.	Small frequent meals are less overwhelming than large ones and easier to finish when appetite is poor.
Involve a dietitian.	A dietitian calculates his needs and plans energy-dense foods that suit his illness.
Treat nausea and mouth pain.	Nausea and mouth pain are common reasons for not eating, so treating them removes barriers to eating.
Give supplements if ordered.	Supplements add calories and protein when food alone is not enough.
Record intake.	Recording intake shows how much is really eaten, so the team can see progress and adjust the plan.

Expected outcomes

- Within 1 week: eats at least 75% of meals.
- By discharge: weight stable or rising.
- Patient chooses high-energy foods and accepts supplements.

Linking the data to the diagnosis

The patient has cancer and eats only 2-3 bites per meal. Weight is down 5 kg in one month, BMI is 17.8 and the skin is dry. He says he just does not feel like eating. This is an actual problem because the shortfall in intake and the weight loss are already happening. Poor appetite describes the lack of desire to eat, while this statement covers the result, intake too low for body needs, so it fits better. The plan

aims for eating at least 75% of meals within 1 week, stable or rising weight by discharge, and the patient choosing high-energy foods and accepting supplements.

F2 Eating more than the body needs

Group: Food and fluids | Type: Actual problem

- **Definition:** Intake is higher than the body uses, leading to unhealthy weight gain.
- **Possible causes:** Large portions; low activity; stress eating; medicines; thyroid problems
- **Signs and symptoms:** Weight above the healthy range; eating when not hungry; breathlessness on effort

Scenario

A man with diabetes has gained 10 kg and snacks late at night.

Subjective (S): "I snack at night when I'm bored."

Objective (O): Weight 98 kg, BMI 34; blood sugar 11 mmol/L; waist 112 cm; diet history shows large evening portions.

Assessment tools for this scenario: CP-FLUID Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: MUST, fluid chart, glucose

CarePath diagnosis: Eating more than the body needs related to large portions, as evidenced by weight above the healthy range and eating when not hungry.

Interventions and rationale

Intervention	Rationale
Assess eating habits.	Learning when and why he eats, such as evening snacks from boredom, shows what to target.
Set small realistic goals.	Small goals are more achievable and build confidence, which lasts longer than drastic changes.
Teach portion control and activity.	Portion control and activity lower energy intake and raise energy use, which improves weight and blood sugar.
Involve a dietitian.	A dietitian tailors a plan to his diabetes and food preferences.
Praise progress.	Praise motivates, supports self-esteem and helps him keep up the changes.

Expected outcomes

- Within 1 week: sets 2 realistic eating goals.
- Over 4 weeks: loses 0.5-1 kg per week.
- Names 3 portion-control strategies.

Linking the data to the diagnosis

The man has diabetes and has gained 10 kg. He weighs 98 kg with a BMI of 34 and a waist of 112 cm, blood sugar is 11 mmol/L, and the diet history shows large evening portions. He says he snacks at night when he is bored. This is an actual problem because the excess intake and weight gain are already present, so a risk statement is not needed. Unsteady blood sugar could be confused with it, but the sugar is a result here, not the main problem. The plan aims for two realistic eating goals in 1 week, loss of 0.5-1 kg per week over 4 weeks, and three portion-control strategies named.

F3 Dehydration

Group: Food and fluids | Type: Actual problem

- **Definition:** The body has too little water, shown by thirst, dry mouth, dark urine, or low blood pressure.
- **Possible causes:** Vomiting; diarrhea; poor drinking; fever; diuretics; burns
- **Signs and symptoms:** Thirst; dry mouth; dark urine; low blood pressure; fast pulse; sunken eyes

Scenario

A child with diarrhea has dry lips, sunken eyes, and no tears.

Subjective (S): "I'm so thirsty and tired."

Objective (O): Dry mucous membranes; sunken eyes; heart rate 126/min in a child; reduced skin elasticity; dark scant urine; weight down 0.5 kg.

Assessment tools for this scenario: **CP-FLUID** Fluid Balance & Nutrition Score (p. 266) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-ELIM** Elimination Check (p. 267)

Validated scales to consider: MUST, fluid chart, glucose, Braden Scale, TIME wound chart, Bristol Stool Chart, bladder scan

CarePath diagnosis: Dehydration related to diarrhea, as evidenced by dry mucous membranes, sunken eyes, a fast heart rate, and dark scant urine.

Interventions and rationale

Intervention	Rationale
Measure intake and output.	Measuring intake and output shows whether fluid losses are being replaced and how the kidneys are coping.
Give oral rehydration or intravenous fluids as ordered.	Oral rehydration solution replaces water and salts, and intravenous fluids are used when drinking is not enough or not safe.
Weigh.	Weight changes, especially in a child, reflect fluid loss or gain accurately.
Report low urine output.	Low urine output signals that fluid is still too low and the kidneys are not getting enough blood, so stronger treatment may be needed.

Expected outcomes

- Within 12 hours: urine pale and normal in amount, mucous membranes moist, heart rate and blood pressure normal for age.
- Drinks fluids willingly.

Linking the data to the diagnosis

The child has diarrhea, dry lips, sunken eyes and no tears. The nurse finds dry mucous membranes, heart rate 126/min, reduced skin elasticity, dark scant urine and weight down 0.5 kg. The patient says they are very thirsty and tired. This is an actual problem because fluid loss is already shown by these signs, so a risk statement would be wrong. Fluid build-up in the body is the opposite problem and does not apply. The plan aims for pale urine in normal amounts, moist mucous membranes and a normal heart rate and blood pressure for age within 12 hours, with the child drinking willingly.

F4 Fluid build-up in the body

Group: Food and fluids | Type: Actual problem

- **Definition:** The body holds too much fluid, causing swelling, quick weight gain, or breathlessness.
- **Possible causes:** Heart failure; kidney failure; too much intravenous fluid; liver disease
- **Signs and symptoms:** Swelling; quick weight gain; breathlessness; bulging neck veins

Scenario

A dialysis patient gains 3 kg between sessions and has swollen ankles.

Subjective (S): "My ankles are swollen and I get breathless."

Objective (O): Weight up 3 kg between dialysis sessions; pitting edema 2+; blood pressure 168/94; neck veins distended.

Assessment tools for this scenario: **CP-FLUID** Fluid Balance & Nutrition Score (p. 266) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-BREATH** Breathing & Circulation Check (p. 265)

Validated scales to consider: MUST, fluid chart, glucose, Braden Scale, TIME wound chart, NEWS2, SpO₂, ECG

CarePath diagnosis: Fluid build-up in the body related to kidney failure and fluid taken between dialysis sessions, as evidenced by 2+ swelling, a 3 kg weight gain, and distended neck veins.

Interventions and rationale

Intervention	Rationale
Measure fluids in and out.	Measuring fluids in and out shows whether more fluid is being kept than lost.
Weigh daily.	Daily weight is the most reliable sign of fluid change, because each kilogram gained is about a liter of fluid.
Limit fluids and salt as ordered.	Salt holds water in the body, so limiting salt and fluid reduces build-up, especially when the kidneys cannot remove it.
Raise legs.	Raising the legs helps fluid drain from the ankles back into the circulation.
Give diuretics as ordered.	Diuretics increase urine output to remove extra fluid, and are given as ordered because their effect depends on how well the kidneys work.

Expected outcomes

- Weight gain between sessions under the doctor's target (often under 2 kg).
- Swelling reduced.
- Breathing comfortable.
- Patient states the fluid limit and a plan to keep to it.

Linking the data to the diagnosis

The dialysis patient gained 3 kg between sessions and has pitting edema 2+, blood pressure 168/94 and distended neck veins. He says his ankles are swollen and he gets breathless. This is an actual problem because extra fluid is already being held. Fluid in the lungs could be confused with it, but no frothy sputum or very low oxygen is described, so this wider fluid statement fits better. The plan aims for weight gain between sessions under the doctor's target (often under 2 kg), less swelling, comfortable breathing, and the patient stating the fluid limit and a plan to keep to it.

F5 Unsteady blood sugar URGENT

Group: Food and fluids | Type: Risk problem

- **Definition:** Blood sugar may swing too high or too low because of illness, diet, or medicine.
- **Risk factors:** Diabetes; insulin or tablets; skipped meals; infection; steroids
- **Warning signs to watch for:** Shaking, sweating, hunger (low sugar); thirst and frequent urination (high sugar); unusual readings

Scenario

A patient with diabetes has taken insulin before lunch, but lunch is late and she has just had a chest infection.

Subjective (S): "I took my insulin but lunch has not come yet."

Objective (O): Blood sugar 5.2 mmol/L before lunch; insulin given 30 minutes ago; lunch delayed; recent infection; no sweating or shaking.

Assessment tools for this scenario: **CP-FLUID** Fluid Balance & Nutrition Score (p. 266) · **CP-INFECT** Infection Check (p. 281)

Validated scales to consider: MUST, fluid chart, glucose, qSOFA / sepsis screen

CarePath diagnosis: Unsteady blood sugar related to insulin, a delayed meal and infection (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Check blood sugar before meals and if symptoms appear.	Checking before meals and when symptoms appear finds high or low sugar early, before harm occurs.
Call the kitchen and give a snack if the meal is late.	Insulin keeps working whether or not food arrives, so a late meal risks low sugar. A snack covers the gap.
Treat blood sugar below 4 mmol/L at once per protocol and recheck in 15 minutes.	Blood sugar below 4 mmol/L can quickly cause confusion or loss of consciousness. Fast sugar corrects it and rechecking confirms it worked.
Teach the warning signs of low and high sugar.	Knowing the signs, such as shaking, sweating or thirst, lets her act early.
Record readings.	Records show patterns, which helps the doctor adjust insulin and meal timing.

Expected outcomes

- Blood sugar stays in the doctor's target range with no readings below 4 mmol/L.
- Patient states warning signs and how to treat them.
- Meals matched to insulin timing.

Linking the data to the diagnosis

This is a risk statement: the blood sugar has not become unsafe yet. The patient has diabetes, took insulin 30 minutes ago, lunch is delayed and she has just had a chest infection. Blood sugar is 5.2 mmol/L before lunch, and she has no sweating or shaking. She says lunch has not come yet. The diagnosis rests on these risk factors. It is urgent because a fall below 4 mmol/L needs treatment at once, so help is called first if it happens. The plan aims for sugar in the doctor's range with no readings below 4 mmol/L, warning signs stated by the patient, and meals matched to insulin timing.

F6 Trouble chewing or swallowing

Group: Food and fluids | Type: Actual problem

- **Definition:** Chewing or swallowing is painful or unsafe, with coughing or choking at meals.
- **Possible causes:** Stroke; mouth or throat problems; weak muscles; dementia
- **Signs and symptoms:** Coughing or choking at meals; wet voice; food held in cheeks; drooling; very slow meals

Scenario

After a stroke, a patient coughs every time he drinks water.

Subjective (S): "It feels like the water goes the wrong way."

Objective (O): Coughs after each sip of water; wet gurgling voice; right facial droop; failed bedside swallow screen.

Assessment tools for this scenario: CP-FLUID Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: MUST, fluid chart, glucose

CarePath diagnosis: Trouble chewing or swallowing related to stroke, as evidenced by coughing or choking at meals and wet voice.

Interventions and rationale

Intervention	Rationale
Screen swallowing.	A swallow screen shows whether swallowing is safe before food or drink can go into the lungs.
Sit upright for meals.	An upright position uses gravity and helps the airway close properly, lowering the risk of food entering it.
Follow texture advice from the speech therapist.	The speech therapist knows which food and drink textures he can swallow safely.
Supervise eating.	Supervision lets the nurse notice coughing or choking quickly and help.
Give mouth care.	Mouth care removes bacteria, so if saliva or food does enter the lungs, there are fewer germs to cause pneumonia.

Expected outcomes

- No choking or aspiration during the stay.
- Within 48 hours: safe diet level confirmed by the speech therapist.
- Patient eats and drinks safely following advice.

Linking the data to the diagnosis

After a stroke the patient coughs after each sip of water, has a wet gurgling voice, a right facial droop and failed the bedside swallow screen. He says the water goes the wrong way. This is an actual problem because the swallowing difficulty is already shown. A statement about not eating enough would miss the safety issue, since the danger here is food or fluid entering the airway. The plan aims for no choking or aspiration during the stay, a safe diet level confirmed by the speech therapist within 48 hours, and the patient eating and drinking safely by following advice.

F7 Vomiting

Group: Food and fluids | Type: Actual problem

- **Definition:** Repeated throwing up that may lead to fluid loss, weakness, and poor intake.
- **Possible causes:** Stomach infection; medicines; blockage; pregnancy; chemotherapy
- **Signs and symptoms:** Repeated throwing up; nausea; dry mouth; weakness; weight loss

Scenario

A patient on chemotherapy vomits four times after dinner.

Subjective (S): "I keep throwing up and can't keep anything down."

Objective (O): Vomited four times in 3 hours; dry mouth; weight down 1 kg; pulse 102/min; on chemotherapy.

Assessment tools for this scenario: CP-FLUID Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: MUST, fluid chart, glucose

CarePath diagnosis: Vomiting related to chemotherapy, as evidenced by four episodes of vomiting in 3 hours, dry mouth, and a pulse of 102/min.

Interventions and rationale

Intervention	Rationale
Give anti-sickness medicine as ordered.	Anti-sickness medicine blocks nausea signals, which stops further vomiting and helps keep fluids down.
Keep upright.	An upright position lowers the risk of vomit entering the lungs and eases nausea.
Offer small sips.	Small sips are easier to keep down than large drinks and start replacing lost fluid.
Protect skin and airway.	Vomit irritates skin and can block the airway if the patient is weak, so keeping skin clean and the airway clear prevents harm.
Record amounts.	Recording amounts shows how much fluid is lost and helps decide how much to replace.
Replace fluids.	Replacing fluids corrects the water and salt lost through repeated vomiting. The route follows the doctor's orders.
Give mouth care.	Vomiting leaves a sour taste and can damage the mouth lining, so mouth care adds comfort and protects it.

Expected outcomes

- Within 24 hours: vomiting stops or falls to once a day or less, takes sips without nausea, hydration signs normal.
- Patient reports less nausea.

Linking the data to the diagnosis

The patient is on chemotherapy and vomited four times in 3 hours. The nurse finds a dry mouth, weight down 1 kg and pulse 102/min. He says he keeps throwing up and cannot keep anything down. This is an actual problem because the vomiting is already happening. Dehydration could follow, but it has not been shown here, so this statement is the main one. The plan aims for vomiting to stop or fall to once a day or less within 24 hours, sips taken without nausea, normal hydration signs and less nausea reported by the patient.

F8 Needs tube feeding

Group: Food and fluids | Type: Actual problem

- **Definition:** Food and fluids must be given through a tube, which needs careful care and monitoring.
- **Possible causes:** Cannot swallow safely; unconscious; severe illness; gut surgery
- **Signs and symptoms:** Feeding tube in nose or stomach; relies on prescribed feeds; risk of tube blockage

Scenario

A stroke patient receives nutrition through a nasogastric tube.

Subjective (S): (Unable to swallow.) Wife: "He can't eat anymore since the stroke."

Objective (O): Nasogastric tube in place at the marked length; feeds running at the ordered rate; head of bed 35 degrees; weight steady.

Assessment tools for this scenario: CP-FLUID Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: MUST, fluid chart, glucose

CarePath diagnosis: Needs tube feeding related to cannot swallow safely, as evidenced by feeding tube in nose or stomach and relies on prescribed feeds.

Interventions and rationale

Intervention	Rationale
Check tube position before each feed.	A tube in the wrong place, such as the lungs, can cause serious harm if feed is given, so checking confirms the stomach before feeding.
Keep head raised at least 30 degrees.	A raised head prevents feed flowing back up and entering the lungs.
Flush as ordered.	Flushing keeps the tube clear of blocking feed and medicine.
Give mouth care.	Without eating, the mouth dries and germs grow, so mouth care keeps it clean and comfortable.
Watch for vomiting or diarrhea.	Vomiting or diarrhea may mean a problem with feed rate, position or tolerance that needs a change.

Expected outcomes

- Receives full prescribed nutrition by tube.
- No aspiration, vomiting, or diarrhea.
- Tube stays in place and open.
- Mouth stays clean and moist.

Linking the data to the diagnosis

The stroke patient cannot swallow and receives all nutrition through a nasogastric tube. His wife says he cannot eat anymore since the stroke. The nurse finds the tube in place at the marked length, feeds running at the ordered rate, the head of the bed at 35 degrees and weight steady. This is an actual problem because he depends on the tube now. A statement about trouble swallowing would describe the cause, but this one fits the nursing care of the tube and feeds. The plan aims for full prescribed nutrition, no aspiration, vomiting or diarrhea, a tube that stays in place and open, and a clean moist mouth.

F9 Breastfeeding difficulty

Group: Food and fluids | Type: Actual problem

- **Definition:** The mother or baby struggles with latch, milk flow, or comfort during breastfeeding.
- **Possible causes:** Poor latch; sore nipples; low milk; tongue-tie; stress or lack of support
- **Signs and symptoms:** Baby fussy at feeds; poor weight gain; cracked nipples; few wet diapers

Scenario

A new mother cries because the baby keeps slipping off the breast and her nipples are sore.

Subjective (S): "It hurts so much when she latches and I'm afraid I'm not feeding her enough."

Objective (O): Nipples cracked and red; baby latches shallowly; baby lost 8% of birth weight by day 4; 4 wet diapers in 24 hours.

Assessment tools for this scenario: **CP-FLUID** Fluid Balance & Nutrition Score (p. 266) · **CP-PAIN**

Pain & Comfort Score (p. 268) · **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: MUST, fluid chart, glucose, NRS 0–10, FLACC, PAINAD, Braden Scale, TIME wound chart

CarePath diagnosis: Breastfeeding difficulty related to poor latch, as evidenced by baby fussy at feeds and poor weight gain.

Interventions and rationale

Intervention	Rationale
Teach positions and latch.	A good position and deep latch let the baby take milk well and prevent nipple damage.
Encourage skin-to-skin contact.	Skin-to-skin contact calms the baby, triggers feeding cues and supports milk release.
Treat soreness.	Treating sore nipples relieves pain so the mother can keep feeding instead of stopping.
Refer to a lactation specialist.	A lactation specialist gives skilled, hands-on help with latch and milk supply beyond routine care.
Review diapers and weight.	Wet diapers and weight show whether the baby is getting enough milk, which confirms or eases the mother's worry.

Expected outcomes

- Within 1 week: baby latches deeply and feeds 8-12 times per 24 hours.
- At least 6 wet diapers per day by day 5.
- Mother reports less pain and names positions she can use.

Linking the data to the diagnosis

The new mother has cracked, red nipples and the baby latches shallowly and keeps slipping off. The baby lost 8% of birth weight by day 4 and had 4 wet diapers in 24 hours. The mother says it hurts and she fears she is not feeding enough. This is an actual problem because the feeding trouble and weight loss are already present. Not eating enough to meet body needs would describe the baby's intake only, while this statement includes the latch and the mother's pain. The plan aims for a deep latch with 8-12 feeds per 24 hours within 1 week, at least 6 wet diapers by day 5, and less pain with positions named.

F10 Body salts out of balance

Group: Food and fluids | Type: Risk problem

- **Definition:** Levels of salts such as sodium or potassium may become unsafe.
- **Risk factors:** Vomiting; diarrhea; kidney disease; diuretics; fluid shifts
- **Warning signs to watch for:** Weakness; cramps; confusion; irregular heartbeat; abnormal blood tests

Scenario

A patient on strong water tablets for heart failure has had two days of diarrhea.

Subjective (S): "I have had loose stools and I am passing a lot of urine."

Objective (O): On high-dose diuretic; 6 loose stools in 24 hours; potassium 3.8 mmol/L (low-normal); pulse regular 80/min; no cramps or weakness.

Assessment tools for this scenario: CP-FLUID Fluid Balance & Nutrition Score (p. 266) · CP-ELIM Elimination Check (p. 267)

Validated scales to consider: MUST, fluid chart, glucose, Bristol Stool Chart, bladder scan

CarePath diagnosis: Body salts out of balance related to diuretics and diarrhea (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Check blood results.	Blood results show potassium and sodium levels so a fall is caught early.
Give replacements as ordered.	Replacements restore low salts before they cause weakness or a dangerous heart rhythm.
Monitor heart rhythm.	Low potassium can cause an irregular heartbeat, so monitoring detects it early.
Report symptoms.	Cramps, weakness or confusion can be the first signs of imbalance, and reporting them prompts testing.
Teach diet and medicine advice.	Knowing which foods and medicines help keeps levels safe after discharge.

Expected outcomes

- Within 48 hours: potassium and sodium back in the normal range, no cramps or irregular heartbeat.
- Patient names food and medicine advice.

Linking the data to the diagnosis

This is a risk statement: the salt imbalance has not occurred yet. The patient takes a high-dose diuretic and has had 6 loose stools in 24 hours. Potassium is 3.8 mmol/L (low-normal), the pulse is regular at 80/min, and there are no cramps or weakness. She says she has loose stools and is passing a lot of urine. The diagnosis rests on the risk factors of diuretic use and diarrhea. The plan aims for potassium and sodium in the normal range within 48 hours, no cramps or irregular heartbeat, and the patient naming food and medicine advice.

F11 Poor appetite

Group: Food and fluids | Type: Actual problem

- **Definition:** The person has little desire to eat, so intake falls.
- **Possible causes:** Illness; depression; medicines; dental problems; loneliness
- **Signs and symptoms:** Leaves food on the plate; says not hungry; early fullness; weight drop

Scenario

An older woman living alone pushes her dinner away every day.

Subjective (S): "Nothing tastes good and I'm never hungry."

Objective (O): Leaves most meals; eats about 25% of dinner; lives alone; weight down 2 kg in a month.

Assessment tools for this scenario: CP-FLUID Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: MUST, fluid chart, glucose

CarePath diagnosis: Poor appetite related to illness, as evidenced by leaves food on the plate and says not hungry.

Interventions and rationale

Intervention	Rationale
Find the cause.	Appetite loss can come from nausea, pain, medicines or low mood, so treating the cause works better than just urging her to eat.
Offer favorite foods and small meals.	Favorite foods and small meals are more appealing and less overwhelming.
Make meals pleasant.	A pleasant setting and company make eating more enjoyable and raise intake.
Treat nausea or mouth pain.	Nausea and mouth pain make eating unpleasant, so relieving them removes a barrier.
Involve family and dietitian.	Family can give company and help at home, and the dietitian plans her nutrition.

Expected outcomes

- Within 1 week: eats at least 50% of meals and weight stable.
- Patient names 3 foods she can manage and has a plan for meals at home.

Linking the data to the diagnosis

The older woman lives alone and pushes her dinner away every day. She eats about 25% of dinner, leaves most meals and has lost 2 kg in a month. She says nothing tastes good and she is never hungry. This is an actual problem because the lack of appetite is already reducing her intake. Not eating enough to meet body needs is a close statement, but this one targets the cause, loss of desire to eat, so it fits better. The plan aims for at least 50% of meals eaten and stable weight within 1 week, three manageable foods named, and a plan for meals at home.

F12 Sore or damaged mouth

Group: Food and fluids | Type: Actual problem

- **Definition:** The lining of the mouth or gums is painful, dry, or ulcerated, making eating and speaking hard.
- **Possible causes:** Chemotherapy; poor mouth care; dehydration; dentures; infection
- **Signs and symptoms:** Red or white patches; ulcers; bleeding gums; pain when eating; bad breath

Scenario

A cancer patient has mouth ulcers and cannot eat solid food.

Subjective (S): "My mouth is so sore I can't chew."

Objective (O): Mouth ulcers on inner cheeks and tongue; red inflamed gums; eats only soft foods; on chemotherapy; pain 6/10 when eating.

Assessment tools for this scenario: **CP-FLUID** Fluid Balance & Nutrition Score (p. 266) · **CP-PAIN**

Pain & Comfort Score (p. 268) · **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: MUST, fluid chart, glucose, NRS 0–10, FLACC, PAINAD, Braden Scale, TIME wound chart

CarePath diagnosis: Sore or damaged mouth related to chemotherapy, as evidenced by red or white patches and ulcers.

Interventions and rationale

Intervention	Rationale
Give mouth care with a soft brush.	A soft brush cleans teeth and gums without further injuring tender tissue, and a clean mouth lowers infection risk.
Use rinses as ordered.	Ordered rinses soothe, clean or treat infection of the mouth lining.
Avoid spicy or hot food.	Spicy or hot food irritates ulcers and worsens pain.
Give pain relief before meals.	Pain relief before meals lets him chew and swallow more comfortably, so he eats more.
Check the mouth daily.	Daily checks find new ulcers, infection or bleeding early.

Expected outcomes

- Within 3 days: mouth pain 3/10 or lower, eats a soft diet comfortably, ulcers healing.
- Patient does mouth care correctly 4 times a day.

Linking the data to the diagnosis

The cancer patient is on chemotherapy and has mouth ulcers on the inner cheeks and tongue and red inflamed gums. Pain is 6/10 when eating and he manages only soft foods. He says his mouth is so sore he cannot chew. This is an actual problem because the mouth damage is already present. Not eating enough to meet body needs could follow, but the cause to treat here is the damaged mouth lining, so this statement is the right one. The plan aims for pain of 3/10 or lower, comfortable eating of a soft diet and healing ulcers within 3 days, with correct mouth care 4 times a day.

F13 Unplanned weight loss

Group: Food and fluids | Type: Actual problem

- **Definition:** The person is losing weight without trying, which may signal poor intake or illness.
- **Possible causes:** Poor intake; cancer; depression; infection; thyroid disease
- **Signs and symptoms:** Clothes looser; falling weight chart; muscle loss; weakness

Scenario

An older man has lost 6 kg in two months without dieting.

Subjective (S): "My clothes are loose and I'm not trying to lose weight."

Objective (O): Weight down 6 kg in 2 months; BMI 18.5; reduced muscle bulk; poor appetite.

Assessment tools for this scenario: **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: MUST, fluid chart, glucose

CarePath diagnosis: Unplanned weight loss related to poor intake, as evidenced by clothes looser and falling weight chart.

Interventions and rationale

Intervention	Rationale
Weigh regularly.	Regular weights show the trend and whether treatment is working.
Look for causes.	Unplanned weight loss can signal illness such as infection, cancer or thyroid disease, so finding the cause allows it to be treated.
Give high-energy foods and supplements.	High-energy foods and supplements give more calories in small amounts, which suits a poor appetite.
Involve a dietitian.	A dietitian plans nutrition to his needs.
Report ongoing loss to the doctor.	Ongoing loss despite effort may signal an untreated illness that needs doctor review.

Expected outcomes

- Within 2 weeks: weight stops falling and gradually rises.
- Cause of weight loss investigated.
- Patient eats high-energy small meals about 6 times a day.

Linking the data to the diagnosis

The older man has lost 6 kg in 2 months without dieting. His BMI is 18.5, muscle bulk is reduced and appetite is poor. He says his clothes are loose and he is not trying to lose weight. This is an actual problem because the loss has already happened. Not eating enough to meet body needs is a close statement, but the key finding here is the weight falling without intent, which may point to an illness that must be looked for. The plan aims for weight to stop falling and gradually rise within 2 weeks, the cause investigated, and the patient eating high-energy small meals about 6 times a day.

E - Elimination

Recommended assessment tools

CarePath tool: **CP-ELIM** Elimination Check (p. 267)

Validated scales: Bristol Stool Chart, bladder scan

E1 Hard or infrequent bowel movements

Group: Elimination | Type: Actual problem

- **Definition:** Stools are hard, dry, or rare, with straining or discomfort.
- **Possible causes:** Low fiber and fluids; inactivity; opioids; weak muscles; ignoring the urge
- **Signs and symptoms:** No stool for 3 days; hard dry stools; straining; belly swelling; poor appetite

Scenario

A patient on opioid pain medicine has not passed stool for four days.

Subjective (S): "I haven't had a bowel movement in four days and I feel bloated."

Objective (O): No stool for 4 days; abdomen distended and firm; on morphine; fluid intake 800 ml per day; sluggish bowel sounds.

Assessment tools for this scenario: **CP-ELIM** Elimination Check (p. 267) · **CP-PAIN** Pain & Comfort Score (p. 268) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: Bristol Stool Chart, bladder scan, NRS 0-10, FLACC, PAINAD, MUST, fluid chart, glucose

CarePath diagnosis: Hard or infrequent bowel movements related to opioid medicine and low fluid intake, as evidenced by no stool for 4 days and a firm, distended abdomen.

Interventions and rationale

Intervention	Rationale
Encourage fluids, fiber, and movement.	Fluid softens stool, fiber adds bulk and movement stimulates the gut, so stool moves along more easily.
Offer toilet privacy.	Privacy helps him relax and respond to the urge, since ignoring the urge makes stool harder and drier.
Give laxatives as ordered.	Laxatives soften or stimulate the bowel. Opioid constipation often needs them regularly, and they are given as ordered.
Keep a bowel chart.	A chart shows how long since the last stool and whether the plan is working.

Expected outcomes

- Within 24-48 hours: passes a soft formed stool, abdomen soft and comfortable.
- Drinks 1.5-2 liters per day unless limited.
- Patient states a bowel routine.

Linking the data to the diagnosis

The patient takes morphine and has had no stool for 4 days. The abdomen is distended and firm, bowel sounds are sluggish and fluid intake is only 800 ml per day. He says he is bloated. This is an actual problem because the constipation is already present. Frequent loose stools is the opposite problem and does not apply. The plan aims for a soft formed stool and a soft, comfortable abdomen within 24-48 hours, fluid intake of 1.5-2 liters per day unless limited, and the patient stating a bowel routine.

E2 Frequent loose stools

Group: Elimination | Type: Actual problem

- **Definition:** Watery or frequent stools that risk fluid loss, weakness, and skin damage.
- **Possible causes:** Stomach infection; antibiotics; medicines; food intolerance; stress
- **Signs and symptoms:** Watery stools many times a day; cramps; urgency; sore skin

Scenario

A hospital patient on antibiotics has seven watery stools in a day.

Subjective (S): "I keep running to the toilet and my bottom is sore."

Objective (O): 7 watery stools in 24 hours; skin around the anus red; temperature normal; on antibiotics.

Assessment tools for this scenario: CP-ELIM Elimination Check (p. 267) · CP-SKIN Skin & Wound Score (p. 270)

Validated scales to consider: Bristol Stool Chart, bladder scan, Braden Scale, TIME wound chart

CarePath diagnosis: Frequent loose stools related to antibiotic use, as evidenced by 7 watery stools in 24 hours and red skin around the anus.

Interventions and rationale

Intervention	Rationale
Replace fluids.	Frequent watery stools lose a lot of water and salts, and replacing them prevents dehydration.
Protect skin with barrier cream.	Stool irritates skin, and barrier cream protects it from breakdown and soreness.
Use infection precautions.	The cause may be infectious, so precautions such as gloves, handwashing and a separate toilet prevent spread to others.
Send a stool sample if ordered.	A stool test finds the cause, so the right treatment can be given.
Record each stool.	Records show how much fluid is being lost and whether the problem is improving.

Expected outcomes

- Within 48 hours: stools return to a formed pattern, skin intact and not red, hydration normal.
- Patient follows hand hygiene and infection precautions.

Linking the data to the diagnosis

The hospital patient is on antibiotics and has had 7 watery stools in 24 hours. The skin around the anus is red and temperature is normal. He says he keeps running to the toilet and his bottom is sore. This is an actual problem because the loose stools are already happening. Dehydration could follow, but no signs of it are described, so this statement is the main one. Hard or infrequent bowel movements is the opposite problem. The plan aims for formed stools, intact and non-red skin and normal hydration within 48 hours, with the patient following hand hygiene and infection precautions.

E3 Unable to empty the bladder

Group: Elimination | Type: Actual problem

- **Definition:** Urine stays in the bladder, causing fullness, discomfort, or overflow leaking.
- **Possible causes:** Enlarged prostate; nerve injury; medicines; after surgery; pain
- **Signs and symptoms:** Little urine passed; lower belly fullness; discomfort; dribbling

Scenario

After surgery a man cannot pass urine for eight hours and feels bladder pressure.

Subjective (S): "I need to pass urine but nothing comes out."

Objective (O): No urine for 8 hours after surgery; lower belly distended and tender; bladder scan 650 ml; uncomfortable.

Assessment tools for this scenario: **CP-ELIM** Elimination Check (p. 267) · **CP-SKIN** Skin & Wound

Score (p. 270)

Validated scales to consider: Bristol Stool Chart, bladder scan, Braden Scale, TIME wound chart

CarePath diagnosis: Unable to empty the bladder related to the effects of surgery and anesthesia, as evidenced by no urine for 8 hours and a bladder scan of 650 mL.

Interventions and rationale

Intervention	Rationale
Check with a bladder scan or palpation as ordered.	A scan or palpation confirms how much urine is held, so action is based on facts.
Offer privacy and a normal position.	Privacy and a normal position relax the pelvic muscles, which helps the bladder empty.
Try running water or warm water.	The sound or warmth of water can trigger the urge to pass urine without drugs or tubes.
Catheterize if ordered.	If other methods fail, a catheter drains the bladder, relieving pain and preventing overstretching and kidney damage.

Expected outcomes

- Within 6-8 hours: passes at least 200 ml per void or catheter placed as ordered.
- Leftover urine under 100 ml on scan.
- Discomfort resolved.

Linking the data to the diagnosis

After surgery the man has passed no urine for 8 hours. The lower belly is distended and tender and a bladder scan shows 650 ml. He says he needs to pass urine but nothing comes out. This is an actual problem because the bladder is already full and not emptying. Urinary leaking or frequency statements would not fit, since little urine is passing. The plan aims for passing at least 200 ml per void or catheter placement as ordered within 6-8 hours, leftover urine under 100 ml on scan, and the discomfort resolved.

E4 Leaking urine

Group: Elimination | Type: Actual problem

- **Definition:** Urine escapes without control, for example with coughing, urgency, or at other times.
- **Possible causes:** Weak pelvic muscles; infection; nerve problems; medicines; coughing
- **Signs and symptoms:** Leaking with cough or urgency; wet clothing; skin irritation; embarrassment

Scenario

A woman leaks a little urine each time she coughs or laughs.

Subjective (S): "I leak a little when I cough or laugh and I'm embarrassed."

Objective (O): Leaks small amounts with coughing and laughing; uses 3 pads a day; no signs of infection; has had two children.

Assessment tools for this scenario: **CP-ELIM** Elimination Check (p. 267) · **CP-INFECT** Infection Check (p. 281)

Validated scales to consider: Bristol Stool Chart, bladder scan, qSOFA / sepsis screen

CarePath diagnosis: Leaking urine related to weak pelvic muscles, as evidenced by leaking with cough or urgency and wet clothing.

Interventions and rationale

Intervention	Rationale
Teach pelvic floor exercises.	Strengthening the pelvic floor muscles improves support of the bladder outlet, so less urine escapes when pressure rises with coughing or laughing.
Set a toileting schedule.	Emptying the bladder at regular times keeps it from becoming overfull, which lowers the chance of leaks and reduces urgency.
Use pads.	Pads absorb leaked urine, keeping clothing dry and protecting the patient's confidence and dignity while the muscles are being strengthened.
Encourage fluids but limit caffeine.	Enough fluid keeps urine dilute and less irritating to the bladder, while caffeine irritates the bladder and acts as a diuretic, which can increase urgency and leaking.
Protect skin.	Urine left on the skin causes irritation and breakdown, so gentle cleansing and drying, with a barrier product if needed, keeps the skin intact.

Expected outcomes

- Within 4 weeks: leaking episodes reduced by half, skin dry and intact.
- Patient does pelvic floor exercises correctly and states a toileting routine.

Linking the data to the diagnosis

The woman says she leaks a little when she coughs or laughs and that she is embarrassed. The nurse observed small leaks with coughing and laughing, three pads used each day, no signs of infection, and a history of two children. These facts point to weak pelvic muscles as the cause, and the lack of infection makes a urine infection a less likely explanation. The leaking has already happened, so this is an actual diagnosis and not a risk. The plan aims to cut leaking episodes by half within 4 weeks, keep her skin dry and intact, and help her do pelvic floor exercises correctly and state a toileting routine.

E5 Unable to reach the toilet in time

Group: Elimination | Type: Actual problem

- **Definition:** Bladder control is present but mobility, distance, or timing leads to accidents.
- **Possible causes:** Poor mobility; unfamiliar ward; confusion; poor sight; distance to the bathroom
- **Signs and symptoms:** Arrives too late; calls for help late; wet floor or clothing

Scenario

An older man with a walker has accidents because the toilet is far away.

Subjective (S): "By the time I get to the toilet, it's too late."

Objective (O): Walks slowly with a frame; toilet 12 meters from bed; two wet accidents in 24 hours; bladder control otherwise normal.

Assessment tools for this scenario: **CP-ELIM** Elimination Check (p. 267)

Validated scales to consider: Bristol Stool Chart, bladder scan

CarePath diagnosis: Unable to reach the toilet in time related to poor mobility, as evidenced by arrives too late and calls for help late.

Interventions and rationale

Intervention	Rationale
Place the bed near the toilet.	A bed close to the toilet shortens the distance he must walk, so he can arrive before the bladder empties.
Use a commode.	A commode at the bedside gives a very short, safe route to a toilet seat when walking 12 meters is too slow for him.
Set regular toilet times.	Offering the toilet at regular times means he goes before the urge becomes urgent, so he does not have to rush or wait.
Clear the path.	A clear path lets him move safely with the frame and more quickly, lowering the risk of tripping when he hurries.
Answer the call bell quickly.	A fast response to the call bell gets him to the toilet before the bladder is too full, and it lowers his worry about accidents.

Expected outcomes

- No accidents for 48 hours.
- Commode or nearby toilet used safely.
- Call bell answered within 5 minutes.
- Patient feels less anxious.

Linking the data to the diagnosis

The older man walks slowly with a frame, the toilet is 12 meters from his bed, and he has had two wet accidents in 24 hours. He says that by the time he gets to the toilet it is too late. His bladder control is otherwise normal, so this fits unable to reach the toilet in time and not leaking urine, which would point to loss of control itself. The problem has already happened, so it is an actual diagnosis. The plan aims for no accidents for 48 hours, safe use of a commode or nearby toilet, call bell answers within 5 minutes, and a less anxious patient.

E6 Bowel leakage

Group: Elimination | Type: Actual problem

- **Definition:** Stool passes without control, risking skin damage and embarrassment.
- **Possible causes:** Weak anal muscles; diarrhea; nerve damage; confusion; long labor
- **Signs and symptoms:** Soiled clothing; skin breakdown; avoids social contact

Scenario

A woman after childbirth leaks stool when she passes gas.

Subjective (S): "I leak stool when I pass gas and I'm ashamed."

Objective (O): Soiled underwear twice daily; skin around the anus red; recent vaginal delivery with a tear.

Assessment tools for this scenario: **CP-ELIM** Elimination Check (p. 267) · **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: Bristol Stool Chart, bladder scan, Braden Scale, TIME wound chart

CarePath diagnosis: Bowel leakage related to weak anal muscles, as evidenced by soiled clothing and skin breakdown.

Interventions and rationale

Intervention	Rationale
Set a bowel routine.	A regular bowel routine, such as sitting on the toilet at set times after meals, helps the bowel empty at predictable times and reduces unplanned leakage.
Clean skin gently and use barrier cream.	Stool irritates skin, so gentle cleaning without rubbing and a barrier cream protect the reddened skin around the anus from further breakdown.
Use pads.	Pads absorb leakage and protect clothing, helping her go about daily life with less fear of being soiled.
Protect dignity.	Privacy, discreet disposal and a respectful manner reduce shame, which helps her talk openly about the problem and take part in her care.
Refer for pelvic floor help.	A pelvic floor specialist can assess damage after the delivery tear and teach exercises that rebuild anal muscle strength for lasting control.

Expected outcomes

- Within 4 weeks: fewer leakage episodes, skin intact.
- Patient practices pelvic floor exercises correctly and says she feels more confident.

Linking the data to the diagnosis

After a recent vaginal delivery with a tear, the woman says she leaks stool when she passes gas and that she is ashamed. The nurse found soiled underwear twice daily and red skin around the anus. These facts show the leakage has already happened and the skin is affected, so this is an actual diagnosis, with weak anal muscles as the likely cause. It is not a general bowel pattern problem because the main issue is stool passing without control. The plan aims for fewer leakage episodes and intact skin within 4 weeks, correct pelvic floor exercises, and greater confidence.

E7 Burning or pain passing urine

Group: Elimination | Type: Actual problem

- **Definition:** Urinating hurts or burns, which may signal infection or irritation.
- **Possible causes:** Urine infection; stones; catheter; irritation; sexually transmitted infection
- **Signs and symptoms:** Burning; frequent small amounts; cloudy or smelly urine; lower belly pain

Scenario

A woman has burning when urinating and passes small amounts every hour.

Subjective (S): "It burns when I pass urine and I need to go all the time."

Objective (O): Urine cloudy and strong smelling; small amounts hourly; temperature 37.8 C; dipstick positive for leukocytes and nitrites.

Assessment tools for this scenario: CP-ELIM Elimination Check (p. 267)

Validated scales to consider: Bristol Stool Chart, bladder scan

CarePath diagnosis: Burning or pain passing urine related to urine infection, as evidenced by burning and frequent small amounts.

Interventions and rationale

Intervention	Rationale
Encourage fluids.	Extra fluid dilutes the urine and increases flushing of the bladder, which helps wash germs out and eases burning.
Give antibiotics as ordered.	Antibiotics kill or stop the growth of the bacteria causing the infection, so symptoms settle and the infection does not spread.
Send a urine sample.	A urine sample can be cultured to identify the germ and show which antibiotic works, so treatment can be adjusted if the first drug is not effective.
Teach hygiene.	Wiping front to back and good hygiene reduce bacteria moving from the bowel area to the urethra, lowering the chance of repeat infection.
Report fever or back pain.	Fever or back pain can mean the infection has reached the kidneys, which needs prompt medical review and stronger treatment.

Expected outcomes

- Within 48 hours of treatment: burning stops, urine clear, temperature normal.
- Drinks at least 2 liters daily.
- Patient states hygiene steps.

Linking the data to the diagnosis

The woman says it burns when she passes urine and she needs to go all the time. The nurse found cloudy, strong-smelling urine, small amounts every hour, a temperature of 37.8 C, and a dipstick positive for leukocytes and nitrites. These findings point to a urine infection and show the problem is present, so it is an actual diagnosis and not a risk. Burning and frequency are the main complaints, which separates this from simple leaking. The plan aims to stop the burning, clear the urine and bring the temperature to normal within 48 hours of treatment, with at least 2 liters of fluid daily and hygiene steps stated.

E8 Likely to get urine infection from a catheter

Group: Elimination | Type: Risk problem

- **Definition:** A urinary catheter gives germs a path into the bladder.
- **Risk factors:** Urinary catheter; poor hygiene; long catheter use; bowel contamination
- **Warning signs to watch for:** Fever; cloudy urine; new confusion; pain at the catheter site

Scenario

An older man has had a urinary catheter for two weeks after surgery.

Subjective (S): "The catheter is uncomfortable."

Objective (O): Catheter in place 14 days; urine clear and yellow; temperature 36.8 C; stool soiling seen near the catheter site.

Assessment tools for this scenario: **CP-ELIM Elimination Check** (p. 267)

Validated scales to consider: Bristol Stool Chart, bladder scan

CarePath diagnosis: Likely to get urine infection from a catheter related to long catheter use and poor hygiene (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Use clean technique.	Clean technique stops germs on hands and equipment from entering the closed drainage system and reaching the bladder.
Keep the bag below the bladder.	Keeping the bag below bladder level lets urine drain downward and prevents contaminated urine from flowing back into the bladder.
Give catheter care.	Cleaning around the catheter removes germs and stool from the site, which matters here because stool soiling was seen near it.
Remove the catheter as soon as possible.	The longer a catheter stays in, the higher the infection risk, so removing it as soon as it is not needed is the best prevention.
Check urine.	Checking urine color, clarity and smell helps catch early signs of infection, such as cloudiness, so treatment can start sooner.

Expected outcomes

- No fever or confusion.
- Urine clear.
- Catheter removed as soon as clinically possible.
- Catheter care done correctly each shift.

Linking the data to the diagnosis

The older man has had a urinary catheter for 14 days after surgery, and stool soiling was seen near the catheter site. His urine is clear and yellow, his temperature is 36.8 C, and he only says the catheter is uncomfortable. Because there is no fever, cloudy urine or confusion, infection has not occurred, so a risk diagnosis is correct and an actual urine infection diagnosis would be wrong. The risk rests on long catheter use and poor hygiene. The plan aims to keep him free of fever and confusion with clear urine, correct catheter care each shift, and removal of the catheter as soon as clinically possible.

E9 Very little urine being made **URGENT**

Group: Elimination | Type: Actual problem

- **Definition:** Urine output is lower than expected, which may signal dehydration or kidney trouble.
- **Possible causes:** Dehydration; kidney failure; blocked catheter; low blood pressure; heart problems
- **Signs and symptoms:** Less urine than expected each hour; dark urine; swelling; weight gain

Scenario

A patient after surgery makes only 100 ml of urine in 6 hours.

Subjective (S): "I haven't passed much urine today."

Objective (O): Urine output 100 ml in 6 hours; blood pressure 98/60; dry mouth; post-operative day 1.

Assessment tools for this scenario: **CP-ELIM** Elimination Check (p. 267) · **CP-SKIN** Skin & Wound

Score (p. 270) · **CP-BREATH** Breathing & Circulation Check (p. 265)

Validated scales to consider: Bristol Stool Chart, bladder scan, Braden Scale, TIME wound chart, NEWS2, SpO₂, ECG

CarePath diagnosis: Very little urine being made related to dehydration, as evidenced by less urine than expected each hour and dark urine.

Interventions and rationale

Intervention	Rationale
Measure output accurately.	Accurate measurement shows whether the kidneys are making enough urine, which is a key sign of fluid balance and blood flow to the organs.
Check the catheter for kinks.	A kinked or blocked catheter can stop urine draining, so checking it separates a drainage problem from truly low urine production.
Encourage fluids if allowed.	Extra fluid can restore blood volume when dehydration is the cause, but it is given only if allowed because some patients must limit fluids.
Report low output.	Low output may signal dehydration, low blood pressure or kidney trouble, so the doctor needs to know early to find and treat the cause.
Check blood pressure.	Low blood pressure means the kidneys may not receive enough blood flow, so checking it shows whether urine output is likely to improve.

Expected outcomes

- Within 6 hours: urine output at least about 30 ml per hour, blood pressure and pulse within normal range.
- Patient drinks as allowed.

Linking the data to the diagnosis

On post-operative day 1 the patient made only 100 ml of urine in 6 hours and says not much urine has been passed today. The nurse also found a blood pressure of 98/60 and a dry mouth. These findings show the problem is present, so it is an actual diagnosis, with dehydration as the likely cause. Output and blood pressure are linked, which is why both are watched, and any catheter is checked so a drainage problem is not missed. The plan aims within 6 hours for urine output of at least about 30 ml per hour, blood pressure and pulse in the normal range, and the patient drinking as allowed.

C - Comfort and rest

Recommended assessment tools

CarePath tool: **CP-PAIN Pain & Comfort Score** (p. 268)

Validated scales: NRS 0–10, FLACC, PAINAD

C1 Short-term pain

Group: Comfort and rest | Type: Actual problem

- **Definition:** Pain of recent onset from injury, surgery, or illness that is expected to ease with healing.
- **Possible causes:** Surgery; injury; procedures; inflammation
- **Signs and symptoms:** Reports pain; grimacing; guarding; fast pulse; restlessness; high pain score

Scenario

After knee surgery, a woman rates her pain 7 out of 10 when moving.

Subjective (S): "It hurts a lot when I move my knee."

Objective (O): Pain 7/10 on movement and 3/10 at rest; guarding; grimacing; pulse 98/min; day 1 after knee surgery.

Assessment tools for this scenario: **CP-PAIN Pain & Comfort Score** (p. 268)

Validated scales to consider: NRS 0–10, FLACC, PAINAD

CarePath diagnosis: Short-term pain related to surgery, as evidenced by reports pain and grimacing.

Interventions and rationale

Intervention	Rationale
Assess pain with a scale.	A pain scale gives a measurable score so the nurse can choose treatment and judge whether it is working.
Give pain relief on time.	Giving pain relief on schedule keeps drug levels steady and prevents pain from becoming severe, which makes it easier to move and recover.
Reposition.	Changing position and supporting the knee reduces strain on the painful joint and surgical site.
Use cold or heat as ordered.	Cold reduces swelling and dulls pain after surgery, while heat relaxes tight muscles, so either one adds comfort to medicine when ordered.
Re-check 30 to 60 minutes later.	Re-checking after 30 to 60 minutes shows whether the medicine worked and lets the nurse ask for changes if pain remains high.

Expected outcomes

- Within 1 hour of pain relief: pain 3/10 or lower.
- Moves and repositions without grimacing.
- Sleeps in 2-3 hour blocks.

Linking the data to the diagnosis

On day 1 after knee surgery the woman says it hurts a lot when she moves her knee. She rates pain 7/10 on movement and 3/10 at rest, with guarding, grimacing and a pulse of 98/min. These show pain of recent onset from surgery that should ease with healing, so it is short-term pain and not long-lasting pain, which continues for months. The pain is present now, so this is an actual diagnosis. The plan aims for pain of 3/10 or lower within 1 hour of pain relief, movement and repositioning without grimacing, and sleep in 2 to 3 hour blocks.

C2 Long-lasting pain

Group: Comfort and rest | Type: Actual problem

- **Definition:** Pain that continues for months or longer and affects daily life and mood.
- **Possible causes:** Arthritis; nerve injury; cancer; back problems
- **Signs and symptoms:** Pain for months; poor sleep; low mood; limited activity

Scenario

A man with back pain for three years avoids walking and sleeps poorly.

Subjective (S): "My back hurts every day and I can't do anything."

Objective (O): Pain 6/10 for 3 years; guarded posture; avoids walking; sleeps 4 hours; low mood noted.

Assessment tools for this scenario: CP-PAIN Pain & Comfort Score (p. 268)

Validated scales to consider: NRS 0-10, FLACC, PAINAD

CarePath diagnosis: Long-lasting pain related to arthritis, as evidenced by pain for months and poor sleep.

Interventions and rationale

Intervention	Rationale
Assess pain and its effect on life.	Long-lasting pain affects sleep, mood and activity, so assessing both pain and its effect on life shows which goals matter to the patient.
Give regular medicines as ordered.	Regular scheduled medicines keep pain control steady, which works better than waiting until pain becomes severe.
Teach pacing, gentle exercise, and relaxation.	Pacing, gentle exercise and relaxation keep joints and muscles moving, reduce fear of movement and lower the tension that adds to pain.
Support mood.	Low mood and long-lasting pain feed each other, so emotional support can improve coping, sleep and willingness to be active.

Expected outcomes

- Over 4 weeks: pain score down by at least 2 points, walks short distances daily, sleeps 6 hours.
- Patient uses 2 coping methods.

Linking the data to the diagnosis

The man has had back pain for three years, now 6/10, and says his back hurts every day and he cannot do anything. He avoids walking, sleeps 4 hours, has a guarded posture and low mood. Pain lasting years that disturbs sleep, activity and mood fits long-lasting pain rather than short-term pain, which is recent and expected to settle. The problem is present, so this is an actual diagnosis. The plan aims over 4 weeks to lower the pain score by at least 2 points, restore short daily walks, raise sleep to 6 hours, and give the patient 2 coping methods.

C3 Feeling sick to the stomach

Group: Comfort and rest | Type: Actual problem

- **Definition:** An unpleasant urge to vomit, with or without actual vomiting.
- **Possible causes:** Medicines; surgery; infection; pregnancy; pain; strong smells
- **Signs and symptoms:** Queasy feeling; sweating; drooling; frequent swallowing; pale skin

Scenario

A patient after anesthesia feels sick and turns pale.

Subjective (S): "I feel like I'm going to throw up."

Objective (O): Pale and sweating; swallowing often; retching; just out of anesthesia; blood pressure normal.

Assessment tools for this scenario: **CP-PAIN** Pain & Comfort Score (p. 268) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-BREATH** Breathing & Circulation Check (p. 265)

Validated scales to consider: NRS 0-10, FLACC, PAINAD, Braden Scale, TIME wound chart, NEWS2, SpO₂, ECG

CarePath diagnosis: Feeling sick to the stomach related to medicines, as evidenced by queasy feeling and sweating.

Interventions and rationale

Intervention	Rationale
Give anti-sickness drugs as ordered.	Anti-sickness medicines block the signals in the brain and gut that cause nausea, settling the urge to vomit.
Keep the air fresh.	Fresh air in a well-ventilated room reduces stuffiness and odors that can worsen nausea.
Offer small sips.	Small sips avoid overfilling the stomach, which can trigger vomiting, while still giving some fluid.
Avoid strong smells.	Strong smells from food, perfume or cleaning products can set off nausea, so avoiding them removes common triggers.
Give mouth care.	Mouth care removes unpleasant tastes and freshens the mouth, which makes nausea easier to bear.
Sit upright.	Sitting upright helps the stomach empty and lowers the risk of vomit being inhaled, especially just after anesthesia.

Expected outcomes

- Within 30-60 minutes of treatment: nausea resolved or mild (under 3/10), tolerates sips, no vomiting.

Linking the data to the diagnosis

After anesthesia the patient says they feel like they are going to throw up. The nurse observed pale skin, sweating, frequent swallowing and retching, with a normal blood pressure. These are typical signs of nausea, and the timing right after anesthesia points to medicines as the cause. The nausea has already started, so this is an actual diagnosis. The plan aims for nausea to be resolved or mild (under 3/10) within 30 to 60 minutes of treatment, with the patient tolerating sips and not vomiting.

C4 Unable to sleep well

Group: Comfort and rest | Type: Actual problem

- **Definition:** Trouble falling or staying asleep leaves the person unrefreshed.
- **Possible causes:** Pain; anxiety; noise; caffeine; illness; shift work
- **Signs and symptoms:** Takes long to fall asleep; wakes often; tired in the day; irritable

Scenario

A patient on a busy ward sleeps only three hours a night.

Subjective (S): "I can't sleep with all the noise and I'm exhausted."

Objective (O): Sleeps about 3 hours per night; yawning; irritable; lights and alarms frequent on the ward.

Assessment tools for this scenario: CP-PAIN Pain & Comfort Score (p. 268)

Validated scales to consider: NRS 0–10, FLACC, PAINAD

CarePath diagnosis: Unable to sleep well related to ward noise and light, as evidenced by sleeping only 3 hours a night, yawning, and irritability.

Interventions and rationale

Intervention	Rationale
Group care to allow rest.	Doing care tasks together leaves longer undisturbed periods, which allows the patient to cycle through deeper, more restful sleep.
Reduce noise and light.	Less noise and light make it easier to fall asleep and prevent sudden waking, since the body treats sound and brightness as signals to stay alert.
Avoid caffeine late in the day.	Caffeine is a stimulant that can stay active for hours, so avoiding it late in the day makes falling asleep easier.
Teach relaxation.	Relaxation techniques lower muscle tension and anxiety, which helps the mind and body settle for sleep.
Give sleep medicine only as ordered.	Sleep medicines can cause drowsiness, falls and slowed breathing, so they are given only as prescribed and after other measures.

Expected outcomes

- Within 3 nights: sleeps at least 6 hours and reports feeling rested.
- Patient names two sleep-promoting steps.

Linking the data to the diagnosis

The patient sleeps only about 3 hours per night and says they cannot sleep with the noise and are exhausted. The nurse saw yawning, irritability, and frequent lights and alarms on the ward. Poor sleep that leaves the person unrefreshed fits this diagnosis, and it has already occurred, so it is an actual diagnosis. It overlaps with noise or light disturbing rest, but here the main problem is the poor sleep and its effect on the patient. The plan aims for at least 6 hours of sleep within 3 nights, a rested feeling, and the patient naming two sleep-promoting steps.

C5 Constant tiredness

Group: Comfort and rest | Type: Actual problem

- **Definition:** Ongoing exhaustion that rest does not fix and that limits activity.
- **Possible causes:** Anemia; cancer; poor sleep; depression; infection; heart disease
- **Signs and symptoms:** Exhaustion; needs to rest; weakness; slow thinking; reduced activity

Scenario

A patient after chemotherapy cannot walk to the bathroom without resting.

Subjective (S): "I'm so tired I can't even walk to the bathroom."

Objective (O): Needs rest after 10 meters; heart rate rises 25 beats on walking; hemoglobin 8.5 g/dL; on chemotherapy.

Assessment tools for this scenario: CP-PAIN Pain & Comfort Score (p. 268)

Validated scales to consider: NRS 0–10, FLACC, PAINAD

CarePath diagnosis: Constant tiredness related to anemia, as evidenced by exhaustion and needs to rest.

Interventions and rationale

Intervention	Rationale
Plan rest periods.	Planned rest lets the body recover energy so the patient can take part in important activities without becoming exhausted.
Space out activities.	Spreading tasks across the day prevents too much effort at one time, which would worsen exhaustion and raise heart rate.
Treat causes.	Treating underlying causes such as anemia, as ordered, improves oxygen delivery to the tissues, which is needed to reduce fatigue.
Encourage gentle activity.	Gentle activity maintains muscle strength and stamina, while long inactivity itself increases weakness.
Teach energy saving.	Energy-saving habits, such as sitting for tasks and doing the most important things first, let the patient manage daily needs with less effort.
Check blood tests.	Blood tests such as hemoglobin show whether anemia is improving or worsening and guide treatment.

Expected outcomes

- By day 3: walks to the bathroom with only one rest, lower fatigue score, energy-saving plan in place.
- Patient states 3 energy-saving tips.

Linking the data to the diagnosis

After chemotherapy the patient says they are so tired they cannot even walk to the bathroom. The nurse found they need rest after 10 meters, their heart rate rises 25 beats on walking, and hemoglobin is 8.5 g/dL. This fits constant tiredness because the exhaustion is ongoing and limits activity, and anemia is the likely cause. It is an actual diagnosis because the tiredness is present now. The plan aims by day 3 for the patient to walk to the bathroom with only one rest, a lower fatigue score, an energy-saving plan in place, and 3 energy-saving tips stated by the patient.

C6 Itching or skin discomfort

Group: Comfort and rest | Type: Actual problem

- **Definition:** Skin itch, burning, or irritation that disturbs rest and may lead to scratching damage.
- **Possible causes:** Dry skin; allergy; kidney or liver disease; rash; medicines
- **Signs and symptoms:** Scratching; red or broken skin; disturbed sleep; irritability

Scenario

An older woman scratches her legs until they bleed at night.

Subjective (S): "My skin itches so much at night."

Objective (O): Scratch marks on legs; dry flaky skin; broken sleep; no rash; skin intact except scratches.

Assessment tools for this scenario: **CP-PAIN** Pain & Comfort Score (p. 268) · **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: NRS 0-10, FLACC, PAINAD, Braden Scale, TIME wound chart

CarePath diagnosis: Itching or skin discomfort related to dry skin, as evidenced by scratching and red or broken skin.

Interventions and rationale

Intervention	Rationale
Keep skin moist.	Moisturizer restores the skin barrier and holds water in dry skin, which reduces the itch signals that drive scratching.
Trim nails.	Short, smooth nails cause less damage when the patient scratches, especially during sleep, helping keep skin intact.
Use cool compresses.	Cool compresses calm itching by dulling skin nerve activity and easing irritation.
Avoid harsh soap.	Harsh soaps strip natural oils from the skin and worsen dryness and itching, so mild cleansers are used instead.
Give itch medicine as ordered.	Itch medicine lowers the itch sensation, so the patient can rest and scratch less.
Check for rash.	Checking for rash helps find a different cause, such as allergy or infection, that would need other treatment.

Expected outcomes

- Within 2 days: itching 2/10 or lower, no new scratch wounds, sleeps through most of the night.
- Patient moisturizes twice daily.

Linking the data to the diagnosis

The older woman says her skin itches so much at night, and she scratches her legs until they bleed. The nurse saw scratch marks, dry flaky skin and broken sleep, with no rash and skin otherwise intact. Dry skin explains the itch, and the lack of rash makes a rash-related cause less likely. Because itching and scratch damage are present, this is an actual diagnosis. The plan aims within 2 days for itching of 2/10 or lower, no new scratch wounds, sleep through most of the night, and the patient moisturizing twice daily.

C7 Side effects of pain medicine **URGENT**

Group: Comfort and rest | Type: Actual problem

- **Definition:** Drowsiness, nausea, constipation, or slowed breathing caused by pain medicines.
- **Possible causes:** Opioid medicines; dose too high; older age; kidney problems
- **Signs and symptoms:** Drowsiness; nausea; constipation; slow breathing; confusion; itching

Scenario

A patient after surgery is very sleepy and breathes six times a minute after morphine.

Subjective (S): "I feel very sleepy and sick since the morphine."

Objective (O): Drowsy but rousable; respiratory rate 6/min; oxygen saturation 90%; nausea; no bowel movement for 3 days.

Assessment tools for this scenario: **CP-PAIN** Pain & Comfort Score (p. 268) · **CP-ELIM** Elimination Check (p. 267) · **CP-BREATH** Breathing & Circulation Check (p. 265)

Validated scales to consider: NRS 0-10, FLACC, PAINAD, Bristol Stool Chart, bladder scan, NEWS2, SpO₂, ECG

CarePath diagnosis: Side effects of pain medicine related to opioid medicines, as evidenced by drowsiness, respiratory rate 6/min, oxygen saturation 90% and nausea (urgent: respiratory depression).

Interventions and rationale

Intervention	Rationale
Check sedation level and breathing rate before and after each dose; if drowsy or breathing slowly (under 10/min), hold the dose and call for help at once.	Opioids can slow breathing and cause sedation, so checking before and after doses spots danger early, and holding the dose and calling for help prevents further slowing of breathing.
Give oxygen and prepare an opioid antagonist (for example naloxone) as ordered.	Oxygen supports low saturation while breathing is slow, and an opioid antagonist such as naloxone can quickly reverse the drug's effect on breathing when ordered.
Give laxatives and anti-sickness medicine as ordered.	Opioids slow the bowel and trigger nausea, so laxatives and anti-sickness medicine relieve these effects and make the pain medicine easier to tolerate.
Review the dose and timing with the prescriber.	The prescriber may lower the dose, change the drug or space out the timing to keep pain controlled with fewer side effects.
Teach the patient and family warning signs.	A patient and family who know warning signs, such as unusual sleepiness or slow breathing, can alert staff early so harm is prevented.

Expected outcomes

- Within 1 hour: alert and rousable, respiratory rate 12-20/min, oxygen saturation at target.
- Pain controlled at 3/10 or lower.
- Nausea settled and bowels open within 48 hours.

Linking the data to the diagnosis

After morphine the patient says they feel very sleepy and sick. The nurse found drowsiness but rousable, respiratory rate 6/min, oxygen saturation 90%, nausea and no bowel movement for 3 days. These are known opioid side effects, and the slow breathing is respiratory depression, so help is called first, before anything else. The problem has already occurred, so this is an actual diagnosis. The plan aims within 1 hour for an alert, rousable patient breathing 12 to 20/min with oxygen saturation at target, pain at 3/10 or lower, nausea settled, and bowels open within 48 hours.

C8 Pain near end of life

Group: Comfort and rest | Type: Actual problem

- **Definition:** Pain during advanced illness that needs prompt and frequent comfort measures.
- **Possible causes:** Cancer; advanced organ disease; pressure sores; muscle spasm
- **Signs and symptoms:** Moaning; grimacing; restlessness; refuses to move; family distress

Scenario

A dying patient with cancer groans when turned.

Subjective (S): (Cannot speak clearly.) Family: "He moans every time we turn him."

Objective (O): Moaning and grimacing on turning; clenches fists; observed pain score 7/10; advanced cancer.

Assessment tools for this scenario: CP-PAIN Pain & Comfort Score (p. 268)

Validated scales to consider: NRS 0–10, FLACC, PAINAD

CarePath diagnosis: Pain near end of life related to cancer, as evidenced by moaning and grimacing.

Interventions and rationale

Intervention	Rationale
Assess often, including by behavior.	A patient who cannot speak needs pain judged by behavior, such as moaning, grimacing and clenched fists, so untreated pain is not missed.
Give pain relief regularly as ordered.	Regular scheduled doses keep pain controlled continuously, which is kinder and more effective than waiting for pain to return.
Reposition gently.	Slow, supported turning reduces pulling and pressure on painful areas and lessens the pain that movement provokes.
Use comfort measures.	Comfort measures such as a calm room, gentle touch and good positioning add to medicine and ease distress.
Support the family.	Families are often distressed by seeing suffering, so explanation and support ease their worry and help them take part in comfort care.

Expected outcomes

- Observed pain score 3 or lower.
- Comfortable during care.
- Breakthrough medicine given within 30 minutes.
- Family reports he looks at peace.

Linking the data to the diagnosis

The dying patient with advanced cancer cannot speak clearly, but his family says he moans every time they turn him. The nurse observed moaning, grimacing, clenched fists, and an observed pain score of 7/10. Because he cannot report pain, these behaviors are the evidence, and this fits pain near end of life rather than short-term pain after surgery. The pain is present, so this is an actual diagnosis. The plan aims for an observed pain score of 3 or lower, comfort during care, breakthrough medicine within 30 minutes, and the family reporting that he looks at peace.

C9 Muscle cramps or spasms

Group: Comfort and rest | Type: Actual problem

- **Definition:** Sudden, painful tightening of muscles.
- **Possible causes:** Dehydration; low salts; overuse; pregnancy; nerve problems
- **Signs and symptoms:** Sudden painful tightening; hard muscle; limping; waking at night

Scenario

A runner wakes with a painful calf spasm after losing fluids.

Subjective (S): "My calf is cramping badly."

Objective (O): Hard painful calf muscle; sweating; sodium and potassium slightly low; sudden onset after exercise.

Assessment tools for this scenario: CP-PAIN Pain & Comfort Score (p. 268) · CP-FLUID Fluid

Balance & Nutrition Score (p. 266)

Validated scales to consider: NRS 0-10, FLACC, PAINAD, MUST, fluid chart, glucose

CarePath diagnosis: Muscle cramps or spasms related to dehydration, as evidenced by sudden painful tightening and hard muscle.

Interventions and rationale

Intervention	Rationale
Stretch and massage gently.	Gentle stretching and massage lengthen the tightened muscle and improve blood flow, which can stop the spasm.
Give fluids.	Fluids replace what was lost through sweat and correct dehydration, a common trigger for cramping.
Check salt levels.	Sodium and potassium help muscles contract and relax normally, so checking levels shows whether low salts are contributing.
Apply warmth.	Warmth relaxes the tight muscle and improves circulation, easing pain.
Report frequent cramps.	Frequent cramps may point to an underlying problem such as an electrolyte imbalance or poor circulation that needs medical review.

Expected outcomes

- Cramp relieved within 10 minutes.
- Fluids taken.
- No recurrence in 24 hours.
- Patient states prevention steps.

Linking the data to the diagnosis

The runner woke with a painful calf spasm after losing fluids and says the calf is cramping badly. The nurse found a hard, painful calf muscle, sweating, slightly low sodium and potassium, and sudden onset after exercise. These findings fit muscle cramps related to dehydration, and since the cramp is happening now, it is an actual diagnosis. It is not a long-lasting pain problem because it started suddenly and should pass. The plan aims for relief within 10 minutes, fluids taken, no recurrence in 24 hours, and the patient stating prevention steps.

C10 Headache

Group: Comfort and rest | Type: Actual problem

- **Definition:** Pain in the head that may limit rest and activity.
- **Possible causes:** Tension; migraine; high blood pressure; dehydration; head injury
- **Signs and symptoms:** Head pain; sensitivity to light; nausea; squinting; wants to lie in the dark

Scenario

A woman says her head is pounding and bright light makes her feel sick.

Subjective (S): "My head is pounding and the light makes me feel sick."

Objective (O): Pain 8/10; squints in light; nausea; blood pressure 138/84; no neurological deficit.

Assessment tools for this scenario: **CP-PAIN** Pain & Comfort Score (p. 268) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-BREATH** Breathing & Circulation Check (p. 265)

Validated scales to consider: NRS 0–10, FLACC, PAINAD, Braden Scale, TIME wound chart, NEWS2, SpO₂, ECG

CarePath diagnosis: Headache related to tension, as evidenced by head pain and sensitivity to light.

Interventions and rationale

Intervention	Rationale
Assess pain and warning signs.	Assessing pain and warning signs rates severity and detects danger signs that suggest a more serious cause than tension.
Rest in a quiet dark room.	A quiet, dark room reduces light and noise, which worsen pain and nausea, so the patient can rest.
Give pain relief as ordered.	Pain medicine acts on pain pathways or inflammation, lowering the pain so the patient can rest and recover.
Report sudden severe headache or neurological signs.	Sudden severe headache or neurological signs can mean a serious problem such as bleeding or stroke, which needs urgent medical assessment.

Expected outcomes

- Within 1-2 hours: pain 3/10 or lower and resting comfortably.
- No neurological changes.
- Patient names triggers to avoid.

Linking the data to the diagnosis

The woman says her head is pounding and the light makes her feel sick. The nurse found pain of 8/10, squinting in light, nausea, blood pressure 138/84 and no neurological deficit. Head pain with light sensitivity and nausea fits this diagnosis, and the lack of neurological signs fits a cause such as tension, though warning signs must still be watched. The headache is present now, so it is an actual diagnosis. The plan aims within 1 to 2 hours for pain of 3/10 or lower and comfortable rest, with no neurological changes and the patient naming triggers to avoid.

C11 Dry mouth or thirst

Group: Comfort and rest | Type: Actual problem

- **Definition:** The mouth feels dry or sticky and the person is uncomfortably thirsty.
- **Possible causes:** Fluid restrictions; mouth breathing; oxygen; medicines; fever
- **Signs and symptoms:** Dry sticky mouth; cracked lips; asks for drinks; thick saliva

Scenario

A patient on oxygen says his mouth is dry all the time.

Subjective (S): "My mouth is so dry."

Objective (O): Dry cracked lips; thick saliva; mouth breathing; on oxygen; fluid sips limited.

Assessment tools for this scenario: **CP-PAIN** Pain & Comfort Score (p. 268) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: NRS 0–10, FLACC, PAINAD, MUST, fluid chart, glucose

CarePath diagnosis: Dry mouth or thirst related to fluid restrictions, as evidenced by dry sticky mouth and cracked lips.

Interventions and rationale

Intervention	Rationale
Give frequent mouth care.	Regular mouth care moistens the mouth, removes thick saliva and reduces germs, which improves comfort and protects the teeth and gums.
Offer ice chips or sips if allowed.	Ice chips or sips give moisture in small amounts, easing thirst without going over the fluid limit set by the care team.
Use lip balm.	Lip balm seals in moisture and prevents cracks, which are painful and can let germs in.
Humidify oxygen.	Oxygen is dry and dries the nose and mouth, so humidifying it adds moisture to the air breathed in.
Encourage fluids as allowed.	Allowed fluids replace losses and ease thirst, so the patient drinks as much as permitted without breaking the restriction.

Expected outcomes

- Within 24 hours: mouth moist and lips not cracked.
- Patient reports thirst relief.
- Mouth care done every 2 hours.

Linking the data to the diagnosis

The patient on oxygen says his mouth is so dry. The nurse saw dry cracked lips, thick saliva, mouth breathing and limited fluid sips. These signs show the mouth is dry and sticky now, so this is an actual diagnosis, with the fluid limit and oxygen as likely causes. Because fluids are restricted, the plan must ease thirst within the limit, using mouth care and moisture rather than large drinks. It aims within 24 hours for a moist mouth and uncracked lips, the patient reporting thirst relief, and mouth care every 2 hours.

C12 Noise or light disturbing rest

Group: Comfort and rest | Type: Actual problem

- **Definition:** The surroundings are too noisy or bright for the person to rest.
- **Possible causes:** Busy ward; alarms; staff talk; bright lights; roommates
- **Signs and symptoms:** Cannot rest; irritable; covers eyes or ears; asks for quiet

Scenario

A recovering patient cannot sleep because hallway lights stay on.

Subjective (S): "I can't rest because of the light and noise."

Objective (O): Awake and irritable at 2 am; hallway lights bright; alarm sounding nearby; sleeps in short bursts.

Assessment tools for this scenario: **CP-PAIN** Pain & Comfort Score (p. 268)

Validated scales to consider: NRS 0–10, FLACC, PAINAD

CarePath diagnosis: Noise or light disturbing rest related to busy ward, as evidenced by cannot rest and irritable.

Interventions and rationale

Intervention	Rationale
Close doors.	Closed doors block hall light and noise, creating a quieter, darker space that makes rest easier.
Lower voices and alarms.	Quiet voices and turned-down alarms reduce sudden sounds that wake people or keep them alert.
Dim lights at night.	Dimmed lights at night support the body's natural sleep rhythm, which bright light disrupts.
Offer earplugs and an eye mask.	Earplugs and an eye mask give the patient personal control over noise and light when the surroundings cannot be fully changed.
Group care tasks.	Doing care tasks together leaves longer periods without interruption so the patient can sleep for longer stretches.

Expected outcomes

- By day 2: sleeps at least 5 uninterrupted hours.
- Noise and light reduced.
- Patient says she feels more rested.

Linking the data to the diagnosis

The recovering patient says she cannot rest because of the light and noise. At 2 am she was awake and irritable, the hallway lights were bright, an alarm was sounding nearby, and she slept only in short bursts. The cause lies in the busy ward around her, so this fits noise or light disturbing rest and not a sleep problem from illness or pain. The problem is happening now, so it is an actual diagnosis. The plan aims by day 2 for at least 5 uninterrupted hours of sleep, reduced noise and light, and the patient saying she feels more rested.

S - Safety and protection

Recommended assessment tools

CarePath tool: **CP-SAFE Safety & Falls Score** (p. 269)

Validated scales: Morse Fall Scale

S1 Likely to fall

Group: Safety and protection | Type: Risk problem

- **Definition:** Weakness, medicine, poor balance, or hazards raise the chance of a fall.
- **Risk factors:** Weakness; poor balance; sedating medicines; confusion; wet floors; poor sight; past falls
- **Warning signs to watch for:** Unsteady walking; dizziness; holding on to walls; fall history; rushing to the toilet

Scenario

An older woman who fell last year walks to the bathroom alone at night after taking a sleeping tablet.

Subjective (S): "I always get up at night to use the bathroom and I'm a bit wobbly."

Objective (O): Fell last year; walks unsteadily; takes a sleeping tablet; high fall-risk score; wears loose slippers.

Assessment tools for this scenario: **CP-SAFE Safety & Falls Score** (p. 269)

Validated scales to consider: Morse Fall Scale

CarePath diagnosis: Likely to fall related to weakness and poor balance (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Assess fall risk.	Assessing fall risk identifies which factors, such as past falls and medicine, apply to this patient so prevention can be targeted.
Keep the bed low with the call bell in reach.	A low bed reduces injury if she falls or steps out, and a call bell in reach lets her ask for help instead of walking alone.
Non-slip shoes.	Non-slip shoes give better grip and support than loose slippers, lowering the risk of slipping or tripping.
Clear the path.	A clear path removes objects and spills she could trip on when walking to the bathroom at night.
Assist walking.	Help from staff while walking gives support when she feels wobbly, especially after a sleeping tablet.
Review medicines.	Some medicines, including sleeping tablets, cause drowsiness and unsteadiness, so reviewing them may allow a safer choice or dose.

Expected outcomes

- No falls during the stay.
- Calls for help before getting up.
- Wears non-slip footwear.
- States 3 fall prevention steps by discharge.

Linking the data to the diagnosis

The older woman fell last year, walks unsteadily, takes a sleeping tablet, wears loose slippers and has a high fall-risk score. She says she always gets up at night to use the bathroom and is a bit wobbly. No fall is described now, so the problem has not occurred and the diagnosis rests on risk factors, which makes likely to fall correct. The plan aims for no falls during the stay, calling for help before getting up, non-slip footwear worn, and the patient stating 3 fall prevention steps by discharge.

S2 Likely to catch an infection

Group: Safety and protection | Type: Risk problem

- **Definition:** Wounds, lines, weak defenses, or exposure raise the chance of infection.
- **Risk factors:** Open wound; invasive lines; low immunity; diabetes; poor hygiene; surgery
- **Warning signs to watch for:** Fever; redness; warmth; pus; raised white cell count; new confusion

Scenario

A patient with a central line and chemotherapy has a high risk of infection.

Subjective (S): "I have a catheter line in my chest."

Objective (O): Central line in place; low white cell count (1.2); on chemotherapy; temperature 37.2 C; line site clean.

Assessment tools for this scenario: **CP-SAFE** Safety & Falls Score (p. 269) · **CP-INFECT** Infection Check (p. 281)

Validated scales to consider: Morse Fall Scale, qSOFA / sepsis screen

CarePath diagnosis: Likely to catch an infection related to a central line, chemotherapy, and a low white cell count (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Wash hands.	Hand washing removes germs from the hands, the most common way infection is carried to a patient with weak defenses.
Use clean technique for dressings and lines.	Clean technique for dressings and lines stops germs from entering the bloodstream through the central line.
Monitor temperature.	Fever may be the earliest sign of infection in someone with a low white cell count, so regular checks catch it early.
Teach hygiene.	Teaching hygiene, such as handwashing and keeping the line site dry, lets the patient reduce germs between nursing visits.
Report early signs.	Early reporting of signs such as fever, redness or chills allows quick treatment before infection spreads in a patient with low immunity.

Expected outcomes

- No fever, redness, or pus at the line site.
- Blood tests show no infection.
- Hands cleaned before every contact.
- Patient reports early signs.

Linking the data to the diagnosis

The patient has a central line, is on chemotherapy, and has a low white cell count of 1.2. Their temperature is 37.2 C and the line site is clean, so there is no fever, redness or pus. Infection has not occurred, so this is a risk diagnosis resting on the line and weak defenses, not an actual infection. The patient says they have a catheter line in the chest. The plan aims for no fever, redness or pus at the

line site, blood tests showing no infection, hands cleaned before every contact, and the patient reporting early signs.

S3 Likely to get hurt

Group: Safety and protection | Type: Risk problem

- **Definition:** The person's condition or surroundings raise the chance of accidental harm.
- **Risk factors:** Confusion; weakness; hazards; poor sight; unsafe equipment
- **Warning signs to watch for:** Near misses; bumps; unsafe movements; cluttered space

Scenario

A confused patient climbs over the bed rails.

Subjective (S): "I need to get out and go home."

Objective (O): Confused; climbs over bed rails; unsteady; bed alarm sounding.

Assessment tools for this scenario: **CP-SAFE** Safety & Falls Score (p. 269) · **CP-OLDER** Older Adult Check (p. 278)

Validated scales to consider: Morse Fall Scale, 4AT / CAM, Mini-Cog

CarePath diagnosis: Likely to get hurt related to confusion and weakness (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Remove hazards.	Removing hazards such as clutter and unsafe objects lowers the chance of tripping or bumping.
Supervise.	A confused, unsteady patient cannot judge danger, so close supervision lets staff step in before injury.
Meet needs early.	Needs such as toileting, thirst and pain can drive restlessness, so meeting them early lessens the urge to leave the bed.
Use safe equipment.	Safe equipment, such as a low bed and a working bed alarm, reduces the height of any fall and alerts staff quickly.
Reassure and reorient.	Calm reassurance and reminders of place and time lower fear and confusion, which reduces attempts to leave.

Expected outcomes

- No injuries.
- Stays in bed or sits safely with supervision.
- Needs anticipated.
- Confusion treated and patient calmer.

Linking the data to the diagnosis

The confused patient says they need to get out and go home, climbs over the bed rails, is unsteady, and the bed alarm is sounding. No injury has happened yet, so the diagnosis is a risk one resting on confusion and weakness, not an actual injury. It is related to likely to fall, but here the danger includes climbing and other unsafe movements. The plan aims for no injuries, the patient staying in bed or sitting safely with supervision, needs anticipated, and confusion treated so the patient is calmer.

S4 Broken or damaged skin

Group: Safety and protection | Type: Actual problem

- **Definition:** Skin is cut, torn, blistered, or broken down.
- **Possible causes:** Cuts; surgery; pressure; moisture; friction; burns
- **Signs and symptoms:** Open area; redness; blisters; drainage; pain at the skin

Scenario

A bedbound man has a torn area of skin on his elbow after sliding up the bed.

Subjective (S): "It hurts where the skin came off."

Objective (O): Skin tear 3 cm on the elbow; bedbound; slid up the bed; clean edges; minimal drainage.

Assessment tools for this scenario: **CP-SAFE** Safety & Falls Score (p. 269) · **CP-PAIN** Pain & Comfort Score (p. 268) · **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: Morse Fall Scale, NRS 0-10, FLACC, PAINAD, Braden Scale, TIME wound chart

CarePath diagnosis: Broken or damaged skin related to friction and shearing when sliding up the bed, as evidenced by a 3 cm skin tear on the elbow with minimal drainage.

Interventions and rationale

Intervention	Rationale
Assess skin daily.	Daily skin checks detect changes in the wound or new areas of damage early, before they worsen.
Clean and dress as ordered.	Cleaning removes germs and debris, and a dressing keeps the wound protected and moist, which supports healing and lowers infection risk.
Protect from friction and moisture.	Friction and moisture damage fragile skin further, so protecting it prevents new tears and helps healing.
Position carefully.	Careful positioning avoids the sliding and shearing that caused the tear and keeps pressure off the injured elbow.
Report worsening.	Reporting worsening signs such as spreading redness, more drainage or pain allows early treatment of infection or delayed healing.

Expected outcomes

- Wound clean with no infection signs.
- Heals within 7-14 days.
- No new tears.
- Staff use safe lifting methods.

Linking the data to the diagnosis

The bedbound man says it hurts where the skin came off. The nurse found a 3 cm skin tear on the elbow with clean edges and minimal drainage after he slid up the bed. The skin is already broken, so this is an actual diagnosis, unlike likely to develop pressure sores, which applies while skin is still intact. The plan aims for a clean wound with no signs of infection, healing within 7 to 14 days, no new tears, and staff using safe lifting methods.

S5 Likely to develop pressure sores

Group: Safety and protection | Type: Risk problem

- **Definition:** Staying in one position, moisture, or poor nutrition raise the chance of skin breakdown over bony areas.

- **Risk factors:** Immobility; moisture; poor nutrition; older age; diabetes; thin skin
- **Warning signs to watch for:** Red skin that does not fade; warm or hard spots over bony areas; pain at pressure points

Scenario

A thin, bedbound older patient with a poor appetite stays in the same position for long periods.

Subjective (S): "I cannot move myself much."

Objective (O): Thin and bedbound; skin over the sacrum intact and turns white when pressed; moist skin; poor appetite; high pressure-injury risk score.

Assessment tools for this scenario: CP-SAFE Safety & Falls Score (p. 269) · CP-SKIN Skin & Wound Score (p. 270)

Validated scales to consider: Morse Fall Scale, Braden Scale, TIME wound chart

CarePath diagnosis: Likely to develop pressure sores related to immobility, moisture and poor nutrition (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Turn every 2 hours or per plan.	Regular turning relieves pressure over bony areas, which restores blood flow to the skin and prevents tissue damage.
Check skin.	Checking the skin finds early damage, such as redness that does not fade, while it can still be reversed.
Use a pressure-relieving mattress.	A pressure-relieving mattress spreads body weight over a wider area, so less pressure falls on the sacrum and other bony points.
Keep skin clean and dry.	Moisture softens skin and makes it easier to damage, so keeping it clean and dry protects it.
Encourage nutrition.	Protein, calories and fluids are needed to maintain healthy skin and repair damage, so good nutrition lowers risk.
Lift, do not drag.	Dragging causes friction and shear that damage skin, while lifting avoids rubbing across the sheet.

Expected outcomes

- Skin stays intact.
- Redness resolves within 3 days.
- Position changed at least every 2 hours.
- Food intake improves toward goal.

Linking the data to the diagnosis

The thin, bedbound older patient says they cannot move much, has moist skin, a poor appetite and a high pressure-injury risk score. The skin over the sacrum is intact and turns white when pressed, so no damage has occurred. Because the skin is not broken or damaged, this is a risk diagnosis and not an actual skin problem such as broken or damaged skin. The risk factors are immobility, moisture and poor nutrition. The plan aims for skin to stay intact, position changes at least every 2 hours, and food intake improving toward the goal.

S6 Likely to bleed easily

Group: Safety and protection | Type: Risk problem

- **Definition:** Blood-thinning medicine, low platelets, or illness raise the chance of bleeding.
- **Risk factors:** Blood thinners; low platelets; liver disease; trauma; surgery

- **Warning signs to watch for:** Easy bruising; bleeding gums; nosebleeds; blood in urine or stool

Scenario

A patient has just started warfarin after a heart valve operation.

Subjective (S): "The doctor said this medicine can make me bleed."

Objective (O): Started warfarin 3 days ago; INR 3.4 (target 2.0-3.0); platelets normal; no bruising or bleeding seen; walks with a stick.

Assessment tools for this scenario: CP-SAFE Safety & Falls Score (p. 269)

Validated scales to consider: Morse Fall Scale

CarePath diagnosis: Likely to bleed easily related to blood thinners and an INR above target (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Check blood tests (INR) as ordered and report values above target.	INR shows how long blood takes to clot, so regular tests and reporting values above target let the doctor adjust the dose before bleeding occurs.
Check with the prescriber before each warfarin dose while the INR is above target; give at the same time each day as ordered.	Warfarin is dosed by the INR, so a result above target needs the prescriber's decision before the next dose. Giving it at a fixed time keeps blood levels steady.
Use a soft toothbrush and electric razor.	Soft brushing and electric razors cause less gum and skin injury, lowering the chance of bleeding.
Avoid unneeded injections and protect from falls.	Injections and falls can cause bleeding or bruising, so limiting them lowers risk, especially as the patient walks with a stick.
Apply firm pressure to any bleeding and report it.	Firm pressure helps a clot form to stop bleeding, and reporting it lets staff check whether the dose or INR needs review.

Expected outcomes

- No uncontrolled bleeding during the stay.
- INR within the target range by the date set by the doctor.
- Patient uses a soft toothbrush and reports bleeding early.

Linking the data to the diagnosis

The patient started warfarin 3 days ago after a heart valve operation, and says the doctor told them this medicine can make them bleed. The INR is 3.4 against a target of 2.0 to 3.0, platelets are normal, and no bruising or bleeding is seen. Since bleeding has not occurred, this is a risk diagnosis resting on blood thinners and an INR above target. The patient walks with a stick, so falls are also a concern. The plan aims for no uncontrolled bleeding, INR within target by the date the doctor sets, and the patient using a soft toothbrush and reporting bleeding early.

S7 Body temperature too high or too low **URGENT**

Group: Safety and protection | Type: Actual problem

- **Definition:** Body temperature is outside the safe range because of illness, surroundings, or medicine.
- **Possible causes:** Infection; heat; cold exposure; burns; medicines; brain injury
- **Signs and symptoms:** Very high or very low temperature; shivering or sweating; hot or cold skin; confusion

Scenario

A child has a temperature of 40 degrees and is flushed and restless.

Subjective (S): "I feel really hot."

Objective (O): Temperature 40 C; flushed; heart rate 150/min in a child; restless; poor drinking.

Assessment tools for this scenario: CP-SAFE Safety & Falls Score (p. 269)

Validated scales to consider: Morse Fall Scale

CarePath diagnosis: Body temperature too high or too low related to suspected infection, as evidenced by a temperature of 40 C, flushed skin, a heart rate of 150/min, and restlessness.

Interventions and rationale

Intervention	Rationale
Check temperature.	Regular temperature checks show how high the fever is and whether treatment is working.
Add or remove layers.	Removing extra layers helps heat leave the body when temperature is high, while adding layers helps retain heat if it is too low.
Give fluids.	Fever and fast breathing increase fluid loss, so fluids prevent dehydration and help the child cool.
Give fever medicine as ordered.	Fever medicine acts on the brain's temperature control to lower the temperature and increase comfort.
Use cooling measures only as ordered.	Over-cooling can cause shivering, which raises body heat again, so cooling is used only as ordered and alongside fever medicine.
Report abnormal results.	A very abnormal result may mean serious illness, so the doctor must hear quickly to find the cause and treat it.

Expected outcomes

- Within 2 hours: temperature below 38 C, child calmer and drinking fluids, no convulsions.

Linking the data to the diagnosis

The child says they feel really hot. The nurse found a temperature of 40 C, flushing, a heart rate of 150/min, restlessness and poor drinking. The temperature is well above the safe range, so the problem has already occurred and this is an actual diagnosis, with infection as the likely cause. The plan aims within 2 hours for a temperature below 38 C, a calmer child who is drinking fluids, and no convulsions. Because a child with this temperature, fast heart rate and poor drinking can become seriously unwell, abnormal results are reported promptly.

S8 Likely to inhale food or fluid

Group: Safety and protection | Type: Risk problem

- **Definition:** Weak swallowing or reduced alertness raise the chance of food or fluid entering the lungs.
- **Risk factors:** Stroke; low consciousness; weak cough; tube feeding; dementia
- **Warning signs to watch for:** Coughing at meals; wet voice; chest infection; fever

Scenario

An older woman with dementia eats very quickly and has a weak cough.

Subjective (S): Daughter: "She eats very fast and does not chew well."

Objective (O): Dementia; weak cough; eats quickly, half propped in bed; swallow screen shows delayed swallow; temperature 36.9 C; chest clear.

Assessment tools for this scenario: CP-SAFE Safety & Falls Score (p. 269)

Validated scales to consider: Morse Fall Scale

CarePath diagnosis: Likely to inhale food or fluid related to dementia and weak cough (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Sit fully upright to eat.	Sitting fully upright lets food travel down by gravity and keeps the airway protected, lowering the chance of inhaling food.
Supervise meals.	Watching meals allows the nurse to slow the pace, give prompts and respond at once to coughing or choking.
Follow swallow advice.	Swallow advice from specialists, such as food texture and pace, matches the safest way to eat for her delayed swallow.
Give mouth care.	Mouth care lowers the germs in the mouth, so if a little saliva or food is inhaled it is less likely to cause a lung infection.
Check chest and temperature.	Checking the chest and temperature can reveal early signs of aspiration, such as crackles or fever, so treatment is not delayed.

Expected outcomes

- No signs of aspiration.
- Temperature normal.
- Eats safely upright with supervision.
- Swallow review completed.

Linking the data to the diagnosis

The older woman with dementia eats quickly, has a weak cough, and was half propped in bed while eating. Her daughter says she eats very fast and does not chew well, and a swallow screen showed a delayed swallow. Her temperature is 36.9 C and her chest is clear, so no food has been inhaled yet. This is a risk diagnosis resting on dementia and a weak cough, not an actual chest infection. The plan aims for no signs of aspiration, a normal temperature, safe eating upright with supervision, and completion of the swallow review.

S9 Slow wound or surgical healing

Group: Safety and protection | Type: Risk problem

- **Definition:** Poor nutrition, infection, or illness may slow healing.
- **Risk factors:** Poor nutrition; diabetes; infection; smoking; steroids; older age
- **Warning signs to watch for:** Wound edges apart; redness; drainage; fever; pain that worsens

Scenario

A diabetic smoker has a surgical wound on day 3 after surgery.

Subjective (S): "I smoke, and my sugar is not always good."

Objective (O): Surgical wound day 3; edges together, no redness or drainage; smoker; diabetic; blood sugar 13 mmol/L; poor appetite.

Assessment tools for this scenario: **CP-SAFE** Safety & Falls Score (p. 269) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: Morse Fall Scale, Braden Scale, TIME wound chart, MUST, fluid chart, glucose

CarePath diagnosis: Slow wound or surgical healing related to diabetes and smoking (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Check the wound every shift.	Looking at the wound each shift finds early signs of trouble, such as redness, drainage or separated edges, so care can start sooner.
Support nutrition.	Protein, vitamins and calories are needed to build new tissue, so good nutrition helps the wound heal, which matters when appetite is poor.
Control blood sugar.	High blood sugar weakens defenses against infection and slows repair, so keeping it near target helps healing.
Keep the dressing clean.	A clean, intact dressing protects the wound from germs and keeps conditions right for healing.
Encourage stopping smoking.	Smoking narrows blood vessels and cuts oxygen to tissue, so stopping or cutting down improves healing.
Report signs of infection.	Reporting infection signs promptly allows early treatment before the wound breaks down.

Expected outcomes

- By day 10: wound edges closed with no pus or redness.
- Blood sugar within the doctor's target.
- Patient states a plan to cut down or stop smoking.

Linking the data to the diagnosis

On day 3 after surgery the wound edges are together with no redness or drainage, so healing is on track so far. The patient is diabetic, smokes, has a blood sugar of 13 mmol/L and a poor appetite, and says their sugar is not always good. Because the wound has not broken down or become infected, this is a risk diagnosis resting on diabetes and smoking. The plan aims by day 10 for closed wound edges with no pus or redness, blood sugar within the doctor's target, and a patient plan to cut down or stop smoking.

S10 Reaction to medicine or allergen **URGENT**

Group: Safety and protection | Type: Risk problem

- **Definition:** The person may react to a medicine, food, latex, or other trigger.
- **Risk factors:** Previous allergy; new medicine; latex; food; contrast dye
- **Warning signs to watch for:** Rash; itching; swelling of face or lips; wheeze; low blood pressure

Scenario

A patient with a known penicillin allergy is prescribed an antibiotic.

Subjective (S): "I'm allergic to penicillin, I hope that's on my chart."

Objective (O): Penicillin allergy recorded; new antibiotic prescribed; no rash; observations normal.

Assessment tools for this scenario: **CP-SAFE Safety & Falls Score** (p. 269)

Validated scales to consider: Morse Fall Scale

CarePath diagnosis: Reaction to medicine or allergen related to previous allergy and new medicine (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Check allergies before every drug.	Checking allergy records before each drug prevents giving a medicine the patient is known to react to.
Use an allergy band.	An allergy band alerts all staff to the allergy, even if the chart is missed or the patient cannot speak.
Observe after new medicines.	Most reactions happen soon after a new medicine, so close watching spots rash, swelling or breathing change early.
Stop the drug and call for help if symptoms appear.	Stopping the drug removes the trigger, and calling for help brings fast treatment for a reaction that can become life-threatening.
Give emergency treatment as ordered.	Emergency treatments such as adrenaline act quickly against severe allergic reactions, so they are given as ordered without delay.

Expected outcomes

- No allergic reaction.
- Allergy band and chart alert in place.
- Alternative drug used if needed.
- Patient states allergy and reaction signs.

Linking the data to the diagnosis

The patient has a recorded penicillin allergy, has been prescribed a new antibiotic, and says they hope the allergy is on the chart. There is no rash and observations are normal, so no reaction has occurred and this is a risk diagnosis resting on the previous allergy and new medicine. If any sign appears, the drug is stopped and help is called first. The plan aims for no allergic reaction, an allergy band and chart alert in place, an alternative drug used if needed, and the patient stating the allergy and reaction signs.

S11 Likely to develop blood clots

Group: Safety and protection | Type: Risk problem

- **Definition:** Limited movement, surgery, or illness raise the chance of clots in the veins.
- **Risk factors:** Surgery; immobility; long travel; cancer; dehydration; previous clot
- **Warning signs to watch for:** Swelling, pain, redness, or warmth in one leg; sudden chest pain; breathlessness

Scenario

A patient is bedbound two days after hip surgery.

Subjective (S): "My legs feel fine, but I cannot move much."

Objective (O): Two days after hip surgery; mostly bedbound; both calves soft, not swollen, tender or warm; no chest pain; drinking little.

Assessment tools for this scenario: CP-SAFE Safety & Falls Score (p. 269) · CP-PAIN Pain & Comfort Score (p. 268)

Validated scales to consider: Morse Fall Scale, NRS 0-10, FLACC, PAINAD

CarePath diagnosis: Likely to develop blood clots related to surgery, immobility and poor fluid intake (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Give clot prevention as ordered.	Clot prevention medicine or devices reduce the blood's tendency to clot while the patient is still, as after surgery.
Encourage early movement and fluids as allowed.	Movement and fluids keep blood flowing through the leg veins and prevent blood thickening, lowering clot risk.
Check both legs each shift for swelling, pain, redness or warmth.	Comparing both legs shows early signs of a clot, such as swelling, pain, redness or warmth, which often affect one leg.
If one leg is swollen, tender or warm: do not massage it or apply stockings; keep the patient resting and call the doctor urgently.	Massage could dislodge a clot and send it to the lungs, and stockings are not applied over a possible clot, so rest and urgent medical review are safest.
Report chest pain or breathlessness at once as an emergency.	Chest pain or breathlessness may mean a clot has reached the lungs, which is life-threatening and needs emergency help.

Expected outcomes

- No leg swelling, chest pain or breathlessness during the stay.
- Clot prevention given on time.
- Patient walks as allowed and drinks fluids.
- Any leg change is reported within the shift.

Linking the data to the diagnosis

Two days after hip surgery the patient is mostly bedbound and drinking little, and says their legs feel fine but they cannot move much. Both calves are soft, not swollen, tender or warm, and there is no chest pain. No clot is seen, so this is a risk diagnosis resting on surgery, immobility and poor fluid intake. If a leg becomes swollen or chest pain appears, help is called urgently. The plan aims for no leg swelling, chest pain or breathlessness, clot prevention given on time, walking and drinking as allowed, and any leg change reported within the shift.

S12 Likely to bleed heavily after surgery URGENT

Group: Safety and protection | Type: Risk problem

- **Definition:** The surgical site may bleed more than expected.
- **Risk factors:** Major surgery; blood thinners; clotting problems; slipping stitches
- **Warning signs to watch for:** Soaked dressings; bloody drain output; low blood pressure; fast pulse; pale skin

Scenario

A patient has just come back from major abdominal surgery and is on blood-thinning injections.

Subjective (S): "I feel a bit sore."

Objective (O): Just back from surgery; drain 40 mL blood-stained fluid in the first hour; pulse 84/min; blood pressure 122/76; on blood-thinning injections.

Assessment tools for this scenario: **CP-SAFE** Safety & Falls Score (p. 269) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: Morse Fall Scale, Braden Scale, TIME wound chart, MUST, fluid chart, glucose

CarePath diagnosis: Likely to bleed heavily after surgery related to major surgery and blood thinners (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Check dressings, drain output and vital signs at ordered times.	Regular checks of dressings, drain and vital signs show bleeding early, since a rising pulse and falling blood pressure often appear before blood is visible.
Keep dressings intact and mark any leaking area.	Intact dressings protect the wound, and marking any leaking area lets staff see whether bleeding is growing.
Report quickly rising drain output, bright blood, rising pulse, falling blood pressure or paleness at once.	Fast reports let the surgical team act before blood loss becomes dangerous, as heavy bleeding can lead to shock.
Prepare for treatment as ordered if bleeding is suspected.	Being ready, with equipment and orders at hand, saves time if bleeding is suspected.

Expected outcomes

- Drain output stays low and non-bloody.
- Pulse and blood pressure stay in the doctor's range.
- Any bleeding is reported within minutes and treated promptly.

Linking the data to the diagnosis

The patient has just returned from major abdominal surgery and is on blood-thinning injections, and says they feel a bit sore. The drain shows 40 mL of blood-stained fluid in the first hour, pulse is 84/min and blood pressure is 122/76. Heavy bleeding has not occurred, so this is a risk diagnosis resting on surgery and blood thinners. If signs of bleeding appear, help is called first. The plan aims for low, non-bloody drain output, pulse and blood pressure in the doctor's range, and any bleeding reported within minutes and treated promptly.

S13 Wrong medicine or dose

Group: Safety and protection | Type: Risk problem

- **Definition:** Errors in drug, dose, time, route, or patient may cause harm.
- **Risk factors:** Busy ward; similar drug names; poor handwriting; weak checks; lack of knowledge
- **Warning signs to watch for:** Near-miss reports; wrong patient or dose; unexpected drug reaction

Scenario

A nurse prepares evening medicines on a busy ward where two patients have similar names.

Subjective (S): Patient: "My name is Mr. Khan, not Mr. Khalid."

Objective (O): Two patients with similar names on the ward; busy shift; two similar-looking drug names on the chart; wristband not yet checked.

Assessment tools for this scenario: **CP-SAFE Safety & Falls Score** (p. 269)

Validated scales to consider: Morse Fall Scale

CarePath diagnosis: Wrong medicine or dose related to similar names, similar drug names and a busy ward (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Check the patient's name band and ask the patient to state their name before every medicine.	Two identifiers, the wristband and the patient's own spoken name, catch mix-ups that one check alone can miss, which matters when two patients have similar names.
Check drug, dose, time, route and allergies against the order.	Checking each element against the order, including allergies, stops errors in drug, dose, time or route before the medicine reaches the patient.
Mark similar-name patients with an alert.	An alert on similar-name patients warns every staff member to take extra care, so the risk of confusing the two men is lowered.
Avoid interruptions while preparing medicines.	Interruptions break concentration and are a major cause of slips in drug preparation, so a quiet, uninterrupted process keeps checks accurate on a busy ward.
Report and record any error or near miss.	Reporting errors and near misses lets the team find weak points in the system and fix them before a patient is harmed.

Expected outcomes

- No wrong-patient or wrong-dose event during the shift.
- Two identifiers checked for every medicine.
- Near misses reported.

Linking the data to the diagnosis

The scenario shows a nurse preparing evening medicines on a busy ward with two patients who have similar names. Mr. Khan has said, "My name is Mr. Khan, not Mr. Khalid," the chart holds two similar-looking drug names, and the wristband has not yet been checked. No wrong drug or dose has been given, so this is a risk statement, not an actual error, and it rests on risk factors only. The plan aims to keep the shift free of wrong-patient or wrong-dose events. The nurse checks two identifiers for every medicine and reports any near miss, as the expected outcomes require.

S14 Harm from restraints

Group: Safety and protection | Type: Risk problem

- **Definition:** Physical or chemical restraints can cause injury, distress, and loss of dignity.
- **Risk factors:** Confusion; agitation; devices; long use; poor monitoring
- **Warning signs to watch for:** Skin marks; distress; struggling; poor circulation

Scenario

A confused, agitated patient is pulling at his lines and staff are considering restraints.

Subjective (S): "Let me go home!"

Objective (O): Confused; pulling at lines; no restraint applied yet; pain not yet assessed; full bladder.

Assessment tools for this scenario: **CP-SAFE** Safety & Falls Score (p. 269) · **CP-PAIN** Pain & Comfort Score (p. 268) · **CP-OLDER** Older Adult Check (p. 278)

Validated scales to consider: Morse Fall Scale, NRS 0-10, FLACC, PAINAD, 4AT / CAM, Mini-Cog

CarePath diagnosis: Harm from restraints related to confusion and agitation (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Use the least restrictive option.	Less restrictive options such as redirection or a sitter cause less distress, injury and loss of dignity than physical restraint, so they are tried first.
Follow policy.	Policy sets out legal and safety requirements, such as orders, consent and monitoring, which protect the patient from misuse of restraint.
Check restraints often.	Restraints can reduce circulation, mark the skin or cause distress, so frequent checks find problems early.
Treat the cause of agitation.	Agitation often has a cause such as pain, a full bladder or confusion. Treating it can remove the need for restraint altogether.
Remove as soon as possible.	The longer restraints stay on, the greater the risk of injury, weakness and distress, so they should come off as soon as it is safe.
Document.	Accurate records show why restraint was needed, how it was monitored and when it ended, which protects both patient and staff.

Expected outcomes

- Restraint removed as soon as safe.
- No injury.
- Underlying cause (pain, confusion, full bladder) treated.
- Patient calmer.

Linking the data to the diagnosis

The patient is confused and agitated, calling "Let me go home!" and pulling at his lines. Staff are considering restraints, but none has been applied yet, so no harm from restraints has occurred. The diagnosis is therefore a risk statement based on confusion and agitation, not an actual one. The nurse also notes that pain has not been assessed and that his bladder is full, both possible causes of his restlessness. The plan aims to avoid or limit restraint, remove it as soon as safe, prevent injury and treat the cause so that the patient becomes calmer.

S15 Likely to wander or get lost

Group: Safety and protection | Type: Risk problem

- **Definition:** Confusion or memory loss may lead the person to leave a safe place.
- **Risk factors:** Dementia; confusion; unlocked doors; unfamiliar place
- **Warning signs to watch for:** Pacing; trying to leave; looking for an old home; disorientation

Scenario

A man with dementia tries to leave the ward saying he must go to work.

Subjective (S): "I need to go to work. Where's my coat?"

Objective (O): Dementia; found at the ward exit; pacing; no ID band on one arm.

Assessment tools for this scenario: CP-SAFE Safety & Falls Score (p. 269)

Validated scales to consider: Morse Fall Scale

CarePath diagnosis: Likely to wander or get lost related to dementia and confusion (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Use an ID band.	An ID band lets staff or the public identify the patient and return him to the ward quickly if he leaves unseen.
Place near the nursing station.	Close to the nursing station, staff can see him often and notice early signs of trying to leave.
Distract and redirect.	Gentle distraction and redirection calm a confused person without argument, and they respect his sense of purpose, such as going to work.
Secure exits per policy.	Secured exits make it harder to leave unnoticed, and following policy keeps this safe and lawful.
Involve family.	Family know his routines and history, and familiar people or items can comfort him and reduce the urge to leave.
Report a missing patient quickly.	Quick reporting starts a search early, when the patient is likely to be close by and the risk of harm is lowest.

Expected outcomes

- Patient stays safe.
- Wears ID band.
- Redirected calmly.
- No episode of leaving the ward unseen.

Linking the data to the diagnosis

A man with dementia was found at the ward exit, pacing, saying, "I need to go to work. Where's my coat?" and he has no ID band on one arm. He has not yet left the ward unseen or been lost, so this is a risk diagnosis resting on dementia and confusion, not an actual event. The nurse is concerned because he is already trying to leave. The plan aims to keep him safe by applying an ID band, redirecting him calmly and watching the exits, so that no episode of leaving the ward unseen occurs.

S16 Burn or scald risk

Group: Safety and protection | Type: Risk problem

- **Definition:** Hot water, heat packs, or equipment may burn skin, especially where feeling is reduced.
- **Risk factors:** Hot drinks; hot water bottles; baths; reduced feeling; seizures
- **Warning signs to watch for:** Red skin; blisters; pain; heat injury noticed late

Scenario

A diabetic with numb feet likes to warm his feet with a hot water bottle.

Subjective (S): "My feet are always cold, so I use a hot water bottle."

Objective (O): Diabetic nerve damage; reduced feeling in both feet; uses a hot water bottle at night; skin intact.

Assessment tools for this scenario: **CP-SAFE** Safety & Falls Score (p. 269) · **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: Morse Fall Scale, Braden Scale, TIME wound chart

CarePath diagnosis: Burn or scald risk related to reduced feeling and hot water bottle use (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Test water temperature.	Numb feet cannot sense dangerous heat, so the nurse tests the water with a reliable method before it touches the skin.
Avoid heat packs on numb skin.	Heat packs on skin with reduced feeling can cause burns that the patient does not notice until the damage is deep.
Supervise baths.	Supervision during baths ensures the water is a safe temperature and that any problem is noticed at once.
Teach safe use.	Teaching the patient to test with an elbow or thermometer lets him protect himself at home, where the nurse is not present.
Check skin.	Regular skin checks find redness or blisters early, which matters because nerve damage hides pain and delays notice of injury.

Expected outcomes

- No new burns.
- Feet stay free of redness, blisters, and burns.
- Patient tests temperature with the elbow or a thermometer and avoids heat packs.

Linking the data to the diagnosis

The patient is a diabetic with nerve damage and reduced feeling in both feet who says, "My feet are always cold, so I use a hot water bottle." He uses it at night, and his skin is intact. No burn has happened, so the problem is a risk, based on reduced feeling and hot water bottle use, not an actual injury. The plan aims to prevent burns by testing temperature, avoiding heat on numb skin and teaching him to test with an elbow or thermometer, so that no new burns occur.

S17 Choking **URGENT**

Group: Safety and protection | Type: Risk problem

- **Definition:** Food or objects may block the airway.
- **Risk factors:** Poor chewing; rushing; dementia; large food pieces; talking while eating
- **Warning signs to watch for:** Coughing; clutching the throat; unable to speak; blue face

Scenario

A patient with dementia eats large pieces of meat quickly while talking.

Subjective (S): Carer: "He stuffs his food into his mouth."

Objective (O): Dementia; eats fast; takes large bites; talks while eating; has not choked so far; several teeth missing.

Assessment tools for this scenario: CP-SAFE Safety & Falls Score (p. 269)

Validated scales to consider: Morse Fall Scale

CarePath diagnosis: Choking related to rushing, large food pieces and poor chewing (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Cut food small and serve soft foods if needed.	Small, soft pieces are easier to chew and swallow, which matters because he has missing teeth and takes large bites.
Sit upright and supervise every meal.	An upright position lets food travel down the throat safely, and supervision means help is immediate if he begins to choke.
Remind to eat slowly without talking.	Slow eating with no talking lowers the chance that food enters the airway instead of the stomach.
Know how to give back blows and abdominal thrusts per protocol.	Knowing the correct technique means help can start in seconds, since a blocked airway can cause brain damage within minutes.
If choking: encourage coughing, give back blows and thrusts, and call emergency help at once.	A blocked airway is an emergency. Coughing may clear it, and back blows and thrusts are the standard steps, with emergency help called at once.

Expected outcomes

- No choking episodes during the stay.
- Food cut small and meals supervised at every meal.
- Carers state how to respond to choking.
- If choking occurs: airway cleared and help called at once.

Linking the data to the diagnosis

A patient with dementia eats large pieces of meat quickly while talking, and the carer says, "He stuffs his food into his mouth." He also has several teeth missing. He has not choked so far, so this is a risk diagnosis based on rushing, large bites and poor chewing, not an actual event. The plan aims for no choking episodes, with food cut small and every meal supervised. Because choking can block the airway, the nurse treats any episode as urgent: help is called first, and back blows and thrusts are given while waiting.

S18 Poisoning risk URGENT

Group: Safety and protection | Type: Risk problem

- **Definition:** Access to harmful substances or medicine overdose raises the chance of poisoning.
- **Risk factors:** Unlocked medicines; chemicals; confusion; small children; overdose
- **Warning signs to watch for:** Vomiting; drowsiness; strange behavior; open containers nearby

Scenario

A toddler lives in a home where adult tablets are kept in a handbag within reach.

Subjective (S): Parent: "She climbs everything."

Objective (O): Toddler aged 2; tablets in an unlocked handbag on a low table; cleaning products under the sink without a lock; no child-safe lids.

Assessment tools for this scenario: **CP-SAFE Safety & Falls Score** (p. 269)

Validated scales to consider: Morse Fall Scale

CarePath diagnosis: Poisoning risk related to unlocked medicines and chemicals and a small child (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Teach parents to lock medicines and chemicals away, out of sight and reach.	Toddlers climb and explore, so locked storage out of sight and reach is the most reliable way to stop them touching harmful substances.
Use child-safe lids and keep medicines in original labelled containers.	Child-safe lids add a barrier, and original labelled containers prevent mix-ups and give poison services the information they need.
Give the poison-control number and put it near the phone.	A number near the phone means parents can get expert advice fast, when delay can make poisoning worse.
Teach what to do if swallowing is suspected: call poison control or emergency services at once and bring the container.	Poisoning can be an emergency. Calling for help at once and bringing the container allows quick, correct treatment.
Recheck the home plan at follow-up.	Rechecking the plan confirms that changes were made and kept, and gives a chance to correct gaps before harm occurs.

Expected outcomes

- Within 1 week: medicines and chemicals locked away.
- Parents state storage rules and the poison-control number.
- No poisoning event.

Linking the data to the diagnosis

A two-year-old lives in a home where adult tablets sit in an unlocked handbag on a low table, cleaning products are under the sink without a lock, and there are no child-safe lids. The parent says, "She climbs everything." Nothing has been swallowed, so the problem is a risk, based on these hazards and her age, not an actual poisoning. Because poisoning can be life-threatening, teaching stresses calling poison control or emergency services first if swallowing is suspected. The plan aims for locked storage within 1 week and no poisoning event.

S19 Unsafe home

Group: Safety and protection | Type: Risk problem

- **Definition:** Hazards such as clutter, poor lighting, or loose rugs raise the chance of injury.
- **Risk factors:** Loose rugs; poor lighting; clutter; stairs; no handrails; poor heating
- **Warning signs to watch for:** Falls at home; near misses; narrow paths; faulty equipment

Scenario

An older man lives upstairs with no stair rail and a dark hallway.

Subjective (S): "I go up the stairs every day and the hall is dark."

Objective (O): No stair rail; clutter in the hallway; poor lighting; walks with a stick.

Assessment tools for this scenario: CP-SAFE Safety & Falls Score (p. 269)

Validated scales to consider: Morse Fall Scale

CarePath diagnosis: Unsafe home related to no stair rail, hallway clutter, and poor lighting (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Do a home safety check.	A home check finds the specific hazards that could cause a fall, so changes are aimed at real risks and not guesses.
Improve lighting.	Good lighting helps him see steps and obstacles, which matters on stairs in a dark hallway.
Clear clutter and secure loose items.	Loose rugs catch feet and sticks and are a common cause of falls in older adults, so removing them lowers the risk.
Install rails.	A stair rail gives support and balance on stairs, particularly for a man who walks with a stick.
Refer for occupational therapy.	Occupational therapy can assess how he moves at home and recommend equipment and changes that suit him.

Expected outcomes

- Home hazards fixed within 2 weeks.
- No falls at home.
- Patient states the safety changes made.

Linking the data to the diagnosis

An older man says, "I go up the stairs every day and the hall is dark." The home has no stair rail, clutter in the hallway and poor lighting, and he walks with a stick. He has not yet fallen or been injured, so this is a risk diagnosis based on hazards, not an actual injury. The plan aims to fix home hazards within 2 weeks. If lighting, clutter and the missing rail are corrected, falls are prevented, and the patient can state the safety changes that were made.

S20 Abuse or violence exposure

Group: Safety and protection | Type: Risk problem

- **Definition:** The person may be exposed to harm from others or be recovering from it.
- **Risk factors:** Violence at home; assault; unsafe relationships; neglect
- **Warning signs to watch for:** Unexplained injuries; fear; withdrawn behavior; delays in seeking care; partner answers for the patient

Scenario

A woman attends the clinic for the third time in four months with minor injuries; her partner always stays in the room.

Subjective (S): "I am just clumsy."

Objective (O): Third visit in 4 months; healed bruise on the wrist; partner answers for her; appears anxious; no new injury today.

Assessment tools for this scenario: **CP-SAFE** Safety & Falls Score (p. 269) · **CP-MIND** Mood & Mind Screen (p. 272)

Validated scales to consider: Morse Fall Scale, PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Abuse or violence exposure related to repeated injuries and a controlling partner (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Ask privately and kindly.	Private, kind questions let a person speak freely without fear of the partner, and a non-judging approach makes disclosure more likely.
Ensure safety.	Her immediate safety comes first, because the risk of further harm can rise if the partner suspects she has spoken.
Document facts.	Factual, objective notes, including injuries, are accurate and may be needed later for care or legal purposes.
Follow local law and policy.	Laws and policies on reporting and confidentiality protect both the patient and the nurse and must be followed.
Offer support services.	Support services give practical help such as safe housing, advice and counselling, which she may not know about.
Do not blame.	Blame can cause shame and silence, so avoiding it keeps trust and makes it likelier she will seek help.

Expected outcomes

- Patient assessed privately at this visit.
- Safety plan and support-service contacts offered.
- Injuries and facts documented.
- Mandatory reporting duties followed.

Linking the data to the diagnosis

A woman attends the clinic for the third time in four months, says, "I am just clumsy," and has a healed bruise on her wrist. Her partner stays in the room and answers for her, and she appears anxious. There is no new injury today and no abuse has been confirmed, so this is a risk diagnosis resting on repeated injuries and a controlling partner. The plan aims to assess her privately at this visit, document the facts, offer a safety plan and support contacts, and follow mandatory reporting duties, without blame.

S21 Likely to harm others

Group: Safety and protection | Type: Risk problem

- **Definition:** Anger, confusion, or illness may lead to violence toward other people.
- **Risk factors:** Anger; psychosis; intoxication; confusion; past violence
- **Warning signs to watch for:** Threats; clenched fists; pacing; shouting; damaging objects

Scenario

A patient with a history of violence is becoming restless and irritable on the ward after an argument with a visitor.

Subjective (S): "Leave me alone."

Objective (O): Pacing; raised voice; clenched jaw; past aggression when intoxicated; no threats or physical acts so far.

Assessment tools for this scenario: **CP-SAFE Safety & Falls Score** (p. 269)

Validated scales to consider: Morse Fall Scale

CarePath diagnosis: Likely to harm others related to anger and past violence (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Stay calm.	A calm nurse sets the tone and lowers the patient's arousal, whereas an anxious or sharp manner can make anger worse.
Keep a safe distance.	A safe distance gives the nurse room to move away and reduces the chance of being hit.
Give space.	Space lets an angry person feel less cornered, which often reduces the urge to lash out.
Use de-escalation.	Calm talk, listening and a low voice can settle anger without force and keep everyone safer.
Call for help.	Extra staff add safety and presence, and calling early is better than waiting until violence has started.
Follow policy.	Policy guides safe, lawful responses and protects the patient, staff and others on the ward.
Treat the cause.	Pain, intoxication, fear or illness can drive aggression, so treating the cause lowers the chance of it returning.

Expected outcomes

- No harm to staff or other patients.
- Patient calms within 30-60 minutes.
- Cause assessed and treated.

Linking the data to the diagnosis

A patient with a history of violence is becoming restless after an argument with a visitor. He says, "Leave me alone," and is pacing, with a raised voice and clenched jaw. He has been aggressive in the past when intoxicated. No threats or physical acts have occurred, so this is a risk diagnosis based on anger and past violence, not actual harm. The plan aims to prevent harm to staff and other patients by staying calm, giving space and calling for help, so he settles within 30 to 60 minutes and the cause is found and treated.

S22 Staff exposure to needles or body fluids (workplace safety)

Group: Safety and protection | Type: Risk problem

- **Definition:** Healthcare workers may be exposed to blood-borne infection through sharps or splashes.
- **Risk factors:** Sharps injuries; splashes; poor technique; lack of protective equipment
- **Warning signs to watch for:** Needle-stick injury; splashes; incomplete hand hygiene

Scenario

A nurse works in a busy clinic where the sharps bin is overfull and needles are sometimes recapped by hand.

Subjective (S): Nurse: "We never have time to use the safety devices."

Objective (O): Overfull sharps bin; needles recapped by hand; safety devices not used; gloves out of stock.

Assessment tools for this scenario: CP-SAFE Safety & Falls Score (p. 269)

Validated scales to consider: Morse Fall Scale

CarePath diagnosis: Staff exposure to needles or body fluids (workplace safety) related to poor technique and lack of protective equipment (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Use safety devices.	Safety devices cover or retract the needle after use, which directly lowers the chance of a needle-stick injury.
Keep a sharps bin at the point of use.	A bin within reach means sharps are discarded at once, so they are not carried or left lying around.
Never recap.	Hand recapping is a common cause of needle-stick injuries, because the needle can slip into the fingers.
Wear gloves and eye protection.	Gloves and eye protection create a barrier against blood and splashes, which can carry infections such as hepatitis B and HIV.
Report exposure immediately.	Early reporting allows quick washing, risk assessment and post-exposure treatment, which work best when started soon.

Expected outcomes

- No needle-stick or splash injury during the shift.
- Sharps bin emptied and safety devices available.
- Staff state the steps to take after an exposure (wash, report at once, post-exposure care).

Linking the data to the diagnosis

A nurse works in a busy clinic where the sharps bin is overfull, needles are sometimes recapped by hand, safety devices are not used and gloves are out of stock. She says, "We never have time to use the safety devices." No injury or splash has happened, so this is a risk diagnosis based on poor technique and lack of protective equipment, not an actual exposure. The plan aims for no needle-stick or splash injury during the shift, an emptied bin, available safety devices and staff who know what to do after an exposure.

S23 Nerve or limb damage from positioning

Group: Safety and protection | Type: Risk problem

- **Definition:** Pressure or poor positioning may damage nerves or reduce blood flow to a limb.
- **Risk factors:** Long unchanged positions; tight casts; anesthesia; reduced feeling; tight devices
- **Warning signs to watch for:** Numbness; tingling; pale or cold limb; weak movement; pain

Scenario

A patient is being positioned for a four-hour operation with an arm resting off the edge of the table.

Subjective (S): (Under anaesthesia; cannot speak.)

Objective (O): Surgery planned for 4 hours; arm on a narrow board; no padding at the elbow; anaesthetized; skin intact; pulses present.

Assessment tools for this scenario: **CP-SAFE** Safety & Falls Score (p. 269) · **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: Morse Fall Scale, Braden Scale, TIME wound chart

CarePath diagnosis: Nerve or limb damage from positioning related to a long unchanged position and anesthesia (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Pad and support limbs.	Padding and support spread pressure over a wider area, protecting nerves and blood vessels, particularly at the elbow, which is not padded in this case.
Avoid pressure.	Prolonged pressure on a nerve or vessel can cause damage, and an anaesthetized patient cannot feel or signal it.
Reposition.	Changing position when possible relieves pressure on nerves and soft tissue and restores blood flow during a long operation.
Check pulses, warmth, and color.	Pulses, warmth and color show whether blood is reaching the limb, so a problem can be found early.
Loosen tight items.	Tight straps, dressings or devices can squeeze nerves and reduce blood flow, so loosening them removes the cause of the damage.
Report changes.	Early reporting lets the team correct positioning and treat a problem before damage becomes permanent.

Expected outcomes

- Normal feeling and movement within 24 hours.
- No permanent nerve damage.
- Limbs positioned correctly.

Linking the data to the diagnosis

A patient is being positioned for a four-hour operation with an arm resting off the edge of the table on a narrow board, with no padding at the elbow. The patient is anaesthetized and cannot speak or report discomfort. Skin is intact and pulses are present, so no nerve or limb damage has occurred and the diagnosis is a risk statement based on a long unchanged position and anaesthesia. The plan aims to keep limbs well supported and checked so that normal feeling and movement return within 24 hours, with no permanent nerve damage.

S24 Likely to spread infection to others

Group: Safety and protection | Type: Risk problem

- **Definition:** An infectious person may pass germs to other patients, staff, or family.
- **Risk factors:** Infectious illness; poor hand hygiene; shared equipment; crowded rooms
- **Warning signs to watch for:** Cough; diarrhea; rash; fever; others becoming ill

Scenario

A patient with new diarrhea shares a room and a bathroom with other patients.

Subjective (S): "I have had loose stools since this morning."

Objective (O): 3 loose stools today; shares a bathroom; stool test pending; temperature 37.0 C; hand hygiene not yet taught.

Assessment tools for this scenario: **CP-SAFE** Safety & Falls Score (p. 269) · **CP-ELIM** Elimination Check (p. 267)

Validated scales to consider: Morse Fall Scale, Bristol Stool Chart, bladder scan

CarePath diagnosis: Likely to spread infection to others related to possible infectious illness and a shared bathroom (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Use isolation as needed.	Isolation separates a possibly infectious patient from others, which is important when he shares a room and bathroom.
Do hand hygiene.	Hand hygiene is the single most effective way to stop germs spreading between people and surfaces.
Wear masks and gloves.	Masks and gloves protect staff and prevent them from carrying germs to other patients on their hands and clothes.
Clean equipment.	Shared equipment and surfaces can carry germs from one person to another, so cleaning removes this route.
Teach patient and visitors.	Patient and visitors who understand why hygiene matters are more likely to follow it, protecting each other.

Expected outcomes

- No other patients develop symptoms.
- Isolation maintained.
- Staff and visitors perform hand hygiene.

Linking the data to the diagnosis

A patient says, "I have had loose stools since this morning," and has had 3 loose stools today. He shares a room and a bathroom with other patients, his stool test is pending, his temperature is 37.0 C and hand hygiene has not yet been taught. The cause is not confirmed and no one else is ill, so this is a risk diagnosis resting on possible infectious illness and a shared bathroom. The plan aims to keep other patients free of symptoms through isolation and hand hygiene by staff, visitors and the patient.

S25 Eye damage in unconscious patients

Group: Safety and protection | Type: Risk problem

- **Definition:** Eyes that do not blink or close may dry out or be scratched.
- **Risk factors:** Sedation; coma; facial nerve weakness; eyes stay open
- **Warning signs to watch for:** Dry eyes; redness; discharge; eyes do not close fully

Scenario

A sedated ICU patient on a ventilator does not blink and his eyes stay partly open.

Subjective (S): (Sedated; cannot communicate.)

Objective (O): Sedated; no blink reflex; eyes partly open; corneas clear and moist; no redness.

Assessment tools for this scenario: CP-SAFE Safety & Falls Score (p. 269) · CP-SKIN Skin & Wound Score (p. 270)

Validated scales to consider: Morse Fall Scale, Braden Scale, TIME wound chart

CarePath diagnosis: Eye damage in unconscious patients related to sedation and incomplete eye closure (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Clean eyes.	Cleaning removes dust, discharge and germs that can irritate or infect the eye of a patient who cannot blink or protect it.
Use lubricant.	Without blinking, tears do not spread over the eye and it dries quickly, so lubricant keeps the cornea moist.
Close eyes gently or cover as ordered.	Closing the eyes or covering them as ordered stops air drying the surface, which would otherwise damage the cornea.
Protect from injury.	Eyes that are open or unprotected can be scratched by linen, tubing or hands, so protection prevents injury.
Report changes.	Redness, discharge or cloudiness can be early signs of damage or infection, and early reporting allows quick treatment.

Expected outcomes

- Eyes stay moist and uninjured.
- No ulcer.
- Eye care every 2-4 hours.

Linking the data to the diagnosis

A sedated ICU patient on a ventilator does not blink, and his eyes stay partly open. He cannot communicate. His corneas are clear and moist and there is no redness, so no eye damage has occurred and the diagnosis is a risk statement based on sedation and incomplete eye closure. The plan aims to keep his eyes moist and uninjured, with no ulcer. Regular eye care every 2 to 4 hours, with lubricant and protection, is meant to prevent the drying and scratching that his missing blink reflex would otherwise allow.

S26 Injury during seizure **URGENT**

Group: Safety and protection | Type: Risk problem

- **Definition:** Falls, tongue bites, or a blocked airway may occur during a seizure.
- **Risk factors:** Epilepsy; head injury; fever in children; missed medicine
- **Warning signs to watch for:** Sudden jerks; loss of awareness; falling; tongue bite; confusion afterwards

Scenario

A patient with epilepsy has missed two doses of anti-seizure medicine.

Subjective (S): "I forgot my tablets for two days."

Objective (O): Epilepsy; two doses missed; last seizure 3 months ago; no seizure now; bed rails and padding not yet in place.

Assessment tools for this scenario: **CP-SAFE** Safety & Falls Score (p. 269) · **CP-NEURO** Brain & Senses Check (p. 280)

Validated scales to consider: Morse Fall Scale, GCS, pupils, NIHSS

CarePath diagnosis: Injury during seizure related to epilepsy and missed medicine (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Give anti-seizure medicine on time and as ordered.	Missed doses lower drug levels in the blood and make a seizure more likely, so regular timing keeps protection steady.
Keep the bed low and padded; clear the area.	A low, padded bed and a clear area reduce injury from falling or striking hard objects during a seizure.
Teach the patient and family seizure first aid.	People nearby who know first aid can act quickly and correctly, which lowers the risk of harm.
During a seizure: protect the head, time it, put nothing in the mouth, turn to the side afterward.	Protecting the head prevents injury, timing shows when help is needed, objects in the mouth can cause harm, and side-lying keeps the airway clear.
Call for help if a seizure lasts over 5 minutes or repeats.	A seizure over 5 minutes or repeated seizures can be life-threatening and need urgent medical treatment.

Expected outcomes

- No injury during the stay.
- Medicine given on time.
- Family states seizure first aid.
- If a seizure occurs: timed, airway kept clear and doctor told.

Linking the data to the diagnosis

A patient with epilepsy says, "I forgot my tablets for two days," so two doses were missed. His last seizure was 3 months ago, he is not seizing now, and bed rails and padding are not yet in place. No seizure or injury has occurred, so this is a risk diagnosis based on epilepsy and missed medicine. Because a seizure can block the airway or cause serious injury, the plan states that help is called first for a long or repeated seizure. It aims for no injury during the stay, medicine on time and a family who can give seizure first aid.

M - Movement and self-care

Recommended assessment tools

CarePath tool: **CP-MOVE** Movement & Self-Care Score (p. 271)

Validated scales: Barthel Index, Katz ADL

M1 Limited ability to move

Group: Movement and self-care | Type: Actual problem

- **Definition:** Pain, weakness, or restrictions reduce the ability to move the body or parts of it.
- **Possible causes:** Pain; weakness; surgery; fear; restrictions
- **Signs and symptoms:** Moves slowly; avoids movement; needs help; stiff

Scenario

After hip replacement, a woman will not move her leg for fear of pain.

Subjective (S): "I'm afraid to move my leg."

Objective (O): Day 1 after hip replacement; will not move the leg; pain 7/10; muscle tight.

Assessment tools for this scenario: **CP-MOVE** Movement & Self-Care Score (p. 271) · **CP-PAIN** Pain & Comfort Score (p. 268)

Validated scales to consider: Barthel Index, Katz ADL, NRS 0-10, FLACC, PAINAD

CarePath diagnosis: Limited ability to move related to pain, as evidenced by moves slowly and avoids movement.

Interventions and rationale

Intervention	Rationale
Give pain relief before activity.	Pain relief given before activity lets her move with less pain, which lowers her fear and makes movement more likely and more comfortable.
Assist with exercises.	Guided exercises keep the joint and muscles working safely and help prevent stiffness and weakness after the surgery.
Encourage safe movement.	Safe, gradual movement rebuilds strength and circulation and lowers the risk of clots and other complications of staying still.
Praise progress.	Praise builds confidence and motivation, which helps a frightened patient keep trying and accept each small step forward.
Follow the therapy plan.	The therapy plan protects the new hip by setting safe movements and limits, so progress does not harm the repair.

Expected outcomes

- Sits at the bedside within 24 hours and walks a short distance with a frame by day 2.
- Pain 4/10 or lower with activity.

Linking the data to the diagnosis

A woman on day 1 after hip replacement says, "I'm afraid to move my leg." She will not move the leg, her pain is 7/10 and the muscle is tight, so she moves slowly and avoids movement. This is an actual problem that has already happened, not a risk, and pain is the main cause. The plan aims to reduce pain with medicine before activity and to encourage safe movement. The expected outcomes are sitting at the bedside within 24 hours, walking a short distance with a frame by day 2 and pain of 4/10 or lower during activity.

M2 Tires quickly during activity

Group: Movement and self-care | Type: Actual problem

- **Definition:** Ordinary activity causes breathlessness, fast heart rate, or exhaustion.
- **Possible causes:** Heart or lung disease; anemia; deconditioning; poor sleep
- **Signs and symptoms:** Breathless on small effort; fast pulse; tired after walking; needs rests

Scenario

A patient with heart failure must rest after walking five steps.

Subjective (S): "I get tired after just a few steps."

Objective (O): Short of breath after 5 steps; heart rate rises from 78 to 112; heart failure; needs rest every 10 meters.

Assessment tools for this scenario: **CP-MOVE** Movement & Self-Care Score (p. 271)

Validated scales to consider: Barthel Index, Katz ADL

CarePath diagnosis: Tires quickly during activity related to heart or lung disease, as evidenced by breathless on small effort and fast pulse.

Interventions and rationale

Intervention	Rationale
Pace activity.	Spreading activity over time with rests keeps demand on the weak heart lower, so breathlessness, fast pulse and fatigue are less likely to occur.
Allow rest.	Rest lets the heart rate and breathing settle and restores energy before the next effort.
Check pulse and breathing.	Pulse and breathing show how hard the heart is working and help the nurse decide when to stop or slow down.
Increase gradually.	Gradual increases in activity build tolerance step by step, without suddenly overloading a heart that is already weak from heart failure.
Teach energy saving.	Energy-saving methods, such as sitting for tasks, let him do what he needs with less effort.
Report chest pain.	Chest pain can signal the heart is not getting enough oxygen and needs prompt medical review.

Expected outcomes

- By day 3: walks 20 meters with one rest, heart rate returns to baseline within 3 minutes, no chest pain.

Linking the data to the diagnosis

A patient with heart failure says, "I get tired after just a few steps." He becomes short of breath after 5 steps, his heart rate rises from 78 to 112, and he needs rest every 10 meters. These findings show the problem is already present, so an actual statement fits and a risk statement does not. The plan aims to raise his activity tolerance safely. By day 3 the expected outcomes are walking 20 meters with one rest, a heart rate that returns to baseline within 3 minutes and no chest pain.

M3 Cannot turn or change position in bed

Group: Movement and self-care | Type: Actual problem

- **Definition:** The person cannot reposition without help.
- **Possible causes:** Weakness; pain; sedation; paralysis; heavy casts
- **Signs and symptoms:** Cannot roll; slides down the bed; needs help to sit up

Scenario

A man in traction cannot turn without two nurses.

Subjective (S): "I can't turn myself."

Objective (O): In traction; needs two nurses to turn; slides down in bed.

Assessment tools for this scenario: **CP-MOVE** Movement & Self-Care Score (p. 271)

Validated scales to consider: Barthel Index, Katz ADL

CarePath diagnosis: Cannot turn or change position in bed related to weakness, as evidenced by cannot roll and slides down the bed.

Interventions and rationale

Intervention	Rationale
Use turning aids.	Slide sheets and other aids reduce friction and force, making turns easier for the patient and safer for staff.
Assist safely.	Safe assistance, with enough people and the correct technique, protects both the patient and the nurses from injury during turning.
Reposition regularly.	Regular repositioning relieves pressure on the skin and lowers the chance of pressure injuries in someone who cannot turn alone.
Check skin.	Skin checks find early redness or damage from pressure, which is a risk when someone cannot move himself.
Teach use of bed handles.	Using bed handles lets him take part in moving, which builds strength, confidence and independence.

Expected outcomes

- Turned every 2 hours safely.
- Skin stays intact.
- Patient uses the bed handle to help.
- No strain injuries to staff.

Linking the data to the diagnosis

A man in traction says, "I can't turn myself." He needs two nurses to turn him and slides down in the bed, so he cannot roll or change position without help. This is an actual problem, not a risk, because the inability to turn is already present. The plan aims to turn him safely every 2 hours with aids so that his skin stays intact and staff are not strained. It also aims to teach him to use the bed handle so that he can help with his own movement.

M4 Difficulty walking

Group: Movement and self-care | Type: Actual problem

- **Definition:** Walking is slow, unsteady, painful, or not possible without help.
- **Possible causes:** Weak legs; pain; stroke; poor balance; arthritis
- **Signs and symptoms:** Shuffling; limping; needs support; slow pace

Scenario

A patient with arthritis walks very slowly and winces.

Subjective (S): "My knees hurt and walking is slow."

Objective (O): Arthritis; shuffling walk; limping; pain 6/10 on walking; uses a stick.

Assessment tools for this scenario: **CP-MOVE** Movement & Self-Care Score (p. 271) · **CP-PAIN** Pain & Comfort Score (p. 268)

Validated scales to consider: Barthel Index, Katz ADL, NRS 0-10, FLACC, PAINAD

CarePath diagnosis: Difficulty walking related to weak legs, as evidenced by shuffling and limping.

Interventions and rationale

Intervention	Rationale
Assess walking.	Assessing the walk shows what is wrong, such as pain, weakness or poor balance, so the plan can target the real problem.
Use a walking aid.	A suitable aid takes weight off painful joints and improves balance, which makes walking safer and less painful for him.
Physiotherapy.	Physiotherapy builds leg strength and teaches better walking patterns, which helps his long-term mobility and independence.
Give pain relief.	Pain relief lets him move with less pain, so he can walk further and take part in exercises.
Ensure safe footwear.	Supportive footwear with good grip improves stability and lowers the risk of slipping or falling.
Assist.	Help close by prevents falls while his walking is slow and unsteady, and it gives him confidence to keep moving.

Expected outcomes

- Within 1 week: walks 30 meters with aid and pain 4/10 or lower.
- Safe footwear.
- Stable walk.

Linking the data to the diagnosis

A patient with arthritis says, "My knees hurt and walking is slow." He has a shuffling, limping walk, pain of 6/10 on walking and uses a stick. The difficulty is already present, so this is an actual diagnosis and not a risk. The plan aims to improve his walking through pain relief, a suitable aid, physiotherapy and safe footwear. Within 1 week the expected outcomes are walking 30 meters with an aid, pain of 4/10 or lower, safe footwear and a stable walk.

M5 Needs help to wash

Group: Movement and self-care | Type: Actual problem

- **Definition:** The person cannot bathe or wash alone.
- **Possible causes:** Weakness; pain; paralysis; low energy; confusion
- **Signs and symptoms:** Needs help to reach, wash, and dry; skin not cleaned

Scenario

A stroke patient cannot wash his back or legs.

Subjective (S): "I can't reach my back."

Objective (O): Needs help washing back and legs after stroke; right arm weak; skin clean otherwise.

Assessment tools for this scenario: **CP-MOVE** Movement & Self-Care Score (p. 271) · **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: Barthel Index, Katz ADL, Braden Scale, TIME wound chart

CarePath diagnosis: Needs help to wash related to weakness, as evidenced by needs help to reach, wash, and dry and skin not cleaned.

Interventions and rationale

Intervention	Rationale
Assist as needed.	Helping with the parts he cannot do keeps him clean and comfortable and protects his skin while he recovers from the stroke.
Let him do what he can.	Doing what he can for himself keeps his abilities, builds confidence and supports recovery after stroke.
Ensure privacy.	Privacy protects his dignity and lowers embarrassment, which helps him accept help with washing after the stroke.
Check skin.	Washing is a chance to look at skin for redness, sores or other changes, especially on areas he cannot reach.
Protect dignity.	Treating him with respect keeps his self-esteem and encourages him to take part in his own care.

Expected outcomes

- Washes face and front independently with set-up.
- Completes bathing with minimal help within 1 week.

Linking the data to the diagnosis

A stroke patient says, "I can't reach my back." He needs help washing his back and legs, and his right arm is weak, although his skin is otherwise clean. He is already unable to wash alone, so an actual statement fits. The plan aims to give help where needed while he does what he can. The expected outcomes are washing his face and front independently with set-up, then completing bathing with minimal help within 1 week, while his privacy and dignity are protected.

M6 Needs help to dress

Group: Movement and self-care | Type: Actual problem

- **Definition:** The person cannot choose, put on, or remove clothing alone.
- **Possible causes:** Arm weakness; arthritis; pain; confusion
- **Signs and symptoms:** Struggles with buttons; cannot lift arms; needs help

Scenario

A woman with a shoulder injury cannot put on a shirt.

Subjective (S): "I can't lift my arm to get my shirt on."

Objective (O): Shoulder injury; cannot raise the right arm; fastens buttons slowly.

Assessment tools for this scenario: CP-MOVE Movement & Self-Care Score (p. 271)

Validated scales to consider: Barthel Index, Katz ADL

CarePath diagnosis: Needs help to dress related to arm weakness, as evidenced by struggles with buttons and cannot lift arms.

Interventions and rationale

Intervention	Rationale
Offer easy-fit clothing.	Loose, stretchy or front-opening clothes need less arm movement, so dressing is easier and less painful.
Dress the affected side first.	Dressing the injured arm first means it goes through the sleeve while it has the most room, which avoids pulling it.
Allow time.	Rushing causes pain and frustration, whereas extra time lets her work at her own pace and succeed.
Encourage independence.	Doing tasks herself builds confidence and keeps her skills, which supports recovery and a sense of control.

Expected outcomes

- Within 1 week: dresses upper body with adaptive clothing in about 10 minutes.
- Patient states the technique.

Linking the data to the diagnosis

A woman with a shoulder injury says, "I can't lift my arm to get my shirt on." She cannot raise her right arm and fastens buttons slowly, so she already struggles to dress. This is an actual problem, not a risk. The plan aims to make dressing possible and safe using easy-fit clothing and a good technique, giving her time and encouraging independence. Within 1 week the expected outcomes are dressing the upper body with adaptive clothing in about 10 minutes and the patient stating the technique herself.

M7 Needs help to eat

Group: Movement and self-care | Type: Actual problem

- **Definition:** The person cannot bring food to the mouth or manage meals alone.
- **Possible causes:** Tremor; weak hands; poor vision; confusion; fatigue
- **Signs and symptoms:** Spills food; cannot cut meat; stops eating early

Scenario

A man with Parkinson's disease shakes and spills his soup.

Subjective (S): "My hands shake and I drop things."

Objective (O): Parkinson's disease; spills soup; takes 45 minutes to eat; eats only half.

Assessment tools for this scenario: CP-MOVE Movement & Self-Care Score (p. 271)

Validated scales to consider: Barthel Index, Katz ADL

CarePath diagnosis: Needs help to eat related to tremor, as evidenced by spills food and cannot cut meat.

Interventions and rationale

Intervention	Rationale
Set up the meal.	Setting out the meal, opening packages and cutting food lets him start eating without wasting energy on tasks he cannot manage.
Use adaptive cutlery.	Weighted or built-up cutlery steadies the hand and cuts spilling, so he can feed himself.
Give time.	Eating slowly with a tremor takes longer, and time lets him finish without rushing or becoming tired and frustrated.
Assist if needed.	Help prevents him going hungry or giving up when the tremor is too strong, while still leaving him to do what he can.
Check intake.	Checking how much he eats shows whether he is getting enough nourishment and whether the plan is working.

Expected outcomes

- Within 1 week: eats at least 75% of meals, uses adaptive cutlery, finishes meals in under 30 minutes.

Linking the data to the diagnosis

A man with Parkinson's disease says, "My hands shake and I drop things." He spills his soup, takes 45 minutes to eat and eats only half. The difficulty is already affecting his food intake, so this is an actual problem and not a risk. The plan aims to help him eat well and keep his independence through set-up, adaptive cutlery and time. Within 1 week the expected outcomes are eating at least 75% of meals, using adaptive cutlery and finishing meals in under 30 minutes.

M8 Needs help to use the toilet

Group: Movement and self-care | Type: Actual problem

- **Definition:** The person cannot get to, use, or clean up after the toilet alone.
- **Possible causes:** Weak legs; pain; confusion; frailty
- **Signs and symptoms:** Cannot transfer to the toilet; needs help to clean

Scenario

A frail woman cannot lift herself from the toilet.

Subjective (S): "I can't get up from the toilet."

Objective (O): Frail; needs two people to stand; transfer unsafe; toilet seat low.

Assessment tools for this scenario: CP-MOVE Movement & Self-Care Score (p. 271)

Validated scales to consider: Barthel Index, Katz ADL

CarePath diagnosis: Needs help to use the toilet related to weak legs, as evidenced by cannot transfer to the toilet and needs help to clean.

Interventions and rationale

Intervention	Rationale
Provide a raised seat and rails.	A raised seat and rails shorten the distance to stand and give something firm to push on, making standing safer and easier.
Assist and give privacy.	Help lowers the risk of falls during transfer, and privacy protects her dignity while she is vulnerable.
Schedule toileting.	Regular offers to toilet prevent urgent rushes and accidents, and the time can be planned when help is ready.

Intervention	Rationale
Protect dignity.	Treating her with respect keeps her self-esteem and her willingness to ask for help when she needs it.

Expected outcomes

- Within 1 week: transfers safely with one person and a raised seat.
- No falls.
- Dignity kept.

Linking the data to the diagnosis

A frail woman says, "I can't get up from the toilet." She needs two people to stand, the transfer is unsafe and the toilet seat is low, so she cannot use the toilet without help. This is already happening, which makes the statement actual and not a risk. The plan aims to make toileting safe with a raised seat and rails, planned toileting and respectful help. Within 1 week the expected outcomes are safe transfers with one person and a raised seat, no falls and her dignity kept.

M9 Too little physical activity

Group: Movement and self-care | Type: Actual problem

- **Definition:** Daily movement is below what is needed for good health.
- **Possible causes:** Sedentary job; fear; pain; obesity; low motivation
- **Signs and symptoms:** Little movement; weight gain; weak muscles; breathlessness

Scenario

An office worker sits ten hours a day and does no exercise.

Subjective (S): "I sit at work all day and don't exercise."

Objective (O): Sedentary job; BMI 31; blood pressure 142/90; no regular activity.

Assessment tools for this scenario: CP-MOVE Movement & Self-Care Score (p. 271) · CP-SKIN Skin & Wound Score (p. 270) · CP-BREATH Breathing & Circulation Check (p. 265)

Validated scales to consider: Barthel Index, Katz ADL, Braden Scale, TIME wound chart, NEWS2, SpO₂, ECG

CarePath diagnosis: Too little physical activity related to sedentary job, as evidenced by little movement and weight gain.

Interventions and rationale

Intervention	Rationale
Set small goals.	Small goals feel achievable, so he is more likely to start and succeed, which builds motivation to continue.
Teach benefits.	Understanding how activity helps weight, blood pressure and heart health gives him a personal reason to change.
Start gently.	Starting gently lowers the risk of injury and discouragement in someone who has not been active.
Plan a walking routine.	A regular walking routine turns intentions into habit, and walking is easy to do at no cost.
Review progress.	Reviewing progress shows what is working, allows goals to be adjusted and keeps him motivated.

Expected outcomes

- Within 4 weeks: walks 20 minutes 5 times weekly.
- Patient states 3 benefits and a personal activity goal.

Linking the data to the diagnosis

An office worker says, "I sit at work all day and don't exercise." He has a sedentary job, a BMI of 31, blood pressure of 142/90 and no regular activity. Because the low activity and its effects are already present, an actual statement fits. The plan aims to raise his activity step by step with small goals, teaching and a walking routine. Within 4 weeks the expected outcomes are walking 20 minutes 5 times weekly and stating 3 benefits of activity and a personal activity goal.

M10 Difficulty using a walking aid

Group: Movement and self-care | Type: Actual problem

- **Definition:** The person struggles with a frame, crutches, stick, or wheelchair.
- **Possible causes:** New equipment; weakness; poor technique; pain
- **Signs and symptoms:** Wrong height; leaning; tripping; avoids using the aid

Scenario

A patient uses crutches that are too long and nearly falls.

Subjective (S): "The crutches feel too long."

Objective (O): Crutches too tall; leans forward; trips; unsteady on stairs.

Assessment tools for this scenario: CP-MOVE Movement & Self-Care Score (p. 271) · CP-SAFE Safety & Falls Score (p. 269)

Validated scales to consider: Barthel Index, Katz ADL, Morse Fall Scale

CarePath diagnosis: Difficulty using a walking aid related to new equipment, as evidenced by wrong height and leaning.

Interventions and rationale

Intervention	Rationale
Check the fit.	Crutches of the wrong height cause leaning, poor balance and strain on the shoulders, so correct fit must come first.
Teach technique.	Correct technique, such as the right gait pattern, keeps weight where it should be and lowers the chance of a fall.
Practice with supervision.	Supervised practice lets the nurse correct mistakes at once, so he learns before he tries alone.
Watch for tiredness.	Tiredness makes technique worse and raises the risk of falls, so he should rest when needed.
Reinforce safe use.	Reinforcing safe habits builds confidence and keeps him using the aid properly, including after discharge when no one is watching.

Expected outcomes

- Within 24 hours: uses crutches safely with correct fit and technique.
- No falls.
- Completes stair practice with the therapist.

Linking the data to the diagnosis

A patient says, "The crutches feel too long." The crutches are too tall, he leans forward, trips and is unsteady on stairs, and he nearly fell. These problems are already present, so an actual statement fits and a risk statement does not. The wrong fit and new equipment are the cause. The plan aims to correct the fit and teach safe technique with supervised practice. Within 24 hours the expected outcomes are using the crutches safely with correct fit and technique, no falls and stair practice completed with the therapist.

M11 Muscle weakness

Group: Movement and self-care | Type: Actual problem

- **Definition:** Muscles lack the strength needed for normal tasks.
- **Possible causes:** Illness; inactivity; poor nutrition; nerve disease; aging
- **Signs and symptoms:** Cannot lift; tires quickly; trembling

Scenario

After a long ICU stay, a patient cannot lift his arms.

Subjective (S): "My arms feel weak."

Objective (O): After 3 weeks in ICU; cannot lift arms above the shoulder; grip 3/5.

Assessment tools for this scenario: CP-MOVE Movement & Self-Care Score (p. 271)

Validated scales to consider: Barthel Index, Katz ADL

CarePath diagnosis: Muscle weakness related to illness, as evidenced by cannot lift and tires quickly.

Interventions and rationale

Intervention	Rationale
Encourage exercise.	Regular exercise rebuilds muscle that has wasted from illness and bed rest, and it must increase gradually so he is not overtired.
Physiotherapy.	Physiotherapists design safe, targeted programs that restore strength and function, which is needed after a long illness such as his ICU stay.
Give protein-rich nutrition.	Muscles need protein to repair and grow, and illness raises protein needs, so a protein-rich diet supports rebuilding his strength.
Assist safely.	Safe help prevents falls and strain while his arms and body are weak, and it still lets him do as much as he can.
Monitor strength.	Measuring strength regularly shows whether he is improving and lets the plan be changed if he is not.

Expected outcomes

- Within 2 weeks: strength improves one grade.
- Sits unsupported 10 minutes.
- Completes daily exercises.

Linking the data to the diagnosis

After 3 weeks in ICU, a patient says, "My arms feel weak." He cannot lift his arms above the shoulder and his grip is 3/5, so the weakness is measurable and already present. That makes this an actual diagnosis, not a risk. Illness is the cause. The plan aims to rebuild strength through exercise, physiotherapy and good nutrition while helping him safely. Within 2 weeks the expected outcomes are strength improving by one grade, sitting unsupported for 10 minutes and completing his daily exercises.

M12 Stiff joints or shortened muscles

Group: Movement and self-care | Type: Actual problem

- **Definition:** Joints move poorly or muscles tighten, limiting range of motion.
- **Possible causes:** Long immobility; arthritis; nerve damage; burns; stroke
- **Signs and symptoms:** Reduced movement; pain on stretching; fixed positions

Scenario

A patient lying in bed for weeks has a bent, stiff knee.

Subjective (S): "My knee won't straighten."

Objective (O): Knee fixed bent after weeks in bed; pain on stretching; range of movement 40 degrees short.

Assessment tools for this scenario: **CP-MOVE** Movement & Self-Care Score (p. 271) · **CP-PAIN** Pain & Comfort Score (p. 268)

Validated scales to consider: Barthel Index, Katz ADL, NRS 0-10, FLACC, PAINAD

CarePath diagnosis: Stiff joints or shortened muscles related to long immobility, as evidenced by reduced movement and pain on stretching.

Interventions and rationale

Intervention	Rationale
Do range-of-motion exercises.	Moving each joint through its full range regularly keeps muscles and joint tissues from tightening and shortening further.
Position correctly.	Good positioning keeps joints in a position that prevents the knee staying bent and the muscles tightening even more.
Use splints as ordered.	Splints hold the joint in a good position and gently stretch tight tissue, but only as ordered so they do no harm.
Encourage early movement.	Early movement keeps joints and muscles flexible and prevents further shortening and stiffness that come from lying still.
Stretch gently.	Gentle, slow stretching gradually lengthens tight tissue without tearing it or causing extra pain, which would make him resist movement.

Expected outcomes

- Within 1 week: range of movement improves by 10 degrees, no new contractures.
- Splint used as ordered.

Linking the data to the diagnosis

A patient who has lain in bed for weeks says, "My knee won't straighten." The knee is fixed bent, it hurts on stretching and the range of movement is 40 degrees short. Stiffness and shortening are already present, so this is an actual diagnosis resulting from long immobility. The plan aims to stop it getting worse and begin to reverse it with exercises, positioning, splints as ordered and gentle stretching. Within 1 week the expected outcomes are improvement of 10 degrees in range of movement, no new contractures and splint use as ordered.

M13 Cannot groom or care for appearance

Group: Movement and self-care | Type: Actual problem

- **Definition:** The person cannot manage hair, teeth, nails, shaving, or similar personal care.
- **Possible causes:** Weakness; fatigue; low mood; paralysis
- **Signs and symptoms:** Unwashed hair; unkempt look; teeth not brushed

Scenario

A depressed patient stops brushing his hair and teeth.

Subjective (S): "I just don't care how I look anymore."

Objective (O): Unwashed hair; unshaven; teeth not brushed for 3 days; low mood noted.

Assessment tools for this scenario: **CP-MOVE** Movement & Self-Care Score (p. 271)

Validated scales to consider: Barthel Index, Katz ADL

CarePath diagnosis: Cannot groom or care for appearance related to low mood, as evidenced by unwashed hair, being unshaven, and teeth not brushed for 3 days.

Interventions and rationale

Intervention	Rationale
Assist with grooming.	Help with the parts he is not managing keeps him clean and comfortable and protects his mouth and skin health.
Encourage independence.	Doing tasks himself keeps his skills and builds a sense of control, which supports recovery of mood.
Offer choices.	Choices, such as what to wear or when to groom, give him back some control, which helps when mood is low.
Support dignity.	Care that respects dignity improves self-worth and encourages him to take an interest in himself again.

Expected outcomes

- Within 1 week: grooms daily with prompting and says he feels more like himself.
- Hygiene checks completed.

Linking the data to the diagnosis

A depressed patient says, "I just don't care how I look anymore." His hair is unwashed, he is unshaven and he has not brushed his teeth for 3 days, with low mood noted. He is not caring for his appearance now, so an actual statement fits and a risk statement does not. The plan aims to restore grooming with help, choices and respect. Within 1 week the expected outcomes are grooming daily with prompting, saying he feels more like himself and completed hygiene checks.

M14 Unsafe wheelchair or transfer

Group: Movement and self-care | Type: Actual problem

- **Definition:** Moving between bed, chair, and toilet is unsafe for the person or the helper.
- **Possible causes:** Weak legs; heavy patient; poor technique; no equipment
- **Signs and symptoms:** Near falls during transfer; pain in the helper's back

Scenario

A nurse transfers a heavy patient alone and strains her back.

Subjective (S): "I'm afraid I'll fall when you move me."

Objective (O): Heavy patient; nurse transferred alone and strained her back; patient grips tightly; near fall.

Assessment tools for this scenario: **CP-MOVE** Movement & Self-Care Score (p. 271) · **CP-SAFE**

Safety & Falls Score (p. 269)

Validated scales to consider: Barthel Index, Katz ADL, Morse Fall Scale

CarePath diagnosis: Unsafe wheelchair or transfer related to weak legs, as evidenced by near falls during transfer and pain in the helper's back.

Interventions and rationale

Intervention	Rationale
Use hoists or slide sheets.	Hoists and slide sheets take the load off the nurse and move the patient smoothly, which lowers the risk of back injury and dropping her.
Use two staff when needed.	A heavy patient is too much for one person, and a second staff member shares the load and helps keep her stable.
Lock wheels.	Locked wheels stop the chair rolling away during transfer, which is a common cause of falls.
Teach safe transfer.	Correct technique protects the nurse's back and keeps the patient steady, so she feels safe and cooperates.
Assess ability first.	Assessment shows how much she can do herself and which equipment and how many staff are needed, so the right method is chosen.

Expected outcomes

- All transfers done with equipment and two staff.
- No falls or injuries.
- Patient says she feels safe.

Linking the data to the diagnosis

A patient says, "I'm afraid I'll fall when you move me." She is heavy, the nurse transferred her alone and strained her back, the patient gripped tightly and there was a near fall. The unsafe transfer has already happened and injured a helper, so an actual statement fits. The plan aims to make every transfer safe by using equipment and two staff, locking wheels and assessing first. The expected outcomes are all transfers with equipment and two staff, no falls or injuries and the patient saying she feels safe.

M15 Cannot do household tasks

Group: Movement and self-care | Type: Actual problem

- **Definition:** Cooking, cleaning, shopping, or laundry are beyond the person's current ability.
- **Possible causes:** Weakness; poor memory; poor vision; pain
- **Signs and symptoms:** Dirty home; no meals; unpaid bills; unsafe kitchen

Scenario

An older widow cannot clean or cook after a fracture.

Subjective (S): "I can't cook or clean since my fracture."

Objective (O): Lives alone; unwashed dishes; no fresh food; uses a walker.

Assessment tools for this scenario: CP-MOVE Movement & Self-Care Score (p. 271)

Validated scales to consider: Barthel Index, Katz ADL

CarePath diagnosis: Cannot do household tasks related to weakness, as evidenced by dirty home and no meals.

Interventions and rationale

Intervention	Rationale
Assess abilities.	Assessing what she can still do shows where help is really needed, so support fits her needs and does not remove her skills.

Intervention	Rationale
Arrange home help.	Home help covers tasks she cannot manage, such as cooking and cleaning, so she has meals and a safe home while she recovers.
Teach safe methods.	Safe methods, such as sitting to prepare food, let her do tasks with less pain and a lower risk of falling.
Refer to community support.	Community services give ongoing support after discharge, which matters because she lives alone and has no one else to help daily.

Expected outcomes

- Within 1 week: home help arranged, regular meals, house safe.
- Patient names community help available.

Linking the data to the diagnosis

An older widow says, "I can't cook or clean since my fracture." She lives alone, has unwashed dishes and no fresh food, and uses a walker. The household tasks are already not being done, so an actual statement fits and a risk statement does not. The plan aims to make sure she is fed and her home is safe by assessing her abilities, arranging home help and linking her with community support. Within 1 week the expected outcomes are home help arranged, regular meals, a safe house and her naming the community help available.

M16 Poor balance

Group: Movement and self-care | Type: Actual problem

- **Definition:** Unsteady standing or walking raises the chance of falling.
- **Possible causes:** Weak legs; dizziness; nerve disease; inner ear problems
- **Signs and symptoms:** Sways; holds furniture; wide steps; falls

Scenario

An older man sways when standing and holds the wall.

Subjective (S): "I feel like I'm swaying."

Objective (O): Sways when standing; holds the wall; wide steps; positive balance test.

Assessment tools for this scenario: CP-MOVE Movement & Self-Care Score (p. 271)

Validated scales to consider: Barthel Index, Katz ADL

CarePath diagnosis: Poor balance related to weak legs and dizziness, as evidenced by swaying when standing, holding the wall, wide steps, and a positive balance test.

Interventions and rationale

Intervention	Rationale
Assess balance.	Assessing balance shows how severe the problem is and which causes, such as weak legs or dizziness, need treatment.
Use an aid.	A suitable aid widens his base of support and gives him something steady to hold, which lowers the risk of falls.
Non-slip shoes.	Non-slip shoes grip the floor and give a stable base, lowering the risk of slipping.
Remove hazards.	Clutter, wet floors and loose rugs can trip someone who is unsteady, so removing them cuts the chance of a fall.
Teach balance exercises.	Balance exercises strengthen the muscles and reflexes that keep a person upright, improving stability over time.

Intervention	Rationale
Assist.	Help close by can catch him if he sways, which prevents a fall while his balance is poor.

Expected outcomes

- No falls.
- Balance score improves in 2-4 weeks.
- Walks with the correct aid.
- Patient does balance exercises.

Linking the data to the diagnosis

The patient sways when he stands, holds the wall, takes wide steps, and has a positive balance test. These findings are present now, so the correct choice is the actual statement Poor balance (M16) and not a risk statement. It is also different from Likely to fall (S1), which describes the chance of a fall. The plan therefore aims to improve balance and to prevent the fall that his weak legs and dizziness make likely, by using an aid, non-slip shoes, and balance exercises.

M17 Loss of limb movement

Group: Movement and self-care | Type: Actual problem

- **Definition:** One or more limbs cannot move or move only weakly.
- **Possible causes:** Stroke; spinal injury; nerve injury; muscle disease
- **Signs and symptoms:** Cannot move an arm or leg; weak grip; one-sided weakness

Scenario

A stroke patient cannot lift his right arm.

Subjective (S): "I can't lift my right arm."

Objective (O): Stroke; right arm and leg weak (2/5); cannot raise arm against gravity.

Assessment tools for this scenario: CP-MOVE Movement & Self-Care Score (p. 271)

Validated scales to consider: Barthel Index, Katz ADL

CarePath diagnosis: Loss of limb movement related to stroke, as evidenced by cannot move an arm or leg and weak grip.

Interventions and rationale

Intervention	Rationale
Position correctly.	Correct positioning keeps the weak joints aligned and supported, which prevents shoulder strain, swelling and stiffness while the arm cannot hold itself against gravity.
Do passive exercises.	Moving the joints gently through their full range for the patient keeps them flexible and maintains circulation, which helps prevent contractures while his own muscle control is limited.
Protect from injury.	A weak limb is easily bumped, pulled or trapped, and the patient may not react in time, so protecting it prevents bruising, joint damage and other avoidable injury.
Encourage use of the affected limb.	Safe, supported use of the affected limb helps the brain relearn movement pathways and builds confidence, which supports recovery of strength after a stroke.
Refer to therapy.	Physiotherapists and occupational therapists have specialist skills to set graded exercises, splints and aids, which gives the patient the best chance of regaining function.

Expected outcomes

- Maintains joint movement with no contracture.
- Improves by one power grade in 2 weeks.
- Supports the affected arm correctly.

Linking the data to the diagnosis

The patient has had a stroke and says, "I can't lift my right arm." The nurse finds the right arm and leg weak at 2/5, and he cannot raise the arm against gravity, so movement is already lost. This is an actual problem, not a risk, because the weakness is present now. The plan aims to keep the joints moving with no contracture, protect the arm, and support it correctly. The expected outcome is improvement by one power grade in 2 weeks, with therapy guiding recovery.

M18 Muscle wasting from bed rest

Group: Movement and self-care | Type: Risk problem

- **Definition:** Long inactivity may cause weakness, stiffness, and loss of muscle.
- **Risk factors:** Long bed rest; paralysis; severe illness; no exercise
- **Warning signs to watch for:** Weak muscles; thin limbs; stiff joints; pressure sores

Scenario

A patient has been on bed rest in ICU for five days with severe illness.

Subjective (S): "I am too weak to move."

Objective (O): Day 5 in ICU; lightly sedated; no exercise yet; muscle bulk normal; joints move freely; skin intact.

Assessment tools for this scenario: CP-MOVE Movement & Self-Care Score (p. 271) · CP-SKIN Skin & Wound Score (p. 270)

Validated scales to consider: Barthel Index, Katz ADL, Braden Scale, TIME wound chart

CarePath diagnosis: Muscle wasting from bed rest related to long bed rest and severe illness (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Mobilize early.	Getting the patient moving early, as soon as it is safe, keeps muscles working and circulation active, which slows the weakness and stiffness that long inactivity causes.
Exercise.	Regular active or assisted exercise loads the muscles and joints, which helps preserve muscle bulk and joint range even while the patient is critically ill.
Give protein nutrition.	Muscle needs enough protein to repair and maintain itself during severe illness, and inactivity speeds muscle loss, so adequate protein supports strength and healing.
Turn often.	Changing position often relieves pressure on bony areas and keeps blood flowing to the skin, which helps prevent pressure injury in a patient who cannot easily move.
Physiotherapy.	Physiotherapists can design safe, graded movement and strengthening for a lightly sedated ICU patient, which reduces the chance of lasting weakness.

Expected outcomes

- Sits out of bed daily.
- Muscle strength improves.
- No new pressure injury.
- Protein targets met.

Linking the data to the diagnosis

The patient has been on bed rest in ICU for five days with severe illness and says, "I am too weak to move." This is a risk diagnosis because the problem has not happened yet: muscle bulk is normal, joints move freely and skin is intact. The diagnosis rests on risk factors, namely day 5 in ICU, light sedation and no exercise so far. The plan aims to prevent wasting by sitting out of bed daily, improving strength, meeting protein targets and avoiding any new pressure injury.

M19 Poor body positioning

Group: Movement and self-care | Type: Actual problem

- **Definition:** The body is held in a position that is uncomfortable or harmful.
- **Possible causes:** Weakness; pain; devices; staff unaware of correct positions
- **Signs and symptoms:** Slumped; twisted spine; hanging limbs; pressure on one area

Scenario

A patient slides down the chair with his neck bent.

Subjective (S): "My neck hurts when I sit."

Objective (O): Slumps in the chair; neck bent; sliding down; pressure on the sacrum.

Assessment tools for this scenario: **CP-MOVE** Movement & Self-Care Score (p. 271) · **CP-PAIN** Pain & Comfort Score (p. 268) · **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: Barthel Index, Katz ADL, NRS 0-10, FLACC, PAINAD, Braden Scale, TIME wound chart

CarePath diagnosis: Poor body positioning related to weakness, as evidenced by slumped and twisted spine.

Interventions and rationale

Intervention	Rationale
Align the body.	Aligning the head, neck, spine and limbs spreads body weight evenly, which reduces strain on muscles and joints and relieves neck pain.
Support with pillows.	Pillows fill gaps and hold the body in a good position, which reduces effort for a weak patient and eases pressure on sore or stressed areas.
Reposition often.	Changing position regularly stops prolonged pressure on one area such as the sacrum, which protects the skin and tissue underneath and prevents stiffness.
Use chair cushions.	A suitable cushion spreads pressure and helps hold the hips back in the chair, which reduces sliding down and protects the skin over the sacrum.
Teach staff.	Staff who know correct positions can keep the patient well placed at every shift and check, so the improvement does not depend on one nurse.

Expected outcomes

- Position corrected every 2 hours.
- No pain or pressure damage.
- Patient sits upright with support.

Linking the data to the diagnosis

The patient slides down the chair with his neck bent and says, "My neck hurts when I sit." The nurse sees him slumped, the neck bent and pressure on the sacrum, so poor positioning is already causing discomfort and risk to the skin. It is an actual problem, not a risk. The plan aims to correct his position every 2 hours, prevent pain or pressure damage, and help him sit upright with support, so the neck pain settles and the sacrum is protected.

P - Emotions and mind

Recommended assessment tools

CarePath tool: **CP-MIND Mood & Mind Screen** (p. 272)

Validated scales: PHQ-9, GAD-7, C-SSRS

P1 Worry or nervousness

Group: Emotions and mind | Type: Actual problem

- **Definition:** An uneasy feeling with tension, restlessness, fast heartbeat, or trouble focusing.
- **Possible causes:** Illness; uncertain future; pain; hospital stay; past trauma; caffeine
- **Signs and symptoms:** Restlessness; fast heartbeat; sweating; trouble sleeping; says they are worried; poor concentration

Scenario

A man waiting for biopsy results cannot sleep and keeps asking questions.

Subjective (S): "I can't stop worrying and I can't sleep."

Objective (O): Heart rate 104/min; restless; sleeps 3 hours; asks the same questions repeatedly; awaiting biopsy results.

Assessment tools for this scenario: **CP-MIND Mood & Mind Screen** (p. 272) · **CP-SKIN Skin & Wound Score** (p. 270)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS, Braden Scale, TIME wound chart

CarePath diagnosis: Worry or nervousness related to illness, as evidenced by restlessness and fast heartbeat.

Interventions and rationale

Intervention	Rationale
Stay calm.	A calm nurse helps settle the patient, because anxious people pick up on the tone and pace of those around them and become more tense if staff seem rushed.
Listen.	Listening without hurrying lets the patient put worries into words, which often lowers distress and shows the nurse what he fears most.
Explain the next steps simply.	Clear, simple information about what happens next reduces fear of the unknown, which is a major driver of worry while waiting for results.
Teach slow breathing.	Slow breathing activates the body's relaxation response, which can lower heart rate and muscle tension and help the patient wind down for sleep.
Limit stimulants.	Caffeine and other stimulants can raise heart rate and restlessness and disturb sleep, so limiting them avoids adding to the physical signs of worry.
Give medicine as ordered.	Prescribed medicine can ease severe worry or help sleep when other measures are not enough, and giving it as ordered keeps dosing safe.
Involve family.	Family are familiar and trusted, so their presence offers comfort and support, and they can help reinforce coping and explanations.

Expected outcomes

- Within 24-48 hours: rates worry 3/10 or lower, sleeps 5-6 hours, uses two coping methods, says he feels calmer.

Linking the data to the diagnosis

The patient is waiting for biopsy results and says, "I can't stop worrying and I can't sleep." The nurse records a heart rate of 104/min, restlessness, only 3 hours of sleep and the same questions asked repeatedly. These are present now, so this is an actual problem rather than a risk. The plan aims, within 24 to 48 hours, for worry of 3/10 or lower, 5 to 6 hours of sleep, two coping methods and a report that he feels calmer.

P2 Fear of a specific thing

Group: Emotions and mind | Type: Actual problem

- **Definition:** Fear directed at a clear threat such as a procedure, pain, or situation.
- **Possible causes:** Procedures; needles; pain; darkness; surgery; injections
- **Signs and symptoms:** Trembling; tearful; avoiding the feared thing; fast heartbeat; clinging to a parent

Scenario

A child cries and hides when she sees the injection tray.

Subjective (S): (Child) "I don't want the needle!"

Objective (O): Crying; hiding behind parent; heart rate 130/min; refuses to hold out arm.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Fear of a specific thing related to procedures, as evidenced by trembling and tearful.

Interventions and rationale

Intervention	Rationale
Explain in simple words.	Simple, age-appropriate words help the child understand what will happen, and unknown things feel scarier than known ones.
Let the child hold a toy.	A familiar toy gives comfort and a sense of control, and holding it can distract her attention from the needle.
Show the equipment.	Letting the child see and touch safe equipment makes it less mysterious, which can reduce fear of the unknown.
Be honest.	Honest explanations build trust, whereas being told it will not hurt when it will can increase fear at the next procedure.
Allow a parent to stay.	A parent is the child's main source of security, so their presence lowers distress and helps her stay calmer and more cooperative.
Praise courage.	Praise reinforces brave behavior and builds confidence, which makes future procedures easier for the child to cope with.

Expected outcomes

- Child allows the procedure with distraction.
- Cries less.
- Parent helps.
- Child says she felt brave.

Linking the data to the diagnosis

The child cries and hides behind her parent when she sees the injection tray, saying, "I don't want the needle!" The nurse records a heart rate of 130/min and refusal to hold out her arm. The fear is aimed at one clear threat, the needle, and is present now, so this fits fear of a specific thing rather than general

worry. The plan aims for the child to allow the procedure with distraction, cry less, be helped by her parent and say she felt brave.

P3 Difficulty handling stress

Group: Emotions and mind | Type: Actual problem

- **Definition:** The person's usual ways of coping are not working.
- **Possible causes:** Chronic illness; job loss; family strain; poor support; many changes
- **Signs and symptoms:** Irritable; withdrawn; poor sleep; increased substance use; sense of overload

Scenario

A man with cancer drinks more and refuses to talk about his illness.

Subjective (S): "I don't want to talk about it. I just need a drink."

Objective (O): Drinks more since diagnosis; withdrawn; irritable; poor sleep.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Difficulty handling stress related to chronic illness, as evidenced by irritable and withdrawn.

Interventions and rationale

Intervention	Rationale
Listen.	Listening without judging shows respect and builds trust, which helps a man who does not want to talk begin to share when he is ready.
Explore how he copes.	Understanding how he currently copes shows what helps and what harms, such as drinking, so the plan can build on his strengths.
Teach relaxation.	Relaxation skills calm the body's stress response and give him a healthier option than alcohol when he feels overloaded.
Encourage support.	Support from family, friends or groups reduces isolation and shares the load, which makes the stress of cancer easier to bear.
Refer for counseling.	Counselors have training to help people build new coping skills and address alcohol use, which goes beyond what routine ward care can offer.
Praise coping efforts.	Praise for healthy coping strengthens those behaviors and boosts confidence, making it more likely he will use them again.

Expected outcomes

- Within 1 week: states 2 healthy ways to cope, accepts support, cuts down alcohol, engages with a counselor.

Linking the data to the diagnosis

The man with cancer says, "I don't want to talk about it. I just need a drink." The nurse notes he drinks more since the diagnosis, is withdrawn and irritable and sleeps poorly. His usual coping is failing and harmful coping has replaced it, so the problem exists now and is not just a risk. The plan aims, within 1 week, for him to state 2 healthy ways to cope, accept support, cut down alcohol and engage with a counselor.

P4 Loss of hope

Group: Emotions and mind | Type: Actual problem

- **Definition:** The person sees little chance of improvement and loses motivation.

- **Possible causes:** Poor prognosis; long illness; loss; lack of support; repeated setbacks
- **Signs and symptoms:** Says nothing will help; flat voice; little effort; passive; withdrawn

Scenario

A patient after amputation says there is no point in rehabilitation.

Subjective (S): "What's the point? I'll never get better."

Objective (O): Flat voice; stays in bed; refuses therapy; after amputation.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Loss of hope related to poor prognosis, as evidenced by says nothing will help and flat voice.

Interventions and rationale

Intervention	Rationale
Show interest.	Showing real interest tells the patient he matters, which counters the sense of isolation and may open the door to talking about how he feels.
Set tiny goals.	Very small goals are achievable, and each success rebuilds a sense that effort can lead to change, which is the base of hope.
Encourage hope.	Encouraging hope, in a realistic way, supports motivation and reminds him that recovery after amputation can progress step by step.
Point out strengths.	Pointing out strengths he already has helps him see himself as capable, which challenges the belief that nothing will help.
Involve family and chaplain.	Family and chaplain offer trusted emotional and spiritual support, which can restore meaning and connection when he feels there is no point.
Assess for depression and suicide risk.	Hopelessness is linked with depression and suicide risk, so asking about these directly and kindly allows the team to keep him safe and get help early.

Expected outcomes

- Within 3 days: sets one personal goal, attends therapy sessions, states a reason for hope.

Linking the data to the diagnosis

After amputation the patient says, "What's the point? I'll never get better." The nurse observes a flat voice, staying in bed and refusing therapy. These show hope is already lost, so this is an actual problem. The nurse must also assess for depression and suicide risk, because hopeless statements can signal danger. The plan aims, within 3 days, for him to set one personal goal, attend therapy sessions and state a reason for hope.

P5 Feeling no control over one's situation

Group: Emotions and mind | Type: Actual problem

- **Definition:** The person feels unable to influence events or decisions about their care.
- **Possible causes:** Hospital routines; loss of independence; serious illness; poor information
- **Signs and symptoms:** Says no one asks me; passive; angry; refuses care; leaves all decisions to others

Scenario

A patient says staff decide everything and stops asking questions.

Subjective (S): "Nobody asks me anything. They just decide."

Objective (O): Passive; refuses some care; asks few questions; says he feels trapped.

Assessment tools for this scenario: **CP-MIND** Mood & Mind Screen (p. 272) · **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS, Braden Scale, TIME wound chart

CarePath diagnosis: Feeling no control over one's situation related to hospital routines, as evidenced by says no one asks me and passive.

Interventions and rationale

Intervention	Rationale
Give information.	Clear information about his condition and care lets him understand what is happening, which reduces feeling trapped and helps him take part in decisions.
Offer choices.	Offering real choices, even small ones such as timing of care, gives back a sense of control that hospital routines have taken away.
Involve him in the care plan.	Including him in the care plan treats him as a partner, and people who help set goals are more likely to follow them.
Respect preferences.	Respecting his preferences, where safe, shows that his views count, which builds trust and reduces anger and refusal of care.
Set small achievable tasks.	Small tasks he can finish successfully build confidence and show he can influence his situation, which counters passivity.

Expected outcomes

- Takes part in two care decisions daily.
- Says he has some control.
- Asks questions.

Linking the data to the diagnosis

The patient says, "Nobody asks me anything. They just decide." The nurse observes that he is passive, refuses some care, asks few questions and says he feels trapped. His sense of no control is present now, so this is an actual problem, linked to hospital routines. The plan aims to return some control through information, choices and involvement. The expected outcomes are that he takes part in two care decisions daily, says he has some control and asks questions.

P6 Low self-worth

Group: Emotions and mind | Type: Actual problem

- **Definition:** A negative view of oneself, often after illness, loss, or change.
- **Possible causes:** Body change; job loss; illness; criticism; failure
- **Signs and symptoms:** Negative self-talk; avoids eye contact; apologizes a lot; reluctant to try

Scenario

After a stroke, a former teacher says he is useless.

Subjective (S): "I'm useless now."

Objective (O): Former teacher; avoids eye contact; says he is a burden; refuses to try tasks.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Low self-worth related to body change, as evidenced by negative self-talk and avoids eye contact.

Interventions and rationale

Intervention	Rationale
Reflect strengths.	Naming the strengths he still has, such as his teaching skills, challenges the belief that he is useless and helps rebuild his sense of identity.
Praise efforts.	Praising effort, not only results, encourages him to keep trying after a stroke when success may be slow.
Give him a role in his care.	A role in his own care gives him purpose and responsibility, which counters feeling like a burden.
Avoid shaming.	Shaming or teasing damages self-worth further and may lead him to withdraw, so avoiding it protects his dignity and trust.
Set achievable goals.	Goals he can reach build a pattern of success, which gradually improves confidence and willingness to try tasks.
Offer counseling if needed.	Counseling gives professional support for deep feelings about loss of role and ability, and can also help spot depression.

Expected outcomes

- Within 1 week: names one strength, tries a task with support, shows a brighter mood.

Linking the data to the diagnosis

After a stroke, the former teacher says, "I'm useless now." The nurse notes he avoids eye contact, says he is a burden and refuses to try tasks. His negative view of himself is present now, so this is an actual problem related to body change. The plan aims, within 1 week, for him to name one strength, try a task with support and show a brighter mood, by reflecting strengths, praising efforts and giving him a role in his care.

P7 Unhappy with body appearance

Group: Emotions and mind | Type: Actual problem

- **Definition:** Distress about body changes from surgery, injury, illness, or aging.
- **Possible causes:** Surgery; scars; hair loss; amputation; weight change; aging
- **Signs and symptoms:** Hides the body; refuses to look; avoids mirrors; withdraws; negative comments

Scenario

After a mastectomy, a woman will not look at her scar.

Subjective (S): "I can't look at myself."

Objective (O): After mastectomy; refuses to view the scar; covers her chest; avoids her partner.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Unhappy with body appearance related to surgery, as evidenced by hides the body and refuses to look.

Interventions and rationale

Intervention	Rationale
Allow her to express feelings.	Being allowed to talk about grief over body change helps her process feelings, and feeling heard reduces shame and isolation.
Support her at her own pace.	Letting her decide when to look or touch respects her control and avoids shock, which makes later acceptance more likely.
Involve her partner.	Her partner is an important source of support, and including them can reduce her fear of rejection and ease intimacy concerns.
Show options.	Information on prostheses, clothing, reconstruction or other options shows practical ways forward and can restore a sense of choice and confidence.
Refer to a counselor or support group.	Counselors and peer groups offer experience and understanding from women with similar changes, which helps with long-term adjustment.

Expected outcomes

- Within 1-2 weeks: looks at the scar with support, discusses feelings, partner included.
- States acceptance steps.

Linking the data to the diagnosis

After a mastectomy, the woman says, "I can't look at myself." The nurse sees that she refuses to view the scar, covers her chest and avoids her partner. These behaviors show she is already distressed about her body, so this is an actual problem related to surgery. The plan aims, within 1 to 2 weeks, for her to look at the scar with support, discuss her feelings, include her partner and state steps toward acceptance.

P8 Sadness after a loss

Group: Emotions and mind | Type: Actual problem

- **Definition:** A natural grief reaction to death, loss of health, or another loss.
- **Possible causes:** Death of a loved one; loss of health; divorce; job loss
- **Signs and symptoms:** Crying; sadness; numbness; sleep and appetite change; yearning

Scenario

A man cries often after his wife died last month.

Subjective (S): "I miss her so much."

Objective (O): Cries often; sleeps poorly; weight down 3 kg; wife died last month.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272) · CP-FLUID Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS, MUST, fluid chart, glucose

CarePath diagnosis: Sadness after a loss related to death of a loved one, as evidenced by crying and sadness.

Interventions and rationale

Intervention	Rationale
Listen.	Listening with full attention shows care and lets him talk about his wife, which is part of normal grieving and reduces loneliness.
Allow tears.	Tears are a natural release of grief, and allowing them shows that his feelings are accepted rather than something to hide.
Do not rush.	Grief runs at its own pace, and hurrying a person can make him feel misunderstood and block healthy mourning.
Encourage rituals and support.	Rituals, faith practices and the support of others give structure and meaning during loss and help him feel connected.
Watch for complicated grief.	Grief that stays severe, or comes with depression or risk of harm, needs different care, so watching for it allows early help.
Refer when needed.	Specialist counselors or a doctor can support him if normal grief is not easing, or if his sleep, weight and function worsen.

Expected outcomes

- Within 2-3 weeks: expresses grief openly, sleeps and eats better, names a support person.
- No signs of complicated grief.

Linking the data to the diagnosis

The man says, "I miss her so much." His wife died last month, and the nurse records frequent crying, poor sleep and a weight loss of 3 kg. These are present now and fit a natural grief reaction, so this is an actual problem and not a risk. It is also not long-lasting grief, because only one month has passed. The plan aims, within 2 to 3 weeks, for him to express grief openly, sleep and eat better, name a support person and show no signs of complicated grief.

P9 Risk of self-harm (needs urgent response) **URGENT**

Group: Emotions and mind | Type: Risk problem

- **Definition:** Thoughts or signs of wanting to end life or cause harm. Needs immediate safety steps and urgent specialist support.
- **Risk factors:** Depression; previous attempt; loss; illness; substance use; access to means
- **Warning signs to watch for:** Talk of death; hopelessness; giving away items; sudden calm; withdrawal

Scenario

A patient with depression, who lost his job two weeks ago, says everyone would be better off without him.

Subjective (S): "Everyone would be better off without me."

Objective (O): Hopeless statements; withdrawn; history of depression; previous attempt two years ago; job loss two weeks ago; eating little.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Risk of self-harm related to depression, a previous attempt and recent job loss (risk factors), with hopeless statements and withdrawal (warning signs); needs urgent response.

Interventions and rationale

Intervention	Rationale
Take every statement seriously and stay with the patient.	Every statement about wanting to die may signal real danger, and staying with the patient keeps him safe, shows he is valued and reduces the isolation that raises risk.
Ask directly and kindly about thoughts of suicide and use the structured risk tool required by local policy.	Asking directly does not cause suicidal thoughts and gives permission to talk. A structured tool gives a consistent, policy-based measure of risk to guide the level of observation.
Remove hazards and keep the patient under the observation level ordered.	Removing hazards limits access to means at a time of crisis, and the ordered observation level makes sure he is watched closely enough to stay safe.
Alert the team and the doctor immediately and follow the safety policy.	Immediate alerting makes sure a doctor and team can assess risk and act quickly, and following policy makes sure the right protections are in place.
Arrange urgent specialist mental health review.	A mental health specialist can assess depression and risk in depth and decide on treatment and the level of care he needs.
Agree a written safety plan before discharge or transfer.	A written plan, made with him, sets out warning signs, coping steps and contacts, so he has a clear guide for moments of crisis after leaving.

Expected outcomes

- Patient remains safe with no self-harm during the stay.
- Urgent mental health review completed.
- Patient helps write a safety plan and names two people or services to call.

Linking the data to the diagnosis

This is an urgent risk diagnosis, so the nurse calls for help and stays with the patient first. He has said, "Everyone would be better off without me," and is withdrawn, eating little and hopeless. Risk factors are depression, a previous attempt two years ago and job loss two weeks ago. Self-harm has not occurred, so the diagnosis rests on risk factors and warning signs, not on harm. The plan aims for safety during the stay, an urgent mental health review and a safety plan he helps write, naming two people or services to call.

P10 Distress after a frightening event

Group: Emotions and mind | Type: Actual problem

- **Definition:** Flashbacks, nightmares, or feeling constantly on edge after trauma.
- **Possible causes:** Accident; assault; war; disaster; abuse; sudden loss
- **Signs and symptoms:** Flashbacks; nightmares; startling easily; avoiding reminders; irritability

Scenario

A road accident survivor wakes from nightmares sweating.

Subjective (S): "I keep seeing the crash."

Objective (O): Nightmares nightly; startles at noise; avoids driving; sweating.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Distress after a frightening event related to accident, as evidenced by flashbacks and nightmares.

Interventions and rationale

Intervention	Rationale
Create a safe place.	Feeling physically and emotionally safe calms the body's alarm system, which helps a person after trauma to relax and begin to heal.
Listen without pushing.	Pushing someone to relive the event can worsen distress, so listening at his own pace builds trust and lets him share when ready.
Teach grounding.	Grounding, such as focusing on the senses in the room, brings attention back to the present and can reduce the intensity of flashbacks.
Encourage routine.	A predictable daily routine restores a sense of order and control and supports better sleep after a frightening event.
Refer for trauma counseling.	Trauma-focused counselors use proven therapies to treat flashbacks and nightmares, which are more effective than routine support alone.

Expected outcomes

- Within 4 weeks: sleeps through most nights, reports fewer flashbacks, uses grounding.
- Accepts counseling.

Linking the data to the diagnosis

The road accident survivor says, "I keep seeing the crash." The nurse records nightly nightmares with sweating, startling at noise and avoidance of driving. These signs of ongoing distress are present now, so this is an actual problem related to the accident. The plan aims, within 4 weeks, for him to sleep through most nights, report fewer flashbacks, use grounding and accept counseling. Staff offer a safe place, listen without pushing and refer for trauma counseling to support recovery.

P11 Confusion or memory problems

Group: Emotions and mind | Type: Actual problem

- **Definition:** Ongoing trouble thinking clearly, remembering, or knowing time and place.
- **Possible causes:** Dementia; stroke; infection; medicine; brain injury; poor sleep
- **Signs and symptoms:** Forgets names and places; repeats questions; gets lost; wrong time of day

Scenario

An older man cannot remember that he is in hospital.

Subjective (S): "Where am I?"

Objective (O): Disoriented to time and place; repeats questions; forgets names; safe when supervised.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272) · CP-OLDER Older Adult Check (p. 278)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS, 4AT / CAM, Mini-Cog

CarePath diagnosis: Confusion or memory problems related to dementia, as evidenced by forgets names and places and repeats questions.

Interventions and rationale

Intervention	Rationale
Reorient gently.	Gentle reminders of where he is and who people are can reduce fear and confusion, and a calm tone keeps him from feeling corrected or distressed.
Use clocks and calendars.	Visible clocks and calendars give him constant cues about time and day, which supports orientation without having to ask.

Intervention	Rationale
Keep routines.	Familiar daily routines reduce the mental effort needed to cope and lower anxiety, because he knows what to expect.
Use simple words.	Short, clear sentences are easier to process when thinking is affected, and they reduce misunderstanding and frustration.
Keep the area safe.	A clutter-free, safe space lowers the chance of falls, wandering or injury in someone who may not recognize hazards.
Involve family.	Familiar faces and personal items calm and orient him, and family can teach staff what works best for him.

Expected outcomes

- Oriented using cues.
- No wandering.
- Safe in the environment.
- Family states how to respond.

Linking the data to the diagnosis

The older man asks, "Where am I?" The nurse finds he is disoriented to time and place, repeats questions and forgets names, but is safe when supervised. These signs are persistent and linked to dementia, so this is an actual problem, not a risk, and it is not a sudden change. The plan aims for him to be oriented using cues, not wander, stay safe in his environment and have family who can state how to respond to his confusion.

P12 Low mood

Group: Emotions and mind | Type: Actual problem

- **Definition:** Persistent sadness, loss of interest, or tearfulness.
- **Possible causes:** Illness; loss; isolation; chronic pain; medicines
- **Signs and symptoms:** Sad; tearful; loss of interest; low energy; sleep and appetite change

Scenario

A woman after retirement stays in bed and cries easily.

Subjective (S): "I don't enjoy anything anymore."

Objective (O): Tearful; stays in bed; poor appetite; not seeing friends; low energy.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Low mood related to illness, as evidenced by sad and tearful.

Interventions and rationale

Intervention	Rationale
Listen.	Listening with patience shows that her feelings matter and reduces isolation, and talking may help her understand what she is experiencing.
Encourage activity.	Gentle, achievable activity improves energy and mood and counters the pull to stay in bed, so it is introduced in small steps.
Support routine.	A regular daily routine for sleep, meals and activity gives structure, which helps when low mood makes organizing the day difficult.
Monitor for suicide risk.	Low mood can deepen into thoughts of self-harm, so monitoring and asking about it allows early help if risk appears.

Intervention	Rationale
Refer to the doctor.	A doctor can check for depression or a medical cause and decide whether treatment such as therapy or medicine is needed.
Offer social support.	Contact with friends and community reduces loneliness, which is a common driver of low mood after retirement.

Expected outcomes

- Within 1 week: takes part in one pleasant activity daily and mood improves.
- No thoughts of self-harm.
- Engaged with support.

Linking the data to the diagnosis

The woman says, "I don't enjoy anything anymore." The nurse sees her tearful, staying in bed, with poor appetite, low energy and no contact with friends. These signs of persistent low mood are present now, so this is an actual problem. Monitoring for suicide risk is part of the care, because low mood can worsen. The plan aims, within 1 week, for one pleasant activity daily, improved mood, no thoughts of self-harm and engagement with support.

P13 Anger or aggression

Group: Emotions and mind | Type: Actual problem

- **Definition:** Irritability or hostility that may escalate to harmful words or actions.
- **Possible causes:** Frustration; pain; fear; confusion; substance use
- **Signs and symptoms:** Shouting; clenched fists; irritability; blaming others

Scenario

A patient who waited hours shouts at staff and slams the door.

Subjective (S): "I've been waiting for hours! This is useless!"

Objective (O): Shouting; slams the door; clenched fists; red face.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Anger or aggression related to frustration after a long wait, as evidenced by shouting, slamming the door, clenched fists, and a red face.

Interventions and rationale

Intervention	Rationale
Stay calm.	A calm voice and body language lower tension, because an angry person often mirrors the energy around them, and staying calm helps prevent escalation.
Give space.	Extra personal space reduces the feeling of being threatened or cornered and gives him room to cool down, which lowers the chance of violence.
Listen.	Listening shows he is being taken seriously, and feeling heard often reduces anger faster than arguing or explaining.
Address the cause.	Dealing with the real cause, such as the long wait or pain, removes the trigger, so the anger is less likely to return.
Set limits kindly.	Firm but kind limits make clear what is not acceptable while respecting him, which keeps everyone safe without shaming him.
Keep staff safe.	Staff safety comes first, so positioning, backup and a clear exit let them respond if anger escalates and protect other patients too.

Expected outcomes

- Calms within 15 minutes.
- No harm.
- Expresses concern verbally.
- Waiting times explained.

Linking the data to the diagnosis

The patient has waited for hours and is now shouting at staff, slamming the door, clenching his fists, and looks flushed. These behaviors are happening now, so the statement is actual, not a risk. The cause is frustration, not illness, so the nurse stays calm, listens, and deals with the reason for the wait. The plan aims to calm him within 15 minutes, keep everyone safe, and let him voice his concerns in words.

P14 Extreme mood swings

Group: Emotions and mind | Type: Actual problem

- **Definition:** Rapid or intense changes in mood that are hard to control.
- **Possible causes:** Mental illness; medicines; stress; brain disease
- **Signs and symptoms:** Laughs then cries; sudden anger; cannot calm down; irritable

Scenario

A patient swings from joy to anger within minutes.

Subjective (S): "I'm fine one minute and furious the next."

Objective (O): Laughs then shouts within minutes; irritable; cannot calm herself.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Extreme mood swings related to mental illness, as evidenced by laughs then cries and sudden anger.

Interventions and rationale

Intervention	Rationale
Stay calm and consistent.	A calm, steady and predictable approach gives a sense of stability when her own moods are changing quickly, and it avoids feeding the swings.
Keep stimulation low.	Quiet surroundings with few demands reduce overstimulation, which can trigger or intensify sudden emotional changes.
Teach coping.	Learning coping skills, such as pausing, breathing or using a quiet space, gives her tools to steady herself when a mood shifts.
Give medicine as ordered.	Prescribed medicine can help stabilize mood, and giving it as ordered keeps treatment safe and effective.
Report severe changes.	Severe changes may signal worsening illness, side effects or risk of harm, so reporting them allows prompt review and treatment changes.

Expected outcomes

- Within 1 week: fewer mood swings, uses a calming strategy.
- No harm to self or others.

Linking the data to the diagnosis

The patient says, "I'm fine one minute and furious the next." The nurse observes that she laughs and then shouts within minutes, is irritable and cannot calm herself. These intense, rapid changes are

present now, so this is an actual problem related to mental illness, not a risk. The plan aims, within 1 week, for fewer mood swings and use of a calming strategy, with no harm to herself or others. Staff stay calm, reduce stimulation and give medicine as ordered.

P15 Hearing or seeing things others do not

Group: Emotions and mind | Type: Actual problem

- **Definition:** The person perceives voices or images that are not there.
- **Possible causes:** Mental illness; withdrawal; fever; brain disease; drugs
- **Signs and symptoms:** Talks to someone unseen; frightened; says he hears voices; distracted

Scenario

A patient covers his ears and says voices tell him to run.

Subjective (S): "The voices are telling me to leave."

Objective (O): Covers ears; talks to an unseen person; frightened; paces.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Hearing or seeing things others do not related to mental illness, as evidenced by talks to someone unseen and frightened.

Interventions and rationale

Intervention	Rationale
Do not argue.	Arguing about whether the voices are real can increase fear and mistrust, so accepting that they are real to him while not agreeing keeps trust.
Reassure.	Calm reassurance that he is safe and not alone eases the fear that often comes with hearing voices.
Ask about the voices and any commands.	Asking about what the voices say, especially commands to harm himself or others, shows how much risk there is and guides what safety steps are needed.
Ensure safety.	A safe, low-stimulation environment lowers the chance of harm if he acts on fear or commands, such as trying to run.
Report command voices.	Command voices can lead to dangerous actions, so the team needs to know quickly to assess risk and adjust observation and treatment.
Give medicine as ordered.	Antipsychotic or other ordered medicine can reduce the voices and distress, and giving it as prescribed keeps treatment safe and effective.

Expected outcomes

- Feels safe.
- Commands not acted on.
- Voices less distressing within days.
- Takes medicine as ordered.

Linking the data to the diagnosis

The patient says, "The voices are telling me to leave." The nurse sees him cover his ears, talk to an unseen person, pace and appear frightened. He is experiencing perceptions that others do not, now, so this is an actual problem related to mental illness. The nurse asks about commands because they raise the risk of harm. The plan aims for him to feel safe, not act on commands, find the voices less distressing within days and take medicine as ordered.

P16 Suspicious or distorted thinking

Group: Emotions and mind | Type: Actual problem

- **Definition:** Strong false beliefs or mistrust that do not match reality.
- **Possible causes:** Psychosis; paranoia; substance use; dementia
- **Signs and symptoms:** Believes people are plotting against him; refuses food or medicine; guarded

Scenario

A patient refuses meals saying the food is poisoned.

Subjective (S): "The food is poisoned."

Objective (O): Refuses meals and medicines; guarded; eyes scan the room.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Suspicious or distorted thinking related to psychosis, as evidenced by believes people are plotting against him and refuses food or medicine.

Interventions and rationale

Intervention	Rationale
Stay calm and honest.	Calm, honest communication reduces threat and builds trust, which is hard for someone who feels people are plotting against him.
Do not argue.	Arguing with a fixed belief rarely changes it and may make him more fearful and guarded, so staying neutral protects the relationship.
Keep routines.	Predictable routines reduce surprises that might feed suspicion and help him feel safer in an unfamiliar setting.
Respect feelings.	Acknowledging that he feels afraid, without agreeing with the belief, shows empathy and helps him feel understood.
Offer choices.	Offering choices, such as which meal or when to take medicine, restores some control and may make accepting food and medicine easier.
Watch for risk.	Suspicion can lead to refusal of food or medicine, hostility or harm, so close watching allows early action to keep everyone safe.

Expected outcomes

- Eats at least some meals.
- Accepts medicines.
- Trusts staff gradually.
- No aggression.

Linking the data to the diagnosis

The patient says, "The food is poisoned." The nurse notes he refuses meals and medicines, is guarded and scans the room with his eyes. The strong false belief is present now and affects his care, so this is an actual problem related to psychosis. The plan aims for him to eat at least some meals, accept medicines, gradually trust staff and show no aggression. Staff stay calm and honest, avoid arguing, keep routines and offer choices.

P17 Poor concentration

Group: Emotions and mind | Type: Actual problem

- **Definition:** Difficulty keeping attention on tasks, conversations, or instructions.

- **Possible causes:** Stress; illness; poor sleep; pain; ADHD; medicines
- **Signs and symptoms:** Easily distracted; forgets instructions; cannot finish tasks

Scenario

A student after a head injury cannot follow a lesson.

Subjective (S): "I can't focus on anything."

Objective (O): After head injury; cannot follow a lesson; forgets instructions; fatigue.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Poor concentration related to head injury and fatigue, as evidenced by being unable to follow a lesson, being easily distracted, and forgetting instructions.

Interventions and rationale

Intervention	Rationale
Give short clear instructions.	Short, clear instructions fit a reduced attention span and are easier to remember, which lowers frustration and mistakes.
Reduce distractions.	Noise and clutter compete for limited attention, so a quiet, simple space helps him focus on one thing at a time.
Repeat.	Repeating information gives more chances for it to be taken in and remembered when memory and attention are weak.
Break tasks into steps.	Smaller steps make a task less overwhelming and let him finish and feel success, which builds focus and confidence.
Allow rest.	Fatigue worsens concentration, and the brain needs rest to recover after injury, so planned breaks let him do better in the next task.
Refer if it persists.	Persisting problems may show a lasting injury or another cause that needs specialist assessment and treatment.

Expected outcomes

- Follows a 3-step instruction and completes a short task with support.
- Concentration improves over weeks.

Linking the data to the diagnosis

The student says, "I can't focus on anything." After a head injury, the nurse notes he cannot follow a lesson, forgets instructions and has fatigue. These difficulties are present now, so this is an actual problem rather than a risk. The listed cause is stress, but the data also point to the head injury and tiredness. The plan aims for him to follow a 3-step instruction and complete a short task with support, with concentration improving over weeks. Staff give short instructions, cut distractions and allow rest.

P18 Sudden confusion **URGENT**

Group: Emotions and mind | Type: Actual problem

- **Definition:** An abrupt change in awareness or thinking, often from infection, medicine, or acute illness.
- **Possible causes:** Infection; dehydration; medicines; surgery; low oxygen; pain
- **Signs and symptoms:** Sudden disorientation; restlessness; drowsiness; hallucinations; symptoms that come and go

Scenario

An older man becomes confused on day 2 after surgery.

Subjective (S): "Who are you? Where am I?"

Objective (O): Day 2 after surgery; sudden confusion; temperature 38.5 C; hallucinating at night.

Assessment tools for this scenario: **CP-MIND** Mood & Mind Screen (p. 272) · **CP-OLDER** Older Adult Check (p. 278) · **CP-INFECT** Infection Check (p. 281)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS, 4AT / CAM, Mini-Cog, qSOFA / sepsis screen

CarePath diagnosis: Sudden confusion related to infection, as evidenced by sudden disorientation and restlessness.

Interventions and rationale

Intervention	Rationale
Look for the cause.	Sudden confusion is usually a sign of an underlying problem such as infection, pain or low oxygen, so finding and treating the cause is the key to recovery.
Check vital signs and blood sugar.	Changes in temperature, pulse, blood pressure, oxygen or blood sugar can show infection or other reversible causes that need treatment.
Reorient.	Gentle reminders of place, time and people reduce fear and help him make sense of his surroundings, without arguing or confronting him.
Keep safe.	Confusion raises the risk of falls, pulling out tubes and wandering, so close supervision and a safe space prevent injury.
Avoid restraints.	Restraints increase agitation, injury and the length of confusion, so less restrictive ways to keep him safe are preferred.
Have family present.	Familiar faces and voices calm and orient him, which can reduce fear and agitation.
Report quickly.	Sudden confusion can signal a serious illness, so prompt reporting lets the doctor start treatment quickly.

Expected outcomes

- Within 24-48 hours: oriented, cause treated, no falls or injuries, sleeps at night.

Linking the data to the diagnosis

On day 2 after surgery, the older man asks, "Who are you? Where am I?" The nurse records sudden confusion, a temperature of 38.5 C and hallucinations at night. The abrupt change and likely infection set this apart from ongoing confusion or memory problems, which develop slowly. It is an actual problem, and the nurse reports quickly. The plan aims, within 24 to 48 hours, for him to be oriented, the cause treated, no falls or injuries and sleep at night.

P19 Difficulty making decisions

Group: Emotions and mind | Type: Actual problem

- **Definition:** The person is unsure which care option to choose or is torn between choices.
- **Possible causes:** Complex choices; fear; conflicting advice; lack of information
- **Signs and symptoms:** Hesitates; asks many questions; changes mind; distress

Scenario

A woman cannot choose between surgery and medicine.

Subjective (S): "I don't know if I should have the surgery."

Objective (O): Asks many questions; changes her mind; tearful; family disagrees.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Difficulty making decisions related to complex choices, as evidenced by hesitates and asks many questions.

Interventions and rationale

Intervention	Rationale
Give balanced information.	Fair, balanced facts about benefits and risks of each option let her compare them clearly rather than being pushed toward one.
Explore her values.	Exploring what matters most to her, such as family, comfort or independence, helps her connect the choice to her own values.
Allow time.	Rushing a big decision increases stress and regret, so time to think and ask questions supports a choice she is comfortable with.
Involve family.	Family are part of her support, and including them can ease conflict and let everyone hear the same information, while her wishes stay central.
Refer to a counselor.	A counselor can help her work through fear and mixed feelings that make it hard to choose.
Support her decision.	Supporting her decision respects her right to decide about her own care and builds trust, even if others would choose differently.

Expected outcomes

- Within 48 hours: understands options, states her decision and reasons, feels supported.

Linking the data to the diagnosis

The woman says, "I don't know if I should have the surgery." The nurse observes that she asks many questions, changes her mind, is tearful and has family who disagree. The difficulty in choosing is present now, so this is an actual problem rather than a risk. The plan aims, within 48 hours, for her to understand her options, state her decision and her reasons, and feel supported. Staff give balanced information, allow time and support whichever choice she makes.

P20 Trouble controlling impulses

Group: Emotions and mind | Type: Actual problem

- **Definition:** The person acts without thinking in ways that risk harm.
- **Possible causes:** Mental illness; brain injury; substance use; stress
- **Signs and symptoms:** Acts before thinking; breaks rules; risky actions

Scenario

A patient leaves the ward repeatedly without telling staff.

Subjective (S): "I just wanted some fresh air."

Objective (O): Leaves the ward repeatedly; acts on urges; ignores rules.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Trouble controlling impulses related to mental illness, as evidenced by acts before thinking and breaks rules.

Interventions and rationale

Intervention	Rationale
Set clear limits.	Clear, consistent limits show what is expected and keep him safe, because acting on urges without boundaries can lead to harm.
Teach coping.	Teaching ways to pause and manage urges, such as delaying or using a calming activity, gives him a safer choice in the moment.
Reward self-control.	Positive feedback for self-control strengthens the behavior and builds confidence, which works better than punishment.
Supervise.	Supervision lowers the chance of unsafe leaving, such as wandering off the ward, while he is still learning to control urges.
Give medicine as ordered.	Ordered medicine may reduce impulsive urges linked to mental illness, and giving it as prescribed supports safety and treatment.

Expected outcomes

- No unsafe leaving.
- Uses a plan to manage urges.
- Follows ward rules for 48 hours.

Linking the data to the diagnosis

The patient who leaves the ward repeatedly says, "I just wanted some fresh air." The nurse notes that he acts on urges and ignores rules, so poor impulse control is already causing unsafe behavior and is an actual problem. The plan aims for no unsafe leaving, use of a plan to manage urges and following ward rules for 48 hours. Staff set clear limits, supervise, teach coping skills and give medicine as ordered.

P21 Dependence on alcohol or drugs

Group: Emotions and mind | Type: Actual problem

- **Definition:** Regular substance use that harms health or daily life.
- **Possible causes:** Repeated use; stress; peer pressure; mental illness; easy access
- **Signs and symptoms:** Cravings; failed attempts to quit; neglected duties; tolerance; secrecy

Scenario

A patient drinks daily and cannot stop despite liver problems.

Subjective (S): "I can stop whenever I want."

Objective (O): Daily drinking; high liver tests; shaky in the morning; failed quit attempts.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Dependence on alcohol or drugs related to repeated use, as evidenced by cravings and failed attempts to quit.

Interventions and rationale

Intervention	Rationale
Assess without judging.	A nonjudgmental approach encourages honest answers about use, which gives an accurate picture and keeps him engaged in care.
Monitor for withdrawal.	Stopping alcohol suddenly can cause dangerous withdrawal, such as tremor, seizures or confusion, so early signs need to be spotted and treated.

Intervention	Rationale
Motivate.	Motivational support helps him see for himself how drinking affects his liver and life, which is more effective than being told to stop.
Refer to treatment.	Specialist addiction services offer treatment and long-term support that ward care alone cannot provide.
Teach harm reduction.	Harm reduction advice lowers the risk of serious damage while he is still using, and it keeps the door open for treatment.
Support the family.	Family are affected by dependence and are often a key support, so helping them improves his chances of recovery.

Expected outcomes

- States a plan to cut down.
- Completes detox safely.
- Agrees to a treatment referral.
- No withdrawal complications.

Linking the data to the diagnosis

The patient says, "I can stop whenever I want," yet drinks daily, has high liver tests, is shaky in the morning and has failed quit attempts. These signs show ongoing dependence now, so this is an actual problem, not a risk. It is not yet withdrawal, though the nurse monitors for it. The plan aims for him to state a plan to cut down, complete detox safely, agree to a treatment referral and avoid withdrawal complications.

P22 Withdrawal symptoms

Group: Emotions and mind | Type: Actual problem

- **Definition:** Shaking, sweating, agitation, or cravings after stopping a substance.
- **Possible causes:** Stopping alcohol or drugs; reduced doses
- **Signs and symptoms:** Shaking; sweating; anxiety; vomiting; seizures; confusion; fast pulse

Scenario

A heavy drinker admitted for surgery develops tremors on day 2.

Subjective (S): "I feel terrible and I'm shaking."

Objective (O): Tremor; sweating; pulse 112/min; anxious; day 2 after admission; heavy drinker.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272) · CP-BREATH Breathing & Circulation Check (p. 265)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS, NEWS2, SpO₂, ECG

CarePath diagnosis: Withdrawal symptoms related to stopping alcohol or drugs, as evidenced by shaking and sweating.

Interventions and rationale

Intervention	Rationale
Use a withdrawal scale.	A withdrawal scale gives a consistent score of symptom severity, which guides when and how much medicine is needed.
Give medicines as ordered.	Ordered medicines calm the overactive nervous system and reduce the risk of seizures and confusion, and giving them as prescribed keeps doses safe.
Monitor vital signs.	Pulse, blood pressure, temperature and other signs can show worsening withdrawal early, so changes can be treated before they become dangerous.

Intervention	Rationale
Keep a safe quiet room.	A quiet, safe, low-stimulation room reduces agitation and the chance of injury if he becomes shaky, confused or has a seizure.
Report seizures or confusion urgently.	Seizures and confusion are serious complications that need immediate medical treatment, so they must be reported urgently.

Expected outcomes

- Within 72 hours: withdrawal symptoms controlled, no seizures, vital signs stable, patient safe.

Linking the data to the diagnosis

The heavy drinker admitted for surgery says, "I feel terrible and I'm shaking." On day 2 the nurse records tremor, sweating, a pulse of 112/min and anxiety. These signs appeared after stopping alcohol, so this is an actual problem, not the underlying dependence. The nurse reports seizures or confusion urgently. The plan aims, within 72 hours, for controlled symptoms, no seizures, stable vital signs and a safe patient.

P23 Harmful eating behaviors

Group: Emotions and mind | Type: Actual problem

- **Definition:** Eating patterns such as severe restriction, bingeing, or purging that harm health.
- **Possible causes:** Body image problems; stress; need for control; perfectionism
- **Signs and symptoms:** Severe restriction; bingeing or purging; weight loss; secrecy; fear of gaining weight

Scenario

A teenager skips meals and exercises excessively.

Subjective (S): "I'm too fat."

Objective (O): Teen skipping meals; BMI 16; weight down 8 kg; excessive exercise; secretive about food.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272) · CP-FLUID Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS, MUST, fluid chart, glucose

CarePath diagnosis: Harmful eating behaviors related to body image problems, as evidenced by skipped meals, excessive exercise, BMI 16, and weight down 8 kg.

Interventions and rationale

Intervention	Rationale
Build trust.	Trust is the base of care for eating problems, because a person who feels judged tends to hide behaviors and resist help.
Supervise meals as planned.	Supervised meals make sure planned food is eaten and help her feel supported, which lowers anxiety and the chance of hiding or discarding food.
Avoid blame.	Blame increases shame and secrecy, so a neutral, caring tone helps her stay engaged in treatment.
Monitor vital signs and labs.	Severe restriction and weight loss can affect heart rate, blood pressure and body chemicals, so checking them finds danger early.
Refer to a specialist team.	Specialist teams have training in treating eating disorders and offer therapy, nutrition and medical care together.

Intervention	Rationale
Involve family.	Family can support meals and recovery at home, and including them helps everyone understand and respond well.

Expected outcomes

- Eats planned meals.
- Weight stabilizes within 2 weeks.
- Vital signs stable.
- Accepts specialist care.

Linking the data to the diagnosis

The teenager says, "I'm too fat," while skipping meals and exercising excessively. The nurse records a BMI of 16, an 8 kg weight loss and secrecy about food. These signs show harmful eating is present now and already affecting health, so this is an actual problem. The data describe restriction and over-exercise, not bingeing or purging. The plan aims for her to eat planned meals, have weight stabilize within 2 weeks, keep stable vital signs and accept specialist care.

P24 Self-injury

Group: Emotions and mind | Type: Actual problem

- **Definition:** Deliberately hurting oneself. Needs safe, nonjudgmental care and specialist support.
- **Possible causes:** Emotional pain; trauma; shame; mental illness; need for relief
- **Signs and symptoms:** Cuts or burns; hiding wounds; secrecy; long sleeves in hot weather

Scenario

A teenager has fresh cuts on her arms.

Subjective (S): "I do it to feel something."

Objective (O): Fresh cuts on the forearms; wears long sleeves; avoids discussing.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Self-injury related to emotional pain, as evidenced by cuts or burns and hiding wounds.

Interventions and rationale

Intervention	Rationale
Treat wounds calmly.	Calm, prompt wound care treats injury and shows the patient that she is cared for, which helps her stay open to talking.
Do not judge.	Judgment can increase shame, which often drives self-injury, so a kind approach keeps her willing to trust and accept help.
Assess safety and suicide risk.	Self-injury can occur alongside thoughts of suicide, so assessing safety and risk makes sure she gets the right level of protection.
Teach safe coping.	Safer ways to cope with strong feelings give her alternatives to use when the urge to hurt herself comes up.
Involve the mental health team.	Mental health professionals can treat the emotional pain behind self-injury and plan longer-term care.
Limit access to means.	Reducing access to things that could be used for harm lowers the chance of injury during moments of distress.

Expected outcomes

- Wounds heal.
- Patient remains safe.
- Names two safer coping skills.
- Engages with the mental health team.

Linking the data to the diagnosis

The teenager has fresh cuts on her forearms, wears long sleeves and avoids discussing them, saying, "I do it to feel something." The harm has already happened, so this is an actual problem, not a risk. The nurse treats wounds, shows no judgment and assesses safety and suicide risk. The plan aims for wounds to heal, the patient to stay safe, name two safer coping skills and engage with the mental health team.

P25 Guilt or shame

Group: Emotions and mind | Type: Actual problem

- **Definition:** Painful feelings of blame or inadequacy about illness or past events.
- **Possible causes:** Past events; blaming oneself for illness; cultural beliefs; family conflict
- **Signs and symptoms:** Self-blame; frequent apologies; withdrawn; fear of judgment

Scenario

A man blames himself for his own heart attack.

Subjective (S): "It's my fault I had the heart attack."

Objective (O): Self-blame; apologizes constantly; avoids family.

Assessment tools for this scenario: **CP-MIND** Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Guilt or shame related to past events, as evidenced by self-blame and frequent apologies.

Interventions and rationale

Intervention	Rationale
Listen.	Listening without interrupting lets him express painful feelings and shows that he is respected, which can ease shame.
Correct unfair self-blame gently.	Gently pointing out that a heart attack has many causes and is not a personal failing counters unfair self-blame and reduces guilt.
Encourage forgiveness.	Forgiveness of oneself helps people move forward and focus on recovery and healthy changes rather than on past events.
Offer a chaplain or counselor if needed.	A chaplain or counselor can offer spiritual or professional support for deep guilt that is beyond what routine care can address.

Expected outcomes

- States less self-blame.
- Accepts support.
- Shares feelings with a counselor or chaplain.

Linking the data to the diagnosis

The man says, "It's my fault I had the heart attack." The nurse notes self-blame, constant apologizing and avoidance of family. These signs of painful guilt are present now, so this is an actual problem related to past events. The plan aims for him to state less self-blame, accept support and share his

feelings with a counselor or chaplain. The nurse listens, gently corrects unfair blame and encourages forgiveness, so he can focus on recovery.

P26 Long-lasting grief

Group: Emotions and mind | Type: Actual problem

- **Definition:** Grief that stays intense for a long time and blocks daily functioning.
- **Possible causes:** Sudden death; no support; unresolved conflict; trauma
- **Signs and symptoms:** Intense grief lasting beyond a year; cannot function; stuck on the past; withdrawal

Scenario

A woman is still unable to work two years after her child's death.

Subjective (S): "I can't go on without my child."

Objective (O): Two years after loss; cannot work; still grieving intensely; isolated.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Long-lasting grief related to sudden death, as evidenced by intense grief lasting beyond a year and cannot function.

Interventions and rationale

Intervention	Rationale
Acknowledge the pain.	Naming and respecting the depth of the loss tells her that her grief is real and valid, which reduces isolation.
Offer grief counseling.	Grief counselors are trained to help with grief that stays intense and blocks daily life, using approaches beyond ordinary support.
Encourage support groups.	Other bereaved parents understand her loss and can offer shared experience and hope, which reduces loneliness.
Monitor for depression.	Long-lasting grief increases the risk of depression, so watching for it allows early treatment and protects her health.
Involve family.	Family can provide ongoing comfort and practical help, and including them helps them understand what she is going through.

Expected outcomes

- Attends grief counseling.
- Takes part in one daily activity.
- Screened for depression and risk.

Linking the data to the diagnosis

The woman says, "I can't go on without my child." Two years after the loss she still grieves intensely, cannot work and is isolated. Grief this intense and lasting well beyond a year differs from ordinary sadness after a loss, so this is an actual problem related to sudden death. The nurse also screens for depression and risk, because the statement may signal danger. The plan aims for her to attend grief counseling, take part in one daily activity and be screened for depression and risk.

P27 Stress from illness or hospital stay

Group: Emotions and mind | Type: Actual problem

- **Definition:** Strain from illness, an unfamiliar setting, and loss of routine.

- **Possible causes:** Serious illness; unfamiliar setting; loss of control; many changes
- **Signs and symptoms:** Tense; irritable; poor sleep; withdrawn; cannot cope

Scenario

A patient admitted for the first time is restless and tearful.

Subjective (S): "I don't know what's happening and I'm scared."

Objective (O): First admission; tearful; restless; asks to go home; poor sleep.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Stress from illness or hospital stay related to serious illness, as evidenced by tense and irritable.

Interventions and rationale

Intervention	Rationale
Explain the surroundings and routines.	Knowing where things are and what will happen each day reduces fear of the unknown, which is a main source of stress in a first admission.
Encourage questions.	Encouraging questions shows that her concerns matter and corrects misunderstandings that can fuel fear.
Allow personal items.	Familiar items from home provide comfort and a sense of identity and control in an unfamiliar setting.
Teach relaxation.	Relaxation methods calm the body's stress response and can ease tension and help sleep.
Involve family.	Family are a familiar source of comfort, and their visits can reduce loneliness and fear.
Give emotional support.	Kind reassurance and attention help her feel safe and cared for, which lowers distress.

Expected outcomes

- Within 48 hours: rates stress 3/10 or lower, knows ward routines, sleeps 6 hours, uses two coping methods.

Linking the data to the diagnosis

The patient admitted for the first time says, "I don't know what's happening and I'm scared." The nurse notes she is tearful, restless, asks to go home and sleeps poorly. These signs of strain from illness and the hospital setting are present now, so this is an actual problem rather than a risk. The plan aims, within 48 hours, for stress of 3/10 or lower, knowledge of ward routines, 6 hours of sleep and two coping methods. Staff explain routines, welcome questions, allow personal items and give support.

P28 Loss of sense of identity

Group: Emotions and mind | Type: Actual problem

- **Definition:** The person feels they no longer know who they are after illness, injury, or a change of role.
- **Possible causes:** Amputation; stroke; role change; mental illness; aging
- **Signs and symptoms:** Says he does not know who he is; withdrawn; lost purpose; confusion about roles

Scenario

After retirement and illness, a man says he no longer knows who he is.

Subjective (S): "I don't know who I am now."

Objective (O): Retired and ill; withdrawn; says he has no purpose; refuses visitors.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Loss of sense of identity related to retirement and illness, as evidenced by saying he does not know who he is, withdrawal, and refusing visitors.

Interventions and rationale

Intervention	Rationale
Explore values and strengths.	Helping him name what he values and what he can still do rebuilds a sense of self that illness and retirement have shaken, and shows he is seen as a whole person.
Encourage meaningful activity.	Taking part in activities that matter to him restores purpose and a feeling of being useful, which counters withdrawal and the belief that he has no role.
Link to peer support.	Meeting others who have faced similar losses shows him he is not alone and gives real examples of people who rebuilt their sense of who they are.
Offer counseling.	A trained counselor can help him grieve lost roles and abilities and can screen for depression, which often goes along with loss of identity.
Praise abilities.	Genuine recognition of what he can still do strengthens self-worth and confidence, helping him see himself as more than his illness.

Expected outcomes

- Within 2 weeks: names one meaningful role or interest, takes part in activities, engages with support.

Linking the data to the diagnosis

The patient says, "I don't know who I am now," is retired and ill, appears withdrawn, says he has no purpose, and refuses visitors. These data point to a problem with how he sees himself and his roles, not simply low mood or loneliness, so this statement fits better than a social isolation diagnosis. The problem is already present, so it is an actual diagnosis, not a risk one. The plan aims for him, within 2 weeks, to name one meaningful role or interest, take part in activities, and engage with support, which would show his sense of identity and purpose is returning.

P29 Ready for better coping

Group: Emotions and mind | Type: Actual problem

- **Definition:** The person wants to build stronger coping skills.
- **Possible causes:** Motivation to learn; recent stress; wish to grow
- **Signs and symptoms:** Asks how to cope; uses healthy strategies; seeks support

Scenario

A patient asks how to manage stress better after discharge.

Subjective (S): "How can I handle stress better?"

Objective (O): Asks for strategies; calm; motivated; recent hospital stay.

Assessment tools for this scenario: CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Ready for better coping related to motivation to learn, as evidenced by asks how to cope and uses healthy strategies.

Interventions and rationale

Intervention	Rationale
Praise readiness.	Recognizing his readiness reinforces motivation and confidence, which makes it more likely he will keep using and building healthy coping skills.
Teach skills.	Practical skills such as relaxation, problem solving and breathing give him tools he can use at home when stress returns after discharge.
Set goals.	Clear, personal goals turn a general wish to cope better into specific steps he can try and measure his progress against.
Link to support groups.	Support groups offer ongoing encouragement and shared experience, so he does not have to manage stress alone once he leaves hospital.
Follow up.	Follow up checks whether the skills are working, lets problems be fixed early, and keeps his motivation going after discharge.

Expected outcomes

- Describes and practices two stress skills.
- Links to a support group.
- Sets personal goals.

Linking the data to the diagnosis

The patient asks, "How can I handle stress better?", asks for strategies, is calm and motivated, and has had a recent hospital stay. Nothing suggests ineffective coping or crisis; instead he shows a wish to grow, so a readiness statement fits better than a problem statement such as anxiety or poor coping. This is a health promotion diagnosis built on strengths, not a risk. The plan aims for him to describe and practice two stress skills, link to a support group, and set personal goals, building on the motivation he already has after discharge.

R - Communication and relationships

Recommended assessment tools

CarePath tool: **CP-TALK Communication Check** (p. 273)

Validated scales: Communication barrier checklist

R1 Difficulty speaking or being understood

Group: Communication and relationships | Type: Actual problem

- **Definition:** Speech is unclear, limited, or absent, so needs are hard to communicate.
- **Possible causes:** Stroke; throat injury; brain disease; sedation; ventilator
- **Signs and symptoms:** Slurred speech; cannot find words; silence; gestures; frustration

Scenario

After a stroke, a man tries to talk but only makes sounds.

Subjective (S): (Tries to speak.) "Wa... wa..."

Objective (O): Slurred speech; cannot find words; frustrated; right-sided weakness.

Assessment tools for this scenario: **CP-TALK Communication Check** (p. 273) · **CP-NEURO Brain & Senses Check** (p. 280)

Validated scales to consider: Communication barrier checklist, GCS, pupils, NIHSS

CarePath diagnosis: Difficulty speaking or being understood related to stroke, as evidenced by slurred speech and cannot find words.

Interventions and rationale

Intervention	Rationale
Speak slowly.	A slow pace gives a person with damaged speech pathways more time to process each word and respond, and lowers pressure and frustration.
Use yes or no questions.	Yes or no questions need only a simple answer, so he can say what he needs without having to find or form words.
Use picture boards.	Pictures let him point to needs when words fail, giving him a reliable way to be understood and some control.
Allow extra time.	Stroke affects the speed of finding and forming words, so extra time prevents rushing him and reduces anxiety that makes speech harder.
Refer to speech therapy.	A speech therapist can assess the type of speech problem and teach exercises and methods that help recovery of communication.
Keep the call bell reachable.	If he can always reach the call bell, he can summon help when he cannot speak, which protects his safety and independence.

Expected outcomes

- Within 3 days: communicates basic needs using speech, gestures, or a board.
- Less frustration.
- Uses the call bell.

Linking the data to the diagnosis

After a stroke the man tries to speak but only makes sounds such as "Wa... wa...", with slurred speech, difficulty finding words, frustration, and right-sided weakness. These data show speech is already impaired and his needs are hard to communicate, so this is an actual problem, not a risk, and it fits

better than a hearing or language barrier diagnosis because he cannot produce words. The plan aims for him, within 3 days, to communicate basic needs by speech, gestures or a board, feel less frustrated, and use the call bell.

R2 Difficulty hearing or seeing

Group: Communication and relationships | Type: Actual problem

- **Definition:** Hearing or vision loss limits communication, safety, or understanding.
- **Possible causes:** Aging; eye or ear disease; wax; infection; medicines
- **Signs and symptoms:** Misses speech; leans forward; squints; bumps into things; loud television

Scenario

An older woman misunderstands staff and misses cues.

Subjective (S): "What? Can you say that again?"

Objective (O): Leans forward; asks people to repeat; squints; poor hearing and vision; hearing aid battery flat.

Assessment tools for this scenario: CP-TALK Communication Check (p. 273)

Validated scales to consider: Communication barrier checklist

CarePath diagnosis: Difficulty hearing or seeing related to aging, as evidenced by misses speech and leans forward.

Interventions and rationale

Intervention	Rationale
Check hearing and vision aids.	A flat hearing aid battery or dirty glasses can cause avoidable communication problems, so checking and fixing aids is the quickest way to improve what she hears and sees.
Reduce noise.	Background noise makes it harder to pick out speech, especially with hearing loss, so a quieter room helps her follow what is said.
Face the patient.	Facing her lets her see lips and expressions, which support understanding when hearing is poor, and she can see that she is being spoken to.
Speak clearly.	Clear, slightly slower speech without shouting is easier to understand than loud or rushed speech, which distorts sound and can feel disrespectful.
Use writing and large print.	Written words and large print give another route for information when hearing and vision are both reduced, so instructions are not missed.
Check safety.	Poor sight and hearing raise the risk of trips, falls and missed warnings, so checking the surroundings keeps her safe while she cannot rely on her senses.

Expected outcomes

- Understands instructions with aids.
- Moves safely.
- Staff use clear speech.
- Patient says she feels understood.

Linking the data to the diagnosis

The older woman says, "What? Can you say that again?", leans forward, asks people to repeat, squints, has poor hearing and vision, and her hearing aid battery is flat. These data show a sensory problem already limiting communication, so it is an actual diagnosis and fits better than a language barrier or a speech problem, because the difficulty is receiving information. The plan aims for her to understand instructions with her aids, move safely, be spoken to clearly by staff, and say she feels understood.

R3 Feeling alone or cut off from others

Group: Communication and relationships | Type: Actual problem

- **Definition:** The person has little contact or connection with other people and feels isolated.
- **Possible causes:** Illness; mobility loss; moving house; bereavement; shyness
- **Signs and symptoms:** Says he feels lonely; few visitors; withdrawn; low mood

Scenario

An older widower sees no one for days.

Subjective (S): "I haven't spoken to anyone for days."

Objective (O): Lives alone; few visitors; low mood; television on all day.

Assessment tools for this scenario: CP-TALK Communication Check (p. 273)

Validated scales to consider: Communication barrier checklist

CarePath diagnosis: Feeling alone or cut off from others related to illness, as evidenced by says he feels lonely and few visitors.

Interventions and rationale

Intervention	Rationale
Encourage contact.	Regular contact with others reduces isolation and loneliness, which are linked to low mood and poorer health.
Arrange visits.	Planned visits from family or friends give predictable company, which is hard for someone living alone to create for himself.
Link to community groups.	Community groups offer shared interests and new relationships beyond family, so social contact can continue after discharge.
Use phone or video calls.	Phone or video calls let him connect with people who cannot visit, which helps when distance or illness limits visits.
Check mood.	Long loneliness can lead to depression, so checking his mood finds problems early so that further help can be arranged.

Expected outcomes

- Within 2 weeks: has regular contact at least 3 times a week and joins one group.
- Says he feels less lonely.

Linking the data to the diagnosis

The older widower says, "I haven't spoken to anyone for days," lives alone, has few visitors, low mood, and keeps the television on all day. These data show a lack of social contact that has already occurred, so this is an actual diagnosis and not a risk. It fits better than a grief or low mood diagnosis because the central problem is a lack of connection with other people. The plan aims for him, within 2 weeks, to have contact at least 3 times a week, join one group, and say he feels less lonely.

R4 Struggling with family or work roles

Group: Communication and relationships | Type: Actual problem

- **Definition:** Illness prevents the person from carrying out usual roles.
- **Possible causes:** Illness; injury; job loss; caregiving demands; disability
- **Signs and symptoms:** Cannot do usual duties; guilt; conflict; frustration

Scenario

A father cannot work after a spinal injury and feels useless.

Subjective (S): "I can't provide for my family anymore."

Objective (O): Father after spinal injury; angry and withdrawn; avoids his children.

Assessment tools for this scenario: **CP-TALK** Communication Check (p. 273)

Validated scales to consider: Communication barrier checklist

CarePath diagnosis: Struggling with family or work roles related to illness, as evidenced by cannot do usual duties and guilt.

Interventions and rationale

Intervention	Rationale
Explore feelings.	Talking through anger, guilt and loss in a safe setting helps him process feelings that could otherwise lead to withdrawal or depression.
Help redefine roles.	Roles can change without losing worth, so redefining them helps him find new ways to contribute to his family.
Involve family.	Including the family helps them understand his feelings, share responsibilities, and support him, which eases strain on relationships.
Refer to a social worker.	A social worker can help with practical problems such as income, benefits and services, which ease the worry behind his sense of failure.
Set goals.	Small, achievable goals give him a sense of progress and control, and rebuild his belief that he still has value.

Expected outcomes

- Within 1 week: discusses new roles with family, sets one goal, reports an increased sense of worth.

Linking the data to the diagnosis

The father cannot work after a spinal injury, says, "I can't provide for my family anymore," feels useless, is angry and withdrawn, and avoids his children. These data show he cannot carry out his usual family and work roles, so this actual diagnosis fits better than a general anxiety or low mood diagnosis. The problem has already happened, so it is not a risk statement. The plan aims for him, within 1 week, to discuss new roles with his family, set one goal, and report an increased sense of worth.

R5 Family caregiver overwhelmed

Group: Communication and relationships | Type: Actual problem

- **Definition:** Tiredness, stress, or strain in the person who gives unpaid care.
- **Possible causes:** Long care; poor sleep; no breaks; financial stress; no help
- **Signs and symptoms:** Exhaustion; anger; poor health; neglecting self; feeling trapped

Scenario

A wife caring for her husband with dementia 24 hours a day is worn out.

Subjective (S): "I'm so tired. I can't do this alone."

Objective (O): Wife caring for her husband with dementia 24 hours a day; sleeps 4 hours; weight down; tearful.

Assessment tools for this scenario: **CP-TALK** Communication Check (p. 273) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: Communication barrier checklist, MUST, fluid chart, glucose

CarePath diagnosis: Family caregiver overwhelmed related to long care, as evidenced by exhaustion and anger.

Interventions and rationale

Intervention	Rationale
Acknowledge her effort.	Recognizing her effort validates the hard work she does and reduces guilt, which can make her more open to accepting help.
Teach skills.	Learning safer, easier ways to give care, such as lifting and handling dementia behaviors, lowers her workload and the risk of injury.
Encourage breaks.	Regular breaks give her time to rest and recover, and chronic exhaustion without rest harms her health and her ability to keep caring.
Arrange respite and support groups.	Respite care lets someone else look after her husband for a while, and support groups give her understanding from people in the same situation.
Refer to a social worker.	A social worker can arrange practical help, services and funding, which reduces the load she is carrying alone.

Expected outcomes

- Within 2 weeks: takes at least 2 breaks a week, names one support source, reports lower strain.

Linking the data to the diagnosis

The wife cares for her husband with dementia 24 hours a day and says, "I'm so tired. I can't do this alone." She sleeps 4 hours, has lost weight, and is tearful. These data show the strain is already affecting her health, so this is an actual diagnosis and not a risk of caregiver strain. It fits better than a diagnosis for the husband, because the problem lies with the carer. The plan aims for her, within 2 weeks, to take at least 2 breaks a week, name one support source, and report lower strain.

R6 Conflict or breakdown in family support

Group: Communication and relationships | Type: Actual problem

- **Definition:** The family cannot work together or support the patient.
- **Possible causes:** Serious illness; disagreements; poor communication; stress
- **Signs and symptoms:** Arguments; blame; missed visits; no shared decisions

Scenario

Siblings argue over the care of their sick mother.

Subjective (S): "My sister never helps and we keep arguing."

Objective (O): Siblings argue at the bedside; blame; no shared plan; patient upset.

Assessment tools for this scenario: CP-TALK Communication Check (p. 273)

Validated scales to consider: Communication barrier checklist

CarePath diagnosis: Conflict or breakdown in family support related to serious illness, as evidenced by arguments and blame.

Interventions and rationale

Intervention	Rationale
Hold a family meeting.	A planned meeting brings everyone together in one place so they hear the same information and can talk instead of arguing at the bedside.
Give facts.	Clear facts about the mother's condition and needs reduce guesswork and blame, so the discussion stays on her care.

Intervention	Rationale
Mediate.	A neutral person can keep the discussion fair, stop blaming, and help each person be heard, which makes agreement more likely.
Set shared goals.	Shared goals focus the family on what is best for their mother and give each person a clear part to play.
Refer to a social worker or counselor.	A social worker or counselor has skills for resolving family conflict and can give support after the meeting.

Expected outcomes

- Within 3 days: family meeting held and shared care plan agreed.
- Fewer arguments.

Linking the data to the diagnosis

The sick mother's adult children argue at her bedside, blame each other, have no shared plan, and the patient is upset. One says, "My sister never helps and we keep arguing." These data show the family is not working together now, so this actual diagnosis fits better than a diagnosis of caregiver strain, because the main problem is conflict. The problem has already occurred. The plan aims for a family meeting to be held within 3 days, a shared care plan agreed, and fewer arguments.

R7 Difficulty trusting or cooperating with care

Group: Communication and relationships | Type: Actual problem

- **Definition:** The person resists or distrusts treatment, staff, or advice.
- **Possible causes:** Past bad experience; fear; culture; poor communication; stigma
- **Signs and symptoms:** Refuses treatment; argues; misses visits; hides information

Scenario

A patient distrusts staff and refuses medicines.

Subjective (S): "I don't trust you people."

Objective (O): Refuses medicines; argues; hides information; past bad experience.

Assessment tools for this scenario: CP-TALK Communication Check (p. 273)

Validated scales to consider: Communication barrier checklist

CarePath diagnosis: Difficulty trusting or cooperating with care related to past bad experience, as evidenced by refuses treatment and argues.

Interventions and rationale

Intervention	Rationale
Build trust.	Trust is the base for any cooperation, and he is more likely to accept care from staff who show they are honest and reliable.
Listen.	Listening shows respect and lets him express fears and past hurts, which are often the real reason for refusal.
Explain reasons.	When he understands why a medicine or treatment is needed, he can make an informed choice instead of refusing from fear or suspicion.
Involve the patient in decisions.	Sharing decisions gives him a sense of control, which reduces resistance and makes him more likely to stick with the plan.
Respect beliefs.	Respecting his beliefs shows that his values matter, which reduces conflict and the feeling that care is being forced on him.

Intervention	Rationale
Be consistent.	Staff who act the same way every time show they can be relied on, which builds trust over time.

Expected outcomes

- Accepts some care within days.
- States concerns.
- Builds rapport.
- Agrees to a shared plan.

Linking the data to the diagnosis

The patient says, "I don't trust you people," refuses medicines, argues, hides information, and has had a past bad experience. These data show distrust that is already blocking care, so this is an actual diagnosis, not a risk. It fits better than a knowledge deficit, because he understands but does not trust, and better than a language barrier because communication is possible. The plan aims for him to accept some care within days, state his concerns, build rapport, and agree to a shared plan.

R8 Not enough help at home

Group: Communication and relationships | Type: Actual problem

- **Definition:** Home support is too little for the person's needs.
- **Possible causes:** Discharge; living alone; limited family; disability; costs
- **Signs and symptoms:** Cannot manage meals or hygiene; no helper; safety risks

Scenario

An older man goes home alone after surgery with no help.

Subjective (S): "I'm going home alone and I don't have anyone."

Objective (O): Lives alone; after surgery; limited mobility; no helper arranged.

Assessment tools for this scenario: CP-TALK Communication Check (p. 273)

Validated scales to consider: Communication barrier checklist

CarePath diagnosis: Not enough help at home related to discharge, as evidenced by cannot manage meals or hygiene and no helper.

Interventions and rationale

Intervention	Rationale
Assess needs.	A full assessment shows what he can and cannot do alone, such as meals, hygiene and moving about, so help matches real needs.
Arrange home care.	Home care services can supply meals, personal care and checks, so he is safe and can recover after surgery without relying on others.
Involve family and a social worker.	Family and a social worker can find extra help, funding and community resources that he may not know about or know how to ask for.
Teach tasks.	Teaching tasks he can safely do himself, adapted to his limited mobility, helps him manage daily needs and avoid injury or setbacks.
Plan follow-up.	Follow-up lets problems at home be spotted early, so help can be adjusted before he becomes unsafe or is readmitted.

Expected outcomes

- Home support arranged before discharge.

- Patient states how to get help.
- Safe discharge.

Linking the data to the diagnosis

The older man says, "I'm going home alone and I don't have anyone." He lives alone, is recovering from surgery, has limited mobility, and no helper is arranged. These data show that support at home does not match his needs, so this actual diagnosis fits better than a risk of injury, because the lack of help is already present. The plan aims for home support to be arranged before discharge, for him to state how to get help, and for a safe discharge.

R9 Language barrier

Group: Communication and relationships | Type: Actual problem

- **Definition:** The person and staff do not share a common language.
- **Possible causes:** Foreign patient; migration; no interpreter; dialect
- **Signs and symptoms:** Misunderstanding; nodding without understanding; mistakes; anxiety

Scenario

A patient who speaks only Arabic cannot understand English instructions.

Subjective (S): (Speaks only Arabic.) "I don't understand."

Objective (O): Nods without understanding; mistakes with medicines; anxious; no interpreter used yet.

Assessment tools for this scenario: **CP-TALK** Communication Check (p. 273) · **CP-MIND** Mood & Mind Screen (p. 272)

Validated scales to consider: Communication barrier checklist, PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Language barrier related to foreign patient, as evidenced by misunderstanding and nodding without understanding.

Interventions and rationale

Intervention	Rationale
Use a qualified interpreter.	A trained interpreter gives accurate, confidential translation of medical terms, which untrained helpers may get wrong, so errors with medicines are less likely.
Use simple words and pictures.	Simple words and pictures support understanding across languages and reduce the chance of misreading instructions.
Give translated leaflets.	Written instructions in his own language let him review them later and share them with family, so he can follow the plan at home.
Confirm understanding.	Nodding does not mean understanding, so asking him to repeat the instruction back through the interpreter shows whether it was really understood.
Involve family only when appropriate.	Family may know the patient well but can change or leave out information and may breach privacy, so they should only help when suitable.

Expected outcomes

- Understands instructions with an interpreter.
- Teach-back accurate.
- Fewer errors.
- Translated written notes given.

Linking the data to the diagnosis

The patient speaks only Arabic and says, "I don't understand." He nods without understanding, has made mistakes with medicines, is anxious, and no interpreter has been used yet. These data show that

staff and patient do not share a language and that errors are already happening, so this is an actual diagnosis and not a risk. It fits better than a health literacy problem, because the barrier is language. The plan aims for him to understand instructions with an interpreter, answer teach-back correctly, make fewer errors, and receive translated written notes.

R10 Trouble understanding health information

Group: Communication and relationships | Type: Actual problem

- **Definition:** Low reading ability or health literacy makes instructions hard to follow.
- **Possible causes:** Low literacy; complex language; stress; poor vision; older age
- **Signs and symptoms:** Cannot explain the plan; misses doses; avoids forms

Scenario

A patient signs forms but cannot explain the medicine plan.

Subjective (S): "I'm fine, I understand." (cannot repeat the plan)

Objective (O): Signs forms but cannot explain medicines; low literacy; embarrassed.

Assessment tools for this scenario: CP-TALK Communication Check (p. 273)

Validated scales to consider: Communication barrier checklist

CarePath diagnosis: Trouble understanding health information related to low literacy, as evidenced by cannot explain the plan and misses doses.

Interventions and rationale

Intervention	Rationale
Use plain words.	Everyday words are easier to understand than medical terms, so plain language makes sure he really understands the plan.
Short steps.	Small steps are easier to take in and remember than a long list, and avoid overwhelming him.
Teach-back.	Asking him to explain the plan in his own words checks real understanding without making him feel tested, since signing a form does not show that he understands.
Pictures.	Pictures show information in a way that does not depend on reading skill, and are easier to remember.
Simple written notes.	Simple notes give him something to look at at home, which helps him remember what to take and when.
Repeat.	Repeating key points over time helps move information into memory, especially when he is stressed or embarrassed.

Expected outcomes

- Within 2 sessions: explains the plan in his own words by teach-back and takes medicines correctly.

Linking the data to the diagnosis

The patient says, "I'm fine, I understand," but cannot repeat the plan. He signs forms yet cannot explain his medicines, has low literacy, is embarrassed, and misses doses. These data show a gap between appearing to understand and truly understanding, so this actual diagnosis fits better than a general lack of knowledge, because the cause is low literacy and not lack of teaching. The plan aims for him, within 2 sessions, to explain the plan in his own words using teach-back and to take his medicines correctly.

R11 Relationship or intimacy difficulty

Group: Communication and relationships | Type: Actual problem

- **Definition:** Illness or treatment strains close relationships.
- **Possible causes:** Illness; surgery; medicines; body change; fear; stress
- **Signs and symptoms:** Avoids closeness; worry; conflict; silence

Scenario

A man after a heart attack fears having sex.

Subjective (S): "I'm afraid it will happen again."

Objective (O): Man after heart attack; avoids his partner; worried; asks few questions.

Assessment tools for this scenario: CP-TALK Communication Check (p. 273)

Validated scales to consider: Communication barrier checklist

CarePath diagnosis: Relationship or intimacy difficulty related to illness, as evidenced by avoids closeness and worry.

Interventions and rationale

Intervention	Rationale
Create a private safe space.	Privacy lets him talk about a sensitive topic without embarrassment, so his real fears can be spoken aloud.
Give information.	Accurate facts about safe activity after a heart attack correct myths and reduce fear that intimacy will cause another one.
Include the partner.	Including his partner lets both share their worries and understand the facts, which can reduce distance between them.
Refer for counseling.	A counselor trained in intimacy and relationship problems can give deeper help if fear and avoidance continue.
Respect values.	Respecting his values and culture keeps the conversation comfortable and makes him more willing to take part.

Expected outcomes

- Discusses concerns openly.
- Receives accurate information.
- Resumes intimacy as advised by the doctor.

Linking the data to the diagnosis

The man after a heart attack says, "I'm afraid it will happen again." He avoids his partner, is worried, and asks few questions. These data show closeness is already affected by fear linked to his illness, so this actual diagnosis fits better than a general anxiety diagnosis because the worry centers on the relationship. The problem has already begun, so it is not a risk. The plan aims for him to discuss his concerns openly, receive accurate information, and resume intimacy as advised by the doctor.

R12 Abuse or neglect in the family

Group: Communication and relationships | Type: Actual problem

- **Definition:** Signs that a family member is being harmed or not properly cared for.
- **Possible causes:** Stress; caregiver burden; power imbalance; substance use
- **Signs and symptoms:** Unexplained injuries; fear; poor hygiene; neglect; conflicting stories

Scenario

A frail patient arrives dirty and underfed with bruises.

Subjective (S): "It's nothing. I'm fine."

Objective (O): Frail patient arrives dirty and underfed; bruises; conflicting stories; caregiver controlling.

Assessment tools for this scenario: **CP-TALK Communication Check** (p. 273)

Validated scales to consider: Communication barrier checklist

CarePath diagnosis: Abuse or neglect in the family related to stress, as evidenced by unexplained injuries and fear.

Interventions and rationale

Intervention	Rationale
Observe and document.	Careful, factual records of injuries, appearance and statements provide objective evidence that supports protective action and any later investigation.
Speak privately.	Speaking alone lets her talk without fear of the caregiver, who may be controlling, so the truth is more likely to come out.
Ensure safety.	Her safety comes first, so she should not be left alone with someone who may be harming her until the situation is assessed.
Report per policy.	Reporting through the right channels brings in people trained and legally empowered to investigate and protect her, so she is not left at risk.
Offer support.	Support such as counseling and social services helps her recover, and may also help a stressed caregiver get help.
Follow the law.	Laws and policies on reporting abuse protect vulnerable adults and nurses, so acting within them keeps the response correct and safe.

Expected outcomes

- Patient safe.
- Concerns reported per policy.
- Support arranged.
- Neglect addressed.

Linking the data to the diagnosis

The frail patient arrives dirty and underfed, with bruises, conflicting stories, and a controlling caregiver. She says, "It's nothing. I'm fine." These data show harm or neglect that has already occurred, so this is an actual diagnosis and not a risk, and the minimizing answer should not reassure the nurse. It fits better than a diagnosis for poor nutrition alone, because the pattern points to the family setting. The plan aims for the patient to be safe, concerns reported per policy, support arranged, and the neglect addressed.

R13 Parenting difficulty

Group: Communication and relationships | Type: Actual problem

- **Definition:** A parent struggles to meet a child's physical, emotional, or safety needs.
- **Possible causes:** Young parent; poor knowledge; stress; poverty; lack of support
- **Signs and symptoms:** Neglect; harsh discipline; missed visits; unsafe home

Scenario

A teenage mother is unsure how to feed her infant.

Subjective (S): "I don't know how to feed my baby."

Objective (O): Teen mother; unsure about feeds; infant crying; limited support.

Assessment tools for this scenario: **CP-TALK Communication Check** (p. 273)

Validated scales to consider: Communication barrier checklist

CarePath diagnosis: Parenting difficulty related to young age and limited support, as evidenced by uncertainty about feeding and an infant who is crying.

Interventions and rationale

Intervention	Rationale
Teach skills.	Showing how to feed and care for her baby gives her the knowledge and confidence she lacks, which supports the baby's growth and safety.
Praise efforts.	Praise for what she does well builds confidence and encourages her to keep learning and trying.
Arrange support.	Support from family, friends or services eases the load on a young parent with limited help and lowers stress.
Make home visits.	Home visits let the nurse see real conditions, give teaching in context, and spot problems that would be missed in hospital.
Link to community resources.	Community resources such as parenting classes and clinics provide continued help after the nurse is no longer involved.
Watch for safety.	Watching for safety makes sure the infant is fed, kept safe, and not harmed while the mother is still learning.

Expected outcomes

- Within 1 week: feeds baby correctly, states hunger cues, links to community support.
- Baby thriving.

Linking the data to the diagnosis

The teen mother says, "I don't know how to feed my baby." She is unsure about feeds, the infant is crying, and she has limited support. These data show a young parent who cannot yet meet her baby's needs, so this actual diagnosis fits better than a risk statement or a weak bond diagnosis, because the main problem is skill and knowledge. The plan aims for her, within 1 week, to feed the baby correctly, state hunger cues, link to community support, and see the baby thriving.

R14 Weak bond between parent and baby

Group: Communication and relationships | Type: Risk problem

- **Definition:** Early bonding may be delayed by separation, illness, or stress.
- **Risk factors:** Premature baby; maternal illness; separation; stress; depression
- **Warning signs to watch for:** Avoids the baby; little eye contact; does not respond to baby's cues

Scenario

A mother separated from her premature baby shows little interest in visits.

Subjective (S): "I'm scared to touch him."

Objective (O): Premature baby in the NICU; mother avoids touching; little eye contact; tearful.

Assessment tools for this scenario: **CP-TALK** Communication Check (p. 273)

Validated scales to consider: Communication barrier checklist

CarePath diagnosis: Weak bond between parent and baby related to premature baby and maternal illness (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Encourage touch and skin-to-skin care.	Touch and skin-to-skin contact help parent and baby bond, steady the baby's heart rate and temperature, and make the mother feel more confident.
Involve her in care.	Taking part in feeding and care shows her she matters to her baby and helps her feel like a mother, not a visitor.
Explain baby's cues.	Understanding what her baby's signals mean helps her respond to him, which builds closeness and reduces her fear.
Praise bonding.	Praise for each small step builds her confidence and encourages her to keep trying to touch, hold and respond to her baby.
Offer support.	Emotional support helps her cope with fear, illness and separation, which can otherwise get in the way of bonding.

Expected outcomes

- Within days: holds baby skin to skin, responds to his cues, says she feels closer to him.

Linking the data to the diagnosis

The mother of a premature baby in the NICU says, "I'm scared to touch him," avoids touching, makes little eye contact, and is tearful. The risk factors are prematurity, separation and maternal illness. The bond is not yet broken; these early signs show she may be at risk but no lasting problem has been shown, so a risk diagnosis is right, not an actual one. The plan aims to prevent it: within days she holds her baby skin to skin, responds to his cues, and says she feels closer to him.

R15 Loss of privacy or dignity

Group: Communication and relationships | Type: Risk problem

- **Definition:** Care may expose the person or treat them with less respect than they deserve.
- **Risk factors:** Exposure; no privacy; rushed care; stigma; cultural insensitivity
- **Warning signs to watch for:** Embarrassment; covers body; refuses care; complaints

Scenario

A patient is due a dressing change in a shared ward where the curtain rail is broken.

Subjective (S): "I hope no one sees me."

Objective (O): Shared ward; broken curtain rail; procedure needs the abdomen exposed; patient pulls the gown closed; anxious.

Assessment tools for this scenario: **CP-TALK** Communication Check (p. 273) · **CP-MIND** Mood & Mind Screen (p. 272)

Validated scales to consider: Communication barrier checklist, PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Loss of privacy or dignity related to no privacy and exposure (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Use curtains and screens.	Curtains and screens block the view of other patients and visitors, which protects privacy during a procedure that exposes the abdomen.
Knock before entering.	Knocking before entering shows respect for personal space and gives the patient a chance to prepare.
Keep covered.	Keeping the body covered except for the area being treated reduces exposure and embarrassment, and respects her wish not to be seen.
Explain care.	Explaining what will happen and why lowers anxiety and lets her feel in control of what is done to her body.
Call by name.	Using her preferred name shows respect and treats her as a person, not a case or bed number.
Respect culture.	Cultural beliefs about modesty and touch vary, so respecting them prevents distress and keeps her willing to accept care.

Expected outcomes

- Privacy kept in all care.
- Patient says she feels respected.
- Accepts care.

Linking the data to the diagnosis

The patient needs a dressing change in a shared ward where the curtain rail is broken, and the procedure needs her abdomen exposed. She says, "I hope no one sees me," pulls her gown closed, and is anxious. Her dignity has not yet been breached, but the risk factors of no privacy and exposure are present, so this is a risk diagnosis and not an actual one. The plan aims to prevent harm: privacy is kept in all care, she says she feels respected, and she accepts care.

R16 Care conflicts with culture

Group: Communication and relationships | Type: Actual problem

- **Definition:** Care routines clash with the person's cultural practices or values.
- **Possible causes:** Beliefs; religion; gender preferences; diet; rituals
- **Signs and symptoms:** Refuses care; delays decisions; conflict with staff; family objections

Scenario

A woman declines male staff for personal care because of her religious beliefs.

Subjective (S): "I can't allow a man to help me wash."

Objective (O): Declines male staff; religious beliefs; delays care.

Assessment tools for this scenario: CP-TALK Communication Check (p. 273)

Validated scales to consider: Communication barrier checklist

CarePath diagnosis: Care conflicts with culture related to beliefs, as evidenced by refuses care and delays decisions.

Interventions and rationale

Intervention	Rationale
Ask respectfully.	Asking respectfully shows that her beliefs matter and finds out exactly what she needs, rather than guessing.
Adapt where safe.	Where it is safe, meeting her preference, such as female staff, respects her values and lets care go ahead without distress.
Involve family and chaplain.	Family and a chaplain can explain what her faith allows and support her in choosing, which may resolve the conflict.
Offer a carer of the same gender for personal care where possible.	Matching carer gender respects religious beliefs and dignity and makes it more likely she will accept care.
Explain options.	Clear explanation of the options lets her make an informed choice and avoids refusal because of misunderstanding.

Expected outcomes

- Preference respected where safe.
- Personal care completed by suitable staff.
- Patient feels respected.

Linking the data to the diagnosis

The woman declines male staff for personal care and says, "I can't allow a man to help me wash." Her religious beliefs are the stated reason, and she is delaying care. These data show a clash between routine and her values that is already affecting care, so this is an actual diagnosis, not a risk. It fits better than a diagnosis of non-adherence, because her reason is cultural and not a lack of willingness. The plan aims for her preference to be respected where safe, personal care completed by suitable staff, and the patient feeling respected.

L - Learning and self-management

Recommended assessment tools

CarePath tool: **CP-LEARN Learning Readiness Check** (p. 274)

Validated scales: Teach-back

L1 Not enough knowledge about the condition

Group: Learning and self-management | Type: Actual problem

- **Definition:** The person lacks information about their illness, treatment, or recovery.
- **Possible causes:** New diagnosis; low literacy; anxiety; poor teaching
- **Signs and symptoms:** Asks many questions; incorrect statements; misses steps

Scenario

A newly diagnosed diabetic does not know what insulin does.

Subjective (S): "What does insulin even do?"

Objective (O): Newly diagnosed diabetic; no knowledge of insulin; asks basic questions.

Assessment tools for this scenario: **CP-LEARN Learning Readiness Check** (p. 274)

Validated scales to consider: Teach-back

CarePath diagnosis: Not enough knowledge about the condition related to new diagnosis, as evidenced by asks many questions and incorrect statements.

Interventions and rationale

Intervention	Rationale
Assess what they know.	Finding out what he already knows avoids repeating information and shows which gaps and misunderstandings need to be taught first.
Teach simply.	Simple, short explanations are easier to absorb when he is new to the diagnosis and may be anxious.
Use pictures.	Pictures show how insulin works and where to inject, and help him remember even if his reading is limited.
Use teach-back.	Asking him to explain in his own words confirms that he understood, rather than only nodding.
Give written notes.	Written notes give him something to review later at home, so he does not have to rely on memory.
Repeat.	Repeating key points over several sessions improves memory and makes safe insulin use more likely.

Expected outcomes

- Within 48 hours: explains the purpose of insulin and 3 key points by teach-back.
- Demonstrates injection technique.

Linking the data to the diagnosis

The newly diagnosed diabetic asks, "What does insulin even do?" and asks basic questions, with no knowledge of insulin. These data show missing knowledge that has already led to a problem, not simply a possible risk, so this is an actual diagnosis. It fits better than a diagnosis of poor management at home, because he has not yet had the chance to learn. The plan aims for him, within 48 hours, to explain the purpose of insulin and 3 key points by teach-back, and to demonstrate injection technique.

L2 Not following the treatment plan

Group: Learning and self-management | Type: Actual problem

- **Definition:** The person does not take medicines, attend visits, or follow advice as agreed.
- **Possible causes:** Side effects; cost; forgetfulness; beliefs; no symptoms; complex plan
- **Signs and symptoms:** Misses doses; skips visits; stops medicines

Scenario

A patient with high blood pressure stops his pills when he feels well.

Subjective (S): "I feel fine so I stopped my pills."

Objective (O): Stopped blood pressure medicine; blood pressure 168/96; missed two appointments.

Assessment tools for this scenario: **CP-LEARN** Learning Readiness Check (p. 274) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-BREATH** Breathing & Circulation Check (p. 265)

Validated scales to consider: Teach-back, Braden Scale, TIME wound chart, NEWS2, SpO₂, ECG

CarePath diagnosis: Not following the treatment plan related to feeling well and not seeing the need for medicine, as evidenced by stopping blood pressure tablets, a blood pressure of 168/96, and two missed appointments.

Interventions and rationale

Intervention	Rationale
Ask kindly why.	Asking without blame helps him say the real reason, such as feeling well, cost or side effects, which must be known to solve the problem.
Explain benefits.	High blood pressure often causes no symptoms, so explaining what the medicine prevents, such as stroke and heart disease, helps him see why he should keep taking it.
Simplify the plan.	A simpler plan, with fewer doses or tablets, is easier to follow and makes missed doses less likely.
Solve barriers.	Solving barriers such as cost, transport or side effects removes the actual reasons for stopping.
Involve family.	Family can remind and encourage him, and support makes it easier to keep up a long-term routine.
Use reminders.	Reminders such as alarms and pill boxes help with forgetfulness, which is a common cause of missed doses.

Expected outcomes

- Takes medicines as prescribed.
- Keeps appointments.
- States why medicine is needed.
- Blood pressure improves.

Linking the data to the diagnosis

The patient says, "I feel fine so I stopped my pills." He stopped his blood pressure medicine, has a blood pressure of 168/96, and missed two appointments. These data show he is already not following the plan, so this actual diagnosis is right, and it fits better than a knowledge deficit because the problem is the behavior itself. The plan aims for him to take medicines as prescribed, keep appointments, state why the medicine is needed, and see his blood pressure improve.

L3 Difficulty managing medicines

Group: Learning and self-management | Type: Actual problem

- **Definition:** The person has trouble with doses, timing, or side effects.
- **Possible causes:** Multiple medicines; poor memory; poor vision; complex timing; side effects
- **Signs and symptoms:** Wrong doses; mixing up pills; double doses; missed doses

Scenario

An older woman takes duplicate tablets.

Subjective (S): "I get confused about which pill is which."

Objective (O): Takes duplicate tablets; 10 medicines; poor vision; missed doses.

Assessment tools for this scenario: CP-LEARN Learning Readiness Check (p. 274) · CP-OLDER

Older Adult Check (p. 278)

Validated scales to consider: Teach-back, 4AT / CAM, Mini-Cog

CarePath diagnosis: Difficulty managing medicines related to multiple medicines, as evidenced by wrong doses and mixing up pills.

Interventions and rationale

Intervention	Rationale
Review medicines.	Reviewing every medicine finds duplicates, unnecessary drugs and risky combinations, which is the first step to making the regimen safer.
Use a pill box.	A pill box sorts doses by day and time, so she can see what to take and whether she has taken it, which prevents doubling up.
Give a simple schedule.	A simple schedule reduces confusion with many medicines and is easier to read with poor vision.
Teach each drug.	Teaching what each drug is for helps her tell them apart and understand why each one matters.
Ask for a pharmacist review.	A pharmacist can check for interactions, suggest fewer or simpler medicines, and provide clear labeling, which adds safety.

Expected outcomes

- Within 2 weeks: uses a pill box correctly, names each medicine's purpose, no duplicate doses.

Linking the data to the diagnosis

The older woman says, "I get confused about which pill is which." She takes duplicate tablets, has 10 medicines, poor vision, and misses doses. These data show that errors are already occurring, so this is an actual diagnosis and not a risk of unsafe medicine use. It fits better than a general knowledge deficit, because the difficulty is with the practical handling of many medicines. The plan aims for her, within 2 weeks, to use a pill box correctly, name each medicine's purpose, and take no duplicate doses.

L4 Difficulty managing the illness at home

Group: Learning and self-management | Type: Actual problem

- **Definition:** The person cannot carry out the daily tasks needed to stay well at home.
- **Possible causes:** Complex tasks; no support; low energy; poor knowledge; costs
- **Signs and symptoms:** Missed monitoring; poor diet; frequent admissions

Scenario

A patient with heart failure does not weigh himself.

Subjective (S): "I don't weigh myself. I forget."

Objective (O): Heart failure; two admissions in 3 months; no weight log; swelling.

Assessment tools for this scenario: **CP-LEARN** Learning Readiness Check (p. 274) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: Teach-back, MUST, fluid chart, glucose

CarePath diagnosis: Difficulty managing the illness at home related to complex tasks, as evidenced by missed monitoring and poor diet.

Interventions and rationale

Intervention	Rationale
Assess needs.	Finding out what he can and cannot manage, and why, makes sure that help targets real obstacles such as forgetting or lack of support.
Teach self-care.	Teaching self-care, such as daily weights, fluid and salt limits and symptom signs, lets him catch worsening heart failure early.
Set a routine.	Linking tasks to a daily habit, such as weighing after waking, makes it easier to remember and keep up.
Arrange support.	Support from family or community services helps with tasks he cannot manage alone and keeps up his routine.
Schedule follow-up visits.	Follow-up visits check his progress, catch early fluid build-up, and can prevent another hospital admission.

Expected outcomes

- Weighs daily and records it.
- States when to call the doctor.
- No readmission in 30 days.

Linking the data to the diagnosis

The patient with heart failure says, "I don't weigh myself. I forget." He has had two admissions in 3 months, keeps no weight log, and has swelling. These data show that he is not carrying out the daily tasks needed at home, and the problem is already affecting his health, so this actual diagnosis is right and not a risk. The plan aims for him to weigh daily and record it, state when to call the doctor, and have no readmission in 30 days.

L5 Ready to learn and improve health

Group: Learning and self-management | Type: Actual problem

- **Definition:** The person is motivated to learn and take more control of their health.
- **Possible causes:** Motivation; new diagnosis; recent scare; good support
- **Signs and symptoms:** Asks for information; sets goals; tries new habits

Scenario

A patient asks how to eat better after a heart attack.

Subjective (S): "How can I eat better after this?"

Objective (O): Asks questions; motivated; recent heart attack; sets goals.

Assessment tools for this scenario: CP-LEARN Learning Readiness Check (p. 274)

Validated scales to consider: Teach-back

CarePath diagnosis: Ready to learn and improve health related to motivation, as evidenced by asks for information and sets goals.

Interventions and rationale

Intervention	Rationale
Reinforce readiness.	Acknowledging his motivation strengthens it, and people who feel supported are more likely to keep up healthy changes.
Give tailored teaching.	Teaching matched to his own needs, such as heart-healthy eating, is more useful and easier to remember than general advice.
Set goals.	Specific goals turn his wish to eat better into steps he can take and check.
Follow up.	Follow-up keeps him engaged, answers new questions, and helps him keep going when changes get hard.

Expected outcomes

- Sets 2 goals.
- Completes education.
- Follows the plan over 4 weeks.

Linking the data to the diagnosis

The patient asks, "How can I eat better after this?", is motivated, sets goals, and has had a recent heart attack. He shows no failure to cope or follow advice; instead he is eager to learn, so a readiness statement fits better than a knowledge deficit or an unhealthy habit diagnosis. It is built on strengths and is not a risk. The plan aims for him to set 2 goals, complete education, and follow the plan over 4 weeks, using the motivation his scare has created.

L6 Unsure how to use equipment or devices

Group: Learning and self-management | Type: Actual problem

- **Definition:** The person cannot safely use devices such as inhalers, monitors, or dressings.
- **Possible causes:** New device; low confidence; poor sight; weak hands
- **Signs and symptoms:** Incorrect use; errors; fear of the device

Scenario

A patient cannot use his inhaler properly.

Subjective (S): "I never use this inhaler properly."

Objective (O): Poor technique; no spacer; breathless; spills powder.

Assessment tools for this scenario: CP-LEARN Learning Readiness Check (p. 274)

Validated scales to consider: Teach-back

CarePath diagnosis: Unsure how to use equipment or devices related to new device, as evidenced by incorrect use and errors.

Interventions and rationale

Intervention	Rationale
Demonstrate.	Seeing the correct technique step by step gives a clear model to copy, which is easier to learn than verbal instructions.
Ask for a return demonstration.	Having him show the technique back reveals errors and proves he can use the device, not only that he nodded.
Give written steps.	Written steps give him a guide to check at home when the nurse is not there.
Correct errors.	Correcting mistakes straight away prevents wrong habits from forming, so that more of each dose reaches his lungs and eases his breathing.
Reassess.	Reassessing later confirms the technique has been kept and shows whether his breathing is improving.

Expected outcomes

- Within 24 hours: demonstrates correct technique.
- Symptoms improve.
- Patient states when to use it.

Linking the data to the diagnosis

The patient says, "I never use this inhaler properly." He has poor technique, no spacer, is breathless, and spills powder. These data show he is already making errors with a device, so this actual diagnosis fits, and it is more specific than a general knowledge deficit about his illness. The problem is not a risk, because the errors are seen. The plan aims for him, within 24 hours, to demonstrate correct technique, have improved symptoms, and state when to use the inhaler.

L7 Unsafe medicine use at home

Group: Learning and self-management | Type: Actual problem

- **Definition:** Mixing, missing, or double-dosing medicines may cause harm.
- **Possible causes:** Confusion; mixed medicines; wrong storage; self-treating; no labels
- **Signs and symptoms:** Taking leftover drugs; wrong doses; mixing with alcohol; drug interactions

Scenario

A patient takes expired antibiotics and extra painkillers.

Subjective (S): "I took what I had left."

Objective (O): Takes expired antibiotics and extra pain tablets; mixes medicines with alcohol.

Assessment tools for this scenario: CP-LEARN Learning Readiness Check (p. 274) · CP-PAIN Pain & Comfort Score (p. 268)

Validated scales to consider: Teach-back, NRS 0–10, FLACC, PAINAD

CarePath diagnosis: Unsafe medicine use at home related to knowledge gaps and self-treating, as evidenced by taking expired antibiotics and extra painkillers and mixing medicines with alcohol.

Interventions and rationale

Intervention	Rationale
Review all medicines.	Looking at everything he takes, including leftovers and over-the-counter drugs, finds dangerous duplicates and interactions.
Teach safe use.	Teaching how to take medicines safely, including doses, timing and avoiding alcohol, lowers the chance of overdose or harmful reactions.
Remove expired drugs.	Expired medicines may be less effective or unsafe, and removing them stops him using them again.

Intervention	Rationale
Involve a pharmacist.	A pharmacist can check for interactions, advise on disposal and clarify labels, which adds expert safety.
Get family help.	Family can notice mistakes and remind him, which helps when he is confused or tends to self-treat.

Expected outcomes

- Takes only prescribed medicines.
- Stores them safely.
- No interactions.
- Discusses with a pharmacist.

Linking the data to the diagnosis

The patient takes expired antibiotics and extra painkillers and mixes medicines with alcohol. The unsafe use is already happening, so the actual statement is chosen and not a risk statement. Difficulty managing medicines (L3) is close but this entry is about harmful use of leftover and unlabeled drugs. The plan aims for the patient to take only prescribed medicines, store them safely, avoid dangerous interactions, and keep in touch with a pharmacist.

L8 Struggling to manage long-term illness

Group: Learning and self-management | Type: Actual problem

- **Definition:** The daily demands of a chronic condition are hard to keep up with.
- **Possible causes:** Complex disease; fatigue; cost; low mood; poor support
- **Signs and symptoms:** Poor control; frequent flare-ups; missed monitoring

Scenario

A diabetic has high sugars and rarely checks them.

Subjective (S): "It's too much to keep up with."

Objective (O): Diabetic with high sugars; rarely checks; skips meals; low mood.

Assessment tools for this scenario: CP-LEARN Learning Readiness Check (p. 274)

Validated scales to consider: Teach-back

CarePath diagnosis: Struggling to manage long-term illness related to complex disease, as evidenced by poor control and frequent flare-ups.

Interventions and rationale

Intervention	Rationale
Set small goals.	Small goals feel achievable and make a heavy daily routine less overwhelming, so each success builds confidence to continue.
Teach self-monitoring.	Teaching him to check and understand his sugar readings lets him see how food, activity and medicine affect them and act early.
Suggest support groups.	Support groups provide encouragement and practical tips from people living with the same illness, and can lift low mood.
Follow up.	Follow-up keeps him accountable, allows plans to be adjusted, and shows he is not managing alone.
Encourage questions.	Inviting questions lets him voice worries and confusion, which otherwise may stay hidden and lead to poor control.

Expected outcomes

- Checks sugar as planned.
- HbA1c improves over 3 months.
- States 3 self-care tasks.

Linking the data to the diagnosis

The diabetic says, "It's too much to keep up with." He has high sugars, rarely checks them, skips meals, and has low mood. These data show daily management is already failing and control is poor, so this is an actual diagnosis and not a risk. It fits better than a knowledge deficit because he feels overwhelmed, not uninformed. The plan aims for him to check his sugar as planned, see his HbA1c improve over 3 months, and state 3 self-care tasks.

L9 Unhealthy habits (smoking, inactivity)

Group: Learning and self-management | Type: Actual problem

- **Definition:** Habits that harm health continue despite risk.
- **Possible causes:** Addiction; stress; habit; lack of knowledge; culture
- **Signs and symptoms:** Smoking; inactivity; poor diet; ignores advice

Scenario

A patient continues smoking despite lung disease.

Subjective (S): "I know smoking is bad but I can't stop."

Objective (O): Smokes 20 a day; lung disease; coughing; ignores advice.

Assessment tools for this scenario: CP-LEARN Learning Readiness Check (p. 274)

Validated scales to consider: Teach-back

CarePath diagnosis: Unhealthy habits (smoking, inactivity) related to addiction, as evidenced by smoking and inactivity.

Interventions and rationale

Intervention	Rationale
Give nonjudgmental advice.	Advice without blame keeps him willing to listen, since criticism often causes defensiveness and more resistance.
Use motivational talk.	Motivational talk helps him find his own reasons to change, which lasts longer than being told what to do.
Set goals.	Realistic goals break change into steps he can reach, which builds confidence in his ability to quit.
Offer quit support.	Quit support such as counseling and nicotine replacement raises the chance of success because addiction is hard to beat alone.
Follow up.	Follow-up gives encouragement, deals with slips and cravings, and keeps him working toward quitting over the weeks it takes to succeed.

Expected outcomes

- Sets a quit date.
- Reduces cigarettes.
- Uses support.
- States reasons to quit.

Linking the data to the diagnosis

The patient says, "I know smoking is bad but I can't stop." He smokes 20 a day, has lung disease, is coughing, and ignores advice. These data show a harmful habit that is already present and affecting his health, so this is an actual diagnosis and not a risk. It fits better than a knowledge deficit, because he already knows the harm. The plan aims for him to set a quit date, reduce cigarettes, use support, and state his reasons to quit.

L10 Cannot reach health services

Group: Learning and self-management | Type: Actual problem

- **Definition:** Distance, cost, transport, or other barriers block access to care.
- **Possible causes:** Cost; distance; transport; stigma; no insurance
- **Signs and symptoms:** Missed appointments; late presentation; untreated conditions

Scenario

A rural patient misses clinic visits for lack of transport.

Subjective (S): "The clinic is too far."

Objective (O): Misses visits; no transport; lives in a rural area; uncontrolled symptoms.

Assessment tools for this scenario: CP-LEARN Learning Readiness Check (p. 274)

Validated scales to consider: Teach-back

CarePath diagnosis: Cannot reach health services related to distance and lack of transport, as evidenced by missed clinic visits and uncontrolled symptoms.

Interventions and rationale

Intervention	Rationale
Identify barriers.	Finding out exactly what blocks him, such as distance or transport, ensures help targets the real problem and not an assumption.
Arrange transport.	Transport removes the main obstacle to attending clinic visits and keeps him in regular care.
Use telehealth.	Telehealth lets him get advice and review without traveling, which suits a rural patient.
Link to social services.	Social services can help with transport, funding and other practical support that the health team cannot supply directly, easing the barriers he faces.
Offer flexible appointments.	Flexible appointment times fit around transport and other limits in rural areas, making it more likely that he will attend and be monitored.

Expected outcomes

- Within 1 month: attends visits or uses telehealth.
- Transport arranged.
- Condition monitored.

Linking the data to the diagnosis

The rural patient says, "The clinic is too far." He misses visits, has no transport, lives in a rural area, and has uncontrolled symptoms. These data show barriers already stopping him from getting care, so this is an actual diagnosis and not a risk. It fits better than a non-adherence diagnosis, because he wants to attend but cannot. The plan aims for him, within 1 month, to attend visits or use telehealth, have transport arranged, and have his condition monitored.

L11 Cannot afford care or medicines

Group: Learning and self-management | Type: Actual problem

- **Definition:** Money problems prevent the person from getting treatment.
- **Possible causes:** Poverty; unemployment; high costs; no insurance
- **Signs and symptoms:** Skips medicines; delays care; splits pills

Scenario

A patient rations his insulin because of cost.

Subjective (S): "I can't afford my insulin."

Objective (O): Rations insulin; high blood sugar; skips doses; money worries.

Assessment tools for this scenario: **CP-LEARN** Learning Readiness Check (p. 274) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)
Validated scales to consider: Teach-back, MUST, fluid chart, glucose

CarePath diagnosis: Cannot afford care or medicines related to poverty, as evidenced by skips medicines and delays care.

Interventions and rationale

Intervention	Rationale
Refer to a social worker.	A social worker knows about benefits and aid and can help with the financial problem that nursing alone cannot solve.
Explore assistance programs.	Assistance programs and manufacturer or government schemes can lower or cover the cost of insulin so he does not have to ration it.
Consider generic options.	Cheaper equivalent options, chosen with the prescriber, may give the same benefit at lower cost.
Prioritize essentials.	Deciding which medicines and care are most essential keeps life-saving treatment, such as insulin, first when money is short.
Follow up.	Follow-up checks whether the help is working and whether his blood sugar is improving, so problems are found early.

Expected outcomes

- Gets an affordable supply.
- Takes insulin as prescribed.
- Blood sugar improves.
- Social worker involved.

Linking the data to the diagnosis

The patient says, "I can't afford my insulin." He rations insulin, skips doses, has high blood sugar, and money worries. These data show cost already limiting treatment and harming control, so this is an actual diagnosis and not a risk. It fits better than a non-adherence diagnosis, because the reason is money, not unwillingness. The plan aims for him to get an affordable supply, take insulin as prescribed, see his blood sugar improve, and have a social worker involved.

L12 Not ready for discharge

Group: Learning and self-management | Type: Actual problem

- **Definition:** The person or home situation is not yet prepared for safe discharge.
- **Possible causes:** Unresolved symptoms; no support; unprepared home; lack of teaching
- **Signs and symptoms:** Unsure about care; no equipment; no helper; anxiety

Scenario

A patient is told to go home but cannot walk or cook.

Subjective (S): "I'm not ready to go home."

Objective (O): Cannot walk or cook; no equipment; anxious about discharge.

Assessment tools for this scenario: **CP-LEARN** Learning Readiness Check (p. 274) · **CP-MIND** Mood & Mind Screen (p. 272)

Validated scales to consider: Teach-back, PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Not ready for discharge related to unresolved mobility problems and no home support, as evidenced by being unable to walk or cook, having no equipment, and feeling anxious about going home.

Interventions and rationale

Intervention	Rationale
Assess readiness.	Checking symptoms, mobility, skills and home conditions shows whether he can manage safely and what is still missing.
Teach.	Teaching the skills he lacks, such as moving safely and basic meal preparation, prepares him for home.
Arrange equipment and home support.	Equipment and home help provide what he cannot do himself, so he is not alone and unsafe on the first day.
Delay discharge if needed.	Sending him home before he can walk or cook risks falls, poor nutrition and readmission, so waiting is safer.
Give a written plan.	A written plan gives clear instructions and contacts that he can check at home when worried or confused.

Expected outcomes

- Discharge delayed until safe.
- Equipment and help arranged.
- Patient states the plan and who to call.

Linking the data to the diagnosis

The patient cannot walk or cook, has no equipment at home, and is anxious about discharge. These unmet needs are present now, so the statement is actual. The nurse checks readiness against safe discharge criteria, not only the date. The plan aims to delay discharge until it is safe, arrange equipment and home help, and give a written plan so that the patient can state it and knows whom to call.

L13 Believes wrong health information

Group: Learning and self-management | Type: Actual problem

- **Definition:** The person holds beliefs about health that are inaccurate and may lead to harm.
- **Possible causes:** Misinformation; online rumors; culture; mistrust
- **Signs and symptoms:** Refuses vaccines; uses unsafe remedies; delays treatment

Scenario

A patient uses herbal paste instead of antibiotics.

Subjective (S): "I'll just use herbal paste instead."

Objective (O): Skin infection worsening; avoids antibiotics; believes herbs are better.

Assessment tools for this scenario: **CP-LEARN** Learning Readiness Check (p. 274) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-INFECT** Infection Check (p. 281)

Validated scales to consider: Teach-back, Braden Scale, TIME wound chart, qSOFA / sepsis screen

CarePath diagnosis: Believes wrong health information related to misinformation, as evidenced by using herbal paste instead of antibiotics while a skin infection worsens.

Interventions and rationale

Intervention	Rationale
Listen.	Listening first shows respect and helps the nurse learn where the belief came from, which makes the patient more willing to hear other information later.
Correct kindly with facts.	Gentle, factual correction replaces the false belief without shaming the patient, and shame often makes people dig in and avoid care.
Use trusted sources.	Information from trusted, recognized sources is more convincing than the nurse's opinion alone and helps the patient compare it with the rumors or online claims they have seen.
Respect culture.	Respecting culture keeps trust intact and lets the nurse fit advice around the patient's values, so the patient does not feel that their background is being dismissed.
Involve the healthcare team.	The doctor, pharmacist or other team members can reinforce the same message and adjust treatment, and hearing it from several trusted people improves the chance the patient accepts care.

Expected outcomes

- Accepts proper treatment.
- Infection resolves.
- Understands the evidence.
- Keeps follow-up.

Linking the data to the diagnosis

The patient says, "I'll just use herbal paste instead," while the skin infection is worsening and antibiotics are being avoided because herbs are believed to be better. This fits believes wrong health information because the belief is inaccurate and is already leading to harm, as the infection is getting worse. It is not simply a refusal of treatment, since the cause is the false belief itself, which can be corrected with facts. The plan aims for the patient to understand the evidence, accept proper treatment, see the infection resolve and keep follow-up visits, all reached by listening, respectful teaching and team support.

V - Spiritual and values

Recommended assessment tools

CarePath tool: **CP-SPIRIT Spiritual & Values Check** (p. 275)

Validated scales: FICA spiritual screen

V1 Struggling with meaning, faith, or purpose

Group: *Spiritual and values* | Type: *Actual problem*

- **Definition:** The person questions meaning, belief, or purpose during illness or loss.
- **Possible causes:** Serious illness; loss; suffering; doubts about faith
- **Signs and symptoms:** Asks why me; feels empty; loss of faith; anger at God

Scenario

After a cancer diagnosis, a woman questions her faith.

Subjective (S): "Why is God doing this to me?"

Objective (O): Cancer diagnosis; tearful; stopped prayers; withdrawn.

Assessment tools for this scenario: **CP-SPIRIT Spiritual & Values Check** (p. 275)

Validated scales to consider: FICA spiritual screen

CarePath diagnosis: Struggling with meaning, faith, or purpose related to serious illness, as evidenced by asks why me and feels empty.

Interventions and rationale

Intervention	Rationale
Listen without judging.	Listening without judging lets the patient voice doubts and anger safely, and being heard is itself comforting when a person is questioning faith and purpose.
Offer presence.	Simply being present tells the patient she is not alone in her suffering, which matters most when there are no easy answers to why-me questions.
Offer a chaplain.	A chaplain is trained in spiritual care and can explore faith questions in depth, which is beyond what the nurse can offer alone.
Support rituals.	Familiar rituals such as prayer, readings or symbols can bring comfort and a sense of continuity, so supporting them helps the patient reconnect with sources of strength.
Allow expression.	Letting her cry, question or be angry prevents bottled-up distress and shows that her feelings are acceptable, which is a first step toward finding meaning.

Expected outcomes

- Expresses feelings.
- Finds one source of meaning or comfort within days.
- Accepts chaplain support.

Linking the data to the diagnosis

After a cancer diagnosis, the woman asks, "Why is God doing this to me?" She is tearful, has stopped her prayers and is withdrawn, and she feels empty. These data fit struggling with meaning, faith, or purpose because the distress is about belief and purpose rather than only sadness or fear of the illness. Her questioning is already present, so this is an actual problem, not a risk. The plan aims for her to express her feelings, find at least one source of meaning or comfort within days and accept chaplain support, through nonjudging listening and respect for her beliefs.

V2 Conflict between care and personal beliefs

Group: *Spiritual and values* | Type: *Actual problem*

- **Definition:** Treatment options clash with the person's values or beliefs.
- **Possible causes:** Blood transfusion refusal; fasting; end-of-life choices; treatment limits
- **Signs and symptoms:** Refuses care; conflict with the team; family distress

Scenario

A patient refuses a blood transfusion for religious reasons.

Subjective (S): "My faith forbids a blood transfusion."

Objective (O): Refuses transfusion; family supportive; low hemoglobin.

Assessment tools for this scenario: **CP-SPIRIT** Spiritual & Values Check (p. 275)

Validated scales to consider: FICA spiritual screen

CarePath diagnosis: Conflict between care and personal beliefs related to blood transfusion refusal, as evidenced by refuses care and conflict with the team.

Interventions and rationale

Intervention	Rationale
Respect values.	Respecting the patient's values upholds the right to make choices about her own body and keeps trust, which is the base for any further discussion.
Explain options and risks.	Clear information about benefits, risks and what may happen without treatment lets her make an informed choice, since low hemoglobin carries real danger.
Involve the ethics team.	An ethics team gives neutral guidance when the team and the patient disagree, helping everyone work within ethical and legal limits.
Document.	Careful records protect the patient's wishes and the team, and make sure all staff know her informed decision, including in an emergency.
Look for alternatives.	Options that fit her beliefs, such as iron, medicines that help red cell production or ways to limit blood loss, may protect her health without breaking her faith.

Expected outcomes

- Informed decision documented.
- Alternatives used where possible.
- Patient feels respected.

Linking the data to the diagnosis

The patient says, "My faith forbids a blood transfusion." She refuses the transfusion, her family is supportive and her hemoglobin is low, with conflict with the team. This fits conflict between care and personal beliefs because a recommended treatment clashes directly with a religious value, and the clash is already causing refusal of care. It is not a knowledge problem, since the refusal comes from belief. The plan aims for an informed decision to be documented, for alternatives to be used where possible and for the patient to feel respected, using clear information, ethics support and respect for her faith.

V3 Ready to grow spiritually

Group: *Spiritual and values* | Type: *Actual problem*

- **Definition:** The person wishes to deepen peace, meaning, or connection.
- **Possible causes:** Peace; personal growth; recovery; reflection
- **Signs and symptoms:** Wants prayer; seeks meaning; reflects on values

Scenario

A recovering patient wants time for prayer and reflection.

Subjective (S): "I want time to pray and reflect."

Objective (O): Calm; asks for a quiet space; recovering; engaged.

Assessment tools for this scenario: CP-SPIRIT Spiritual & Values Check (p. 275)

Validated scales to consider: FICA spiritual screen

CarePath diagnosis: Ready to grow spiritually related to peace, as evidenced by wants prayer and seeks meaning.

Interventions and rationale

Intervention	Rationale
Support practices.	Supporting her practices helps her deepen peace and connection, and recovery goes better when spiritual needs are treated as part of whole-person care.
Arrange a quiet space.	A quiet space gives the privacy and calm needed for prayer and reflection, which are hard to find in a busy ward.
Offer a chaplain.	A chaplain can guide and enrich her spiritual growth and offer resources, even though she is already calm and engaged.
Respect beliefs.	Respecting her beliefs without pushing the nurse's own views keeps the patient in charge of her spiritual path and builds trust.

Expected outcomes

- Has daily time for prayer.
- Reports peace.
- Feels supported.

Linking the data to the diagnosis

The recovering patient says, "I want time to pray and reflect," and she is calm, engaged and asking for a quiet space. This is a readiness to grow, not a problem, so the ready-to-grow wording fits better than a distress statement such as struggling with meaning, faith, or purpose, because she shows peace and motivation, not suffering. The plan aims to build on her strengths so that she has daily time for prayer, reports peace and feels supported, by providing a quiet space, offering a chaplain and respecting her beliefs.

V4 Wishes about end of life unclear

Group: Spiritual and values | Type: Actual problem

- **Definition:** The person has not decided or shared their wishes about end-of-life care.
- **Possible causes:** No advance directive; unclear values; denial; family conflict
- **Signs and symptoms:** Avoids the discussion; unsure choices; conflicting statements

Scenario

An older man has not told his family whether he wants resuscitation.

Subjective (S): "I haven't told my family what I want."

Objective (O): Avoids talking about end of life; family unsure; no advance directive.

Assessment tools for this scenario: CP-SPIRIT Spiritual & Values Check (p. 275)

Validated scales to consider: FICA spiritual screen

CarePath diagnosis: Wishes about end of life unclear related to no advance directive, as evidenced by avoids the discussion and unsure choices.

Interventions and rationale

Intervention	Rationale
Open the conversation gently.	A gentle opening in a private moment lowers the fear that makes people avoid this topic and invites him to share what matters to him.
Explain options.	Plain explanation of options such as resuscitation, comfort care and directives helps him understand what each choice means before deciding.
Document wishes.	Written records of his wishes make sure the team and family can follow them if he cannot speak for himself later.
Involve family.	Including family, with his permission, helps them understand his choices and lowers the risk of conflict or guilt when decisions must be made.
Follow policy.	Following facility policy and law ensures that directives are valid, properly witnessed and available to every team member who needs them.

Expected outcomes

- States wishes.
- Advance directive completed.
- Family informed.

Linking the data to the diagnosis

The older man says, "I haven't told my family what I want." He avoids talking about end of life, his family is unsure and he has no advance directive. This fits wishes about end of life unclear because his choices on resuscitation are not stated or recorded, and the lack of a directive is the clear cause. The problem exists now, so it is an actual diagnosis. The plan aims for him to state his wishes, complete an advance directive and inform his family, by opening the conversation gently, explaining options and following policy.

V5 Fear of dying

Group: Spiritual and values | Type: Actual problem

- **Definition:** Strong fear or distress about death or the dying process.
- **Possible causes:** Terminal illness; the unknown; unfinished matters; pain
- **Signs and symptoms:** Anxiety; sleeplessness; talks of dying; clinging

Scenario

A dying man says he is terrified of what comes next.

Subjective (S): "I'm scared of what comes next."

Objective (O): Terminal illness; sleepless; anxious; talks about dying.

Assessment tools for this scenario: CP-SPIRIT Spiritual & Values Check (p. 275) · CP-MIND Mood & Mind Screen (p. 272)

Validated scales to consider: FICA spiritual screen, PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Fear of dying related to terminal illness, as evidenced by anxiety and sleeplessness.

Interventions and rationale

Intervention	Rationale
Listen.	Listening allows him to say what frightens him most, and naming fears often makes them feel less overwhelming.
Stay with the patient.	Staying with a dying patient prevents isolation and gives comfort, because fear usually grows when a person feels alone.
Control symptoms.	Pain, breathlessness and other symptoms add to fear and sleeplessness, so good symptom control helps him feel safer and rest.
Offer spiritual support.	Spiritual care may help him face the unknown and gives access to rituals or beliefs that give meaning and peace at the end of life.
Reassure that he is not alone.	Hearing that he will not be left alone calms the fear of abandonment, provided the nurse and team really do stay available.

Expected outcomes

- Reports less fear.
- Has support present.
- Symptoms controlled.
- Accepts spiritual care.

Linking the data to the diagnosis

The dying man says, "I'm scared of what comes next." He has a terminal illness, is sleepless, anxious and talks about dying. These data fit fear of dying because the fear is aimed at death and the dying process, and it is already causing anxiety and lost sleep, so it is actual. It is more specific than general anxiety. The plan aims for him to report less fear, to have support present, to have symptoms controlled and to accept spiritual care, through listening, staying with him and offering reassurance that he is not alone.

V6 Cannot practice faith or rituals

Group: Spiritual and values | Type: Actual problem

- **Definition:** Illness or the care setting prevents religious or spiritual practice.
- **Possible causes:** Hospital restrictions; illness; lack of space; staff unaware
- **Signs and symptoms:** Cannot pray; missed rituals; distress

Scenario

A hospitalized patient cannot pray five times a day.

Subjective (S): "I can't pray here."

Objective (O): Misses prayer times; no clean space; distressed.

Assessment tools for this scenario: CP-SPIRIT Spiritual & Values Check (p. 275)

Validated scales to consider: FICA spiritual screen

CarePath diagnosis: Cannot practice faith or rituals related to hospital restrictions, as evidenced by cannot pray and missed rituals.

Interventions and rationale

Intervention	Rationale
Ask about needs.	Asking about needs shows respect and gives the nurse accurate information, since practices differ between people and even within the same faith.
Provide a clean space.	A clean, private space lets her pray properly, because cleanliness and privacy are often part of the ritual itself.

Intervention	Rationale
Adjust schedules.	Moving care tasks away from prayer times lets her keep her practice without delaying needed treatment.
Allow religious items.	Religious items such as a prayer mat, scripture or beads are part of how she practices, and allowing them supports comfort and identity.
Respect prayer times.	Protecting prayer times shows the team values her faith and prevents the distress that comes from repeatedly missing a core practice.

Expected outcomes

- Prays at needed times in a suitable space.
- Reports feeling respected.
- Care schedule adjusted.

Linking the data to the diagnosis

The hospitalized patient says, "I can't pray here." She misses prayer times, has no clean space and is distressed, since she cannot pray five times a day. This fits cannot practice faith or rituals because the barrier comes from the hospital setting and restrictions, not from loss of belief, which separates it from struggling with meaning, faith, or purpose. The problem is already happening, so it is an actual diagnosis. The plan aims for her to pray at needed times in a suitable space, feel respected and have the care schedule adjusted around her prayers.

N - Maternal and newborn

Recommended assessment tools

CarePath tool: **CP-MOTHER** Mother & Newborn Check (p. 276)

Validated scales: MEOWS, APGAR

N1 Pregnancy discomfort

Group: Maternal and newborn | Type: Actual problem

- **Definition:** Physical discomfort during pregnancy such as backache, nausea, or swelling.
- **Possible causes:** Hormones; growing uterus; weight gain; fatigue
- **Signs and symptoms:** Backache; nausea; swelling; heartburn; sleep trouble

Scenario

A woman at 30 weeks has backache and heartburn.

Subjective (S): "My back aches and I get heartburn."

Objective (O): 30 weeks pregnant; backache 5/10; heartburn after meals; ankle swelling; vital signs normal.

Assessment tools for this scenario: **CP-MOTHER** Mother & Newborn Check (p. 276) · **CP-PAIN** Pain & Comfort Score (p. 268)

Validated scales to consider: MEOWS, APGAR, NRS 0–10, FLACC, PAINAD

CarePath diagnosis: Pregnancy discomfort related to hormonal and physical changes of pregnancy, as evidenced by backache 5/10, heartburn after meals, and ankle swelling.

Interventions and rationale

Intervention	Rationale
Reassure.	Reassurance that these common changes are expected in pregnancy lowers worry, and anxiety can make discomfort feel worse.
Teach comfortable positions.	Good posture and positions, such as side-lying with pillows, reduce strain on the back and take pressure off the growing uterus.
Suggest small meals.	Small meals leave less food in the stomach at a time, which reduces pressure and acid reflux that cause heartburn.
Encourage rest.	Rest eases muscle fatigue and strain in the back and legs, and helps the body cope with the extra workload of late pregnancy.
Allow warm baths if permitted.	Warm baths can relax tight muscles, but they are only used if permitted because heat is not safe in every pregnancy.
Teach warning signs to report.	Knowing warning signs lets her tell normal discomfort from problems such as severe headache or bleeding, so she seeks help early when needed.

Expected outcomes

- Within 1 week: reports discomfort 3/10 or lower, uses 2 comfort methods, knows warning signs.

Linking the data to the diagnosis

At 30 weeks, the woman says, "My back aches and I get heartburn." She has backache 5/10, heartburn after meals and ankle swelling, and her vital signs are normal. This fits pregnancy discomfort because the symptoms are common, caused by hormones and the growing uterus, and no danger signs are present, which separates it from the high-risk pregnancy statement. The problem is already present, so

it is actual. The plan aims for her, within 1 week, to report discomfort at 3/10 or lower, use 2 comfort methods and know the warning signs to report.

N2 High-risk pregnancy

Group: Maternal and newborn | Type: Risk problem

- **Definition:** Pregnancy conditions that raise the chance of harm to mother or baby.
- **Risk factors:** Age; diabetes; high blood pressure; twins; past complications
- **Warning signs to watch for:** Abnormal scans or tests; bleeding; severe headache; reduced baby movement

Scenario

A 36-year-old woman with twins and diabetes attends a routine antenatal visit.

Subjective (S): "I am worried about my pregnancy because of my age."

Objective (O): Age 36; twin pregnancy; gestational diabetes; blood pressure 128/80; no protein in urine; no headaches.

Assessment tools for this scenario: CP-MOTHER Mother & Newborn Check (p. 276) · CP-SKIN Skin & Wound Score (p. 270) · CP-ELIM Elimination Check (p. 267)

Validated scales to consider: MEOWS, APGAR, Braden Scale, TIME wound chart, Bristol Stool Chart, bladder scan

CarePath diagnosis: High-risk pregnancy related to age, twins and diabetes (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Arrange regular visits.	Regular visits allow early detection of changes in blood pressure, blood sugar or the growth of the twins before they cause harm.
Monitor vital signs and baby movement.	Vital signs and baby movement are key indicators of her health and the babies' wellbeing, and a change can be the first sign of trouble.
Teach warning signs.	Knowing warning signs such as bleeding, severe headache or reduced movement helps her seek help at once instead of waiting.
Refer early.	Early referral to a specialist team means complications are handled sooner, which improves outcomes for the mother and both babies.

Expected outcomes

- Blood pressure and tests stay in a safe range.
- Attends visits.
- Reports warning signs promptly.
- No complications.

Linking the data to the diagnosis

The 36-year-old woman with twins and gestational diabetes says, "I am worried about my pregnancy because of my age." Her blood pressure is 128/80, there is no protein in her urine and she has no headaches, so no complication has occurred. This is a risk diagnosis because age, a twin pregnancy and diabetes raise the chance of harm, but the harm is not present yet. An actual problem would need abnormal findings. The plan aims for blood pressure and tests to stay in a safe range, for her to attend visits, to report warning signs promptly and to avoid complications.

N3 Fear of labor

Group: Maternal and newborn | Type: Actual problem

- **Definition:** Worry or fear about childbirth, pain, or outcomes.
- **Possible causes:** First birth; frightening stories; fear of pain; uncertainty
- **Signs and symptoms:** Anxious; tearful; avoids classes; many questions

Scenario

A first-time mother is afraid of labor.

Subjective (S): "I'm terrified of labor."

Objective (O): First pregnancy; tearful; asks many questions; avoids classes.

Assessment tools for this scenario: **CP-MOTHER** Mother & Newborn Check (p. 276)

Validated scales to consider: MEOWS, APGAR

CarePath diagnosis: Fear of labor related to first birth, as evidenced by anxious and tearful.

Interventions and rationale

Intervention	Rationale
Explain the stages.	Knowing what happens in each stage removes much of the fear of the unknown, which is a main driver of her terror.
Teach breathing and comfort methods.	Breathing and comfort methods give her practical tools to cope with pain, which increases her sense of control.
Tour the labor ward.	Seeing the labor ward beforehand makes the place familiar, so it feels less frightening when she arrives in labor.
Support her partner.	Her partner is her main support in labor, so a calm and informed partner helps her feel safe and less alone.
Encourage questions.	Open questions allow the nurse to correct myths and frightening stories, and she is more willing to share fears when welcomed.

Expected outcomes

- Attends a class.
- Rates fear 3/10 or lower.
- Practices breathing.
- Feels prepared.

Linking the data to the diagnosis

The first-time mother says, "I'm terrified of labor." She is in her first pregnancy, tearful, asks many questions and avoids classes. These data fit fear of labor because the fear is directed at childbirth and comes from not knowing what to expect, and it is already causing distress and avoidance. It differs from labor pain, which is about pain that is happening now. The plan aims for her to attend a class, rate her fear at 3/10 or lower, practice breathing and feel prepared, using clear teaching, a ward tour and support for her partner.

N4 Labor pain

Group: Maternal and newborn | Type: Actual problem

- **Definition:** Pain during contractions and birth that needs comfort support.
- **Possible causes:** Contractions; cervical changes; fear; position
- **Signs and symptoms:** Moaning; sweating; tense; restless

Scenario

A woman in active labor rates her pain 9 out of 10.

Subjective (S): "I can't take this pain!"

Objective (O): Pain 9/10; contractions every 2 minutes; sweating; restless.

Assessment tools for this scenario: **CP-MOTHER** Mother & Newborn Check (p. 276) · **CP-PAIN** Pain & Comfort Score (p. 268)

Validated scales to consider: MEOWS, APGAR, NRS 0–10, FLACC, PAINAD

CarePath diagnosis: Labor pain related to contractions, as evidenced by moaning and sweating.

Interventions and rationale

Intervention	Rationale
Offer comfort.	A caring, calm presence lowers fear and tension, and fear makes pain worse, so comfort is the base for every other measure.
Massage.	Massage relaxes tight muscles and distracts from contraction pain, and many women find touch from staff or a partner soothing.
Position changes.	Changing position can ease pressure, help the baby move down and make contractions more bearable.
Breathing support.	Guided breathing helps her relax between contractions and gives her something to focus on, which reduces panic and muscle tension.
Water immersion if available.	Warm water can relax the body and ease pain, but it is used only when available and when it is safe for her and the baby.
Pain relief as ordered.	Medicine for pain relief is given as ordered because pain at 9/10 may need more than comfort measures, and orders keep both mother and baby safe.
Reassurance.	Encouraging words help her feel supported and capable, and this reduces the fear that adds to her pain.

Expected outcomes

- Pain 5/10 or lower with comfort measures.
- Feels supported.
- Labor progresses safely.

Linking the data to the diagnosis

The woman in active labor says, "I can't take this pain!" She rates pain 9/10, contractions come every 2 minutes, and she is sweating and restless. This fits labor pain because the pain comes from contractions and is happening now, so it is actual, and it is stronger than the worry described in fear of labor. The plan aims for pain of 5/10 or lower with comfort measures, for her to feel supported and for labor to progress safely, using touch, position changes, breathing support, ordered pain relief and steady reassurance.

N5 Risk of heavy bleeding after birth **URGENT**

Group: Maternal and newborn | Type: Risk problem

- **Definition:** Blood loss after delivery may be higher than expected.
- **Risk factors:** Uterus not contracting; tears; retained tissue; long labor
- **Warning signs to watch for:** Heavy bleeding; soaked pads; fast pulse; dizziness

Scenario

A mother has just delivered after a long labor and has a perineal tear.

Subjective (S): "I feel tired but okay."

Objective (O): Delivery 20 minutes ago; labor lasted 20 hours; perineal tear; uterus firm; pad lightly stained; pulse 82/min; blood pressure 118/74.

Assessment tools for this scenario: **CP-MOTHER** Mother & Newborn Check (p. 276) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-BREATH** Breathing & Circulation Check (p. 265)

Validated scales to consider: MEOWS, APGAR, Braden Scale, TIME wound chart, NEWS2, SpO₂, ECG

CarePath diagnosis: Risk of heavy bleeding after birth related to long labor and a perineal tear (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Check bleeding, uterus firmness and vital signs at ordered times.	Regular checks of bleeding, uterine firmness and vital signs catch early blood loss, since a soft uterus and a rising pulse are warning signs.
Massage the uterus if it feels soft.	A soft uterus cannot clamp the blood vessels where the placenta was attached, and massage encourages it to contract and slow bleeding.
Check pads and weigh them if bleeding seems heavy.	Checking and weighing pads gives a more accurate measure of blood loss than guessing, which is often underestimated.
Give uterus-contracting medicine as ordered.	Medicines that make the uterus contract help it stay firm and reduce bleeding, and they are given only as ordered because dose and timing matter.
Call for help at once if pads soak quickly, the uterus stays soft, pulse rises or the mother feels faint.	Heavy bleeding can cause shock within minutes, so calling for help at once brings extra staff and treatment before the mother becomes unstable.

Expected outcomes

- Within 2 hours: uterus firm and bleeding light.
- Pulse and blood pressure stay normal.
- Heavy bleeding, if it occurs, is reported and treated within minutes.

Linking the data to the diagnosis

The mother delivered 20 minutes ago after a 20-hour labor and has a perineal tear. Her uterus is firm, the pad is lightly stained, her pulse is 82/min and her blood pressure is 118/74, and she says, "I feel tired but okay." This is a risk diagnosis because heavy bleeding has not happened; the long labor and tear raise the chance. Because bleeding can become dangerous quickly, help is called first if signs appear. The plan aims for a firm uterus with light bleeding within 2 hours, normal pulse and pressure, and fast treatment if heavy bleeding occurs.

N6 Slow recovery after birth

Group: Maternal and newborn | Type: Actual problem

- **Definition:** Healing, energy, or comfort after birth is slower than expected.
- **Possible causes:** Tears; surgery; poor sleep; anemia; pain
- **Signs and symptoms:** Soreness; fatigue; slow wound healing; reduced mobility

Scenario

A mother after cesarean cannot lift her baby comfortably.

Subjective (S): "I can't lift my baby."

Objective (O): Cesarean day 2; pain 6/10; low energy; slow walking.

Assessment tools for this scenario: **CP-MOTHER** Mother & Newborn Check (p. 276) · **CP-PAIN** Pain & Comfort Score (p. 268)

Validated scales to consider: MEOWS, APGAR, NRS 0–10, FLACC, PAINAD

CarePath diagnosis: Slow recovery after birth related to cesarean surgery, as evidenced by pain 6/10, low energy, and slow walking.

Interventions and rationale

Intervention	Rationale
Give pain relief.	Pain relief makes it easier for her to move, breathe deeply and hold her baby, and it supports healing by lowering stress on the body.
Encourage rest and mobility.	Rest restores energy for healing, and gentle mobility improves circulation, helps prevent blood clots and speeds recovery after surgery.
Wound care.	Wound care keeps the incision clean and allows early detection of redness, discharge or other signs of infection.
Nutrition.	Good nutrition provides protein, iron and energy that the body needs to repair tissue and restore strength after surgery and blood loss.
Support.	Practical and emotional support helps her care for the baby while recovering and builds her confidence as she regains strength.

Expected outcomes

- By day 3: pain 3/10 or lower, walks unaided, cares for baby comfortably, wound healing.

Linking the data to the diagnosis

The mother is on day 2 after cesarean and says, "I can't lift my baby." She reports pain 6/10, has low energy and walks slowly. This fits slow recovery after birth because healing, energy and comfort are all behind what is expected, and it is already affecting her care of the baby. It is an actual problem, not a risk. The plan aims for her, by day 3, to have pain of 3/10 or lower, walk unaided, care for her baby comfortably and show a healing wound, through pain relief, rest, movement, wound care, nutrition and support.

N7 Baby feeding poorly

Group: Maternal and newborn | Type: Actual problem

- **Definition:** The baby has weak sucking, poor latch, or takes too little milk.
- **Possible causes:** Poor latch; sleepiness; tongue-tie; low milk; illness
- **Signs and symptoms:** Short feeds; poor weight gain; weak suck; fussiness

Scenario

A baby falls asleep early at feeds and loses weight.

Subjective (S): "He keeps falling asleep and won't feed."

Objective (O): Baby lost 9% of birth weight; weak suck; falls asleep; 3 wet diapers daily.

Assessment tools for this scenario: **CP-MOTHER** Mother & Newborn Check (p. 276) · **CP-SAFE** Safety & Falls Score (p. 269) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: MEOWS, APGAR, Morse Fall Scale, MUST, fluid chart, glucose

CarePath diagnosis: Baby feeding poorly related to poor latch, as evidenced by short feeds and poor weight gain.

Interventions and rationale

Intervention	Rationale
Check the latch.	A poor latch is a common cause of weak feeding, so checking it finds problems that can be fixed to help the baby take more milk.
Wake the baby.	Sleepy babies feed poorly, and waking him with gentle stimulation lets him feed long enough to take in needed milk.
Set a feeding plan.	A clear plan with feeding times gives structure so that he is fed often enough, since weight loss shows he is not getting enough now.
Weigh regularly.	Regular weights show whether feeding is working, and tracking them allows the plan to change if weight keeps falling.
Get lactation help.	Lactation specialists have extra skill in fixing latch and supply problems, which can be hard to correct without expert help.
Report problems.	Reporting problems promptly ensures that the doctor reviews him, because a loss of 9% of birth weight and few wet diapers may signal dehydration.

Expected outcomes

- Feeds 8-12 times a day.
- Gains weight by day 7.
- At least 6 wet diapers per day.

Linking the data to the diagnosis

The baby falls asleep at feeds, and his mother says, "He keeps falling asleep and won't feed." He lost 9% of birth weight, has a weak suck and has only 3 wet diapers daily. This fits baby feeding poorly because intake is too low, shown by weight loss and few wet diapers, and the problem is already present, so it is actual. The plan aims for feeding 8 to 12 times a day, weight gain by day 7 and at least 6 wet diapers per day, by checking the latch, waking him, using a feeding plan and getting lactation help.

N8 Baby's temperature unstable

Group: Maternal and newborn | Type: Actual problem

- **Definition:** The newborn cannot keep a safe body temperature.
- **Possible causes:** Prematurity; cold room; low weight; infection
- **Signs and symptoms:** Cold or hot skin; shivering; poor feeding

Scenario

A newborn has a temperature of 35.5 degrees.

Subjective (S): (Parent) "He feels cold."

Objective (O): Temperature 35.5 C; pale; poor feeding; day 1 of life.

Assessment tools for this scenario: **CP-MOTHER** Mother & Newborn Check (p. 276)

Validated scales to consider: MEOWS, APGAR

CarePath diagnosis: Baby's temperature unstable related to immature temperature control in a newborn, as evidenced by a temperature of 35.5 C, pale skin, and poor feeding.

Interventions and rationale

Intervention	Rationale
Do skin-to-skin contact.	Skin-to-skin contact lets the mother's body warm the baby quickly and also calms him and helps feeding.
Warm the room.	A warm room reduces heat lost to the air, since newborns lose heat fast and cannot shiver well.
Use a hat.	A hat covers the head, which is a large part of a newborn's body surface and a major site of heat loss.
Check temperature.	Frequent temperature checks show whether warming is working and catch a fall or rise early.
Feed.	Feeding supplies the energy a baby needs to make heat, and low blood sugar can worsen cold stress.
Report abnormal readings.	Abnormal readings may signal infection or another illness, so reporting lets the team assess and treat him without delay.

Expected outcomes

- Within 1-2 hours: temperature 36.5-37.5 C, feeding well, skin pink and warm.

Linking the data to the diagnosis

The newborn is on day 1 of life with a temperature of 35.5 C, is pale and feeds poorly, and a parent says, "He feels cold." This fits baby's temperature unstable because the reading is below the safe range of 36.5 to 37.5 C and the baby cannot hold his own heat, and it is already happening, so it is actual. The plan aims for temperature of 36.5 to 37.5 C within 1 to 2 hours, good feeding and warm pink skin, using skin-to-skin contact, a warm room, a hat and close monitoring.

N9 Newborn jaundice

Group: Maternal and newborn | Type: Actual problem

- **Definition:** Yellow skin or eyes in a newborn from high bilirubin.
- **Possible causes:** Immature liver; blood group differences; prematurity
- **Signs and symptoms:** Yellow skin and eyes; sleepy; poor feeding

Scenario

A baby on day 3 looks yellow.

Subjective (S): "His skin looks yellow."

Objective (O): Yellow face and chest on day 3; sleepy; high bilirubin.

Assessment tools for this scenario: **CP-MOTHER** Mother & Newborn Check (p. 276) · **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: MEOWS, APGAR, Braden Scale, TIME wound chart

CarePath diagnosis: Newborn jaundice related to immature liver, as evidenced by yellow skin and eyes and sleepy.

Interventions and rationale

Intervention	Rationale
Check bilirubin.	Bilirubin levels show how severe the jaundice is and whether treatment is needed, because skin color alone can be misleading.
Feed often.	Frequent feeds make the baby pass stool and urine, which removes bilirubin from the body, and also prevent dehydration.
Give phototherapy as ordered.	Phototherapy light changes bilirubin into a form the baby can pass out, and it is given as ordered to lower the level safely.
Monitor.	Ongoing monitoring shows whether levels are falling and finds any rise early, since very high bilirubin can harm the brain.

Expected outcomes

- Bilirubin falls below the treatment line.
- Feeds well.
- Yellowing fades.
- No complications.

Linking the data to the diagnosis

The baby is on day 3 with a yellow face and chest, and a parent says, "His skin looks yellow." He is sleepy and his bilirubin is high. This fits newborn jaundice because the yellow color and raised bilirubin are present now, so it is an actual problem, and sleepiness is a sign that needs watching. The plan aims for bilirubin to fall below the treatment line, for him to feed well, for the yellowing to fade and for complications to be avoided, through testing, frequent feeds, ordered phototherapy and close monitoring.

N10 Newborn breathing difficulty **URGENT**

Group: Maternal and newborn | Type: Actual problem

- **Definition:** The baby breathes fast, grunts, or struggles to get enough air.
- **Possible causes:** Prematurity; lung fluid; infection; aspiration
- **Signs and symptoms:** Fast breathing; grunting; chest pulling in; blue color

Scenario

A newborn breathes at 80 breaths a minute and grunts.

Subjective (S): (Parent) "He's breathing fast."

Objective (O): Respiratory rate 80/min; grunting; chest indrawing; oxygen saturation 88%.

Assessment tools for this scenario: CP-MOTHER Mother & Newborn Check (p. 276) · CP-BREATH Breathing & Circulation Check (p. 265)

Validated scales to consider: MEOWS, APGAR, NEWS2, SpO₂, ECG

CarePath diagnosis: Newborn breathing difficulty related to prematurity, as evidenced by fast breathing and grunting.

Interventions and rationale

Intervention	Rationale
Call for help.	Calling for help first brings skilled staff and equipment quickly, because a newborn with these signs can deteriorate within minutes.
Give oxygen.	Oxygen raises the amount in the blood, which is low at 88%, and protects the brain and organs from lack of oxygen.
Keep warm.	Newborns lose heat fast, and cold stress raises oxygen needs and breathing effort, so keeping him warm eases the workload.
Monitor.	Continuous monitoring of breathing rate and oxygen level shows whether treatment is working and detects worsening early.
Position.	A neutral position with the airway open lets air flow more easily and reduces breathing effort.
Prepare for care.	Preparing for further care, such as transfer or extra equipment, saves time if he does not improve quickly.

Expected outcomes

- Respiratory rate 40-60/min.
- Oxygen saturation at target.
- No grunting.
- Stable.

Linking the data to the diagnosis

The newborn breathes at 80 breaths a minute, grunts, has chest indrawing and an oxygen saturation of 88%, and a parent says, "He's breathing fast." This fits newborn breathing difficulty because the rate is far above normal and the signs show he is struggling to get enough air, so it is actual and urgent. Help is called first, before other care. The plan aims for a respiratory rate of 40 to 60/min, oxygen saturation at target, no grunting and a stable baby, using oxygen, warmth, monitoring and preparation for further care.

N11 Difficulty adjusting to new parenthood

Group: Maternal and newborn | Type: Risk problem

- **Definition:** Stress, exhaustion, or lack of support may make adjusting to a baby hard.
- **Risk factors:** First baby; poor sleep; lack of support; stress
- **Warning signs to watch for:** Overwhelmed; worried; crying; doubts about skills

Scenario

A new mother says she does not know what she is doing.

Subjective (S): "I don't know what I'm doing."

Objective (O): New mother; tearful; sleeping 3 hours; baby crying.

Assessment tools for this scenario: **CP-MOTHER** Mother & Newborn Check (p. 276)

Validated scales to consider: MEOWS, APGAR

CarePath diagnosis: Difficulty adjusting to new parenthood related to first baby and poor sleep (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Teach baby care.	Showing her how to feed, handle and settle the baby builds skill, and skill builds the confidence she says she lacks.
Encourage rest.	Sleep loss increases stress and weakens coping, so rest helps her think clearly and manage the baby's demands.
Involve the partner.	Her partner can share care and give emotional support, which reduces her load and strengthens the family.
Praise efforts.	Praise for what she does well builds confidence, and people who feel capable cope better with new tasks.
Link to support.	Links to groups, health visitors or family give ongoing help after discharge, when many parents feel most alone.

Expected outcomes

- Within 1 week: cares for baby with confidence, sleeps in blocks, uses support, says she feels more capable.

Linking the data to the diagnosis

The new mother says, "I don't know what I'm doing." She is tearful, sleeping 3 hours and the baby is crying. This is a risk diagnosis because she has not yet failed to adjust; first baby, poor sleep and stress raise the chance that she will struggle. Her tears are a warning, not a clear sign of a problem, so it differs from sadness after childbirth. The plan aims for her, within 1 week, to care for the baby with confidence, sleep in blocks, use support and say she feels more capable.

N12 Sadness after childbirth

Group: Maternal and newborn | Type: Actual problem

- **Definition:** Low mood, tearfulness, or anxiety in the weeks after delivery.
- **Possible causes:** Hormones; stress; lack of sleep; previous mood illness
- **Signs and symptoms:** Tearfulness; irritability; anxiety; low mood; disinterest in the baby

Scenario

A mother cries daily two weeks after birth.

Subjective (S): "I cry every day and don't feel like myself."

Objective (O): Two weeks after birth; tearful; low mood; anxious.

Assessment tools for this scenario: **CP-MOTHER** Mother & Newborn Check (p. 276) · **CP-MIND**

Mood & Mind Screen (p. 272)

Validated scales to consider: MEOWS, APGAR, PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Sadness after childbirth related to hormones, as evidenced by tearfulness and irritability.

Interventions and rationale

Intervention	Rationale
Listen.	Listening lets her describe feelings without judgment, and being understood eases shame and isolation that often come with low mood after birth.
Screen mood.	Mood screening finds out how severe her symptoms are and whether she may have postpartum depression that needs treatment.
Encourage support and rest.	Support and rest lower stress and tiredness, which both worsen mood, and help her cope with the demands of a baby.
Refer if it lasts or is severe.	Referral for lasting or severe symptoms makes sure she gets proper treatment, since untreated depression can harm both mother and baby.
Watch safety.	Watching safety checks for thoughts of self-harm or of harming the baby, so help can be given at once if either appears.

Expected outcomes

- Within 2 weeks: mood improves, accepts help, uses support.
- Urgent review if symptoms worsen.

Linking the data to the diagnosis

Two weeks after birth, the mother says, "I cry every day and don't feel like myself." She is tearful, low in mood and anxious. This fits sadness after childbirth because the symptoms are present now and match the time after delivery, so it is actual. Because it has lasted two weeks, mood screening is needed to tell ordinary baby blues from a more serious illness. The plan aims for mood to improve within 2 weeks, for her to accept help and use support, with urgent review if symptoms get worse.

N13 Grief after pregnancy loss

Group: Maternal and newborn | Type: Actual problem

- **Definition:** Sorrow after miscarriage, stillbirth, or loss of a newborn.
- **Possible causes:** Miscarriage; stillbirth; death of a newborn
- **Signs and symptoms:** Crying; numbness; guilt; withdrawal

Scenario

A couple grieves after a stillbirth.

Subjective (S): "I wanted her so much."

Objective (O): Stillbirth; crying; numb; partner distressed; no support yet.

Assessment tools for this scenario: CP-MOTHER Mother & Newborn Check (p. 276)

Validated scales to consider: MEOWS, APGAR

CarePath diagnosis: Grief after pregnancy loss related to miscarriage, as evidenced by crying and numbness.

Interventions and rationale

Intervention	Rationale
Show compassion.	Compassion tells the couple that their loss is real and their feelings are valid, which opens the way for grieving.
Allow time with the baby.	Spending time with their baby lets parents say goodbye and make memories, and many find this helps them grieve in a healthy way.

Intervention	Rationale
Offer keepsakes.	Keepsakes such as photos, footprints or a blanket give lasting memories of their daughter and help with later grieving.
Refer to counseling.	Counseling gives specialized help for grief, which can be long and complicated, especially when support is lacking.
Follow up.	Follow-up lets the team check on their coping and physical recovery, since grief can last long after discharge.

Expected outcomes

- Grieves openly.
- Spends time with the baby if wished.
- Support in place.
- Follow-up arranged.

Linking the data to the diagnosis

The couple grieves after a stillbirth, and the mother says, "I wanted her so much." They are crying and numb, the partner is distressed and they have no support yet. This fits grief after pregnancy loss because their sorrow is a direct response to losing the baby, and it is already present, so it is actual. It is specific to pregnancy loss rather than general grief. The plan aims for them to grieve openly, spend time with the baby if they wish, have support in place and have follow-up arranged, through compassion, keepsakes and counseling.

N14 Family planning questions

Group: Maternal and newborn | Type: Actual problem

- **Definition:** The person wants information on contraception or spacing pregnancies.
- **Possible causes:** Wish to space births; health reasons; lack of information
- **Signs and symptoms:** Asks about contraception; unplanned pregnancy; confusion

Scenario

A mother asks which method is safe while breastfeeding.

Subjective (S): "Which method is safe while I'm breastfeeding?"

Objective (O): Asks about contraception; unsure; motivated; recent delivery.

Assessment tools for this scenario: CP-MOTHER Mother & Newborn Check (p. 276)

Validated scales to consider: MEOWS, APGAR

CarePath diagnosis: Family planning questions related to wish to space births, as evidenced by asks about contraception and unplanned pregnancy.

Interventions and rationale

Intervention	Rationale
Give balanced information.	Balanced information about benefits and drawbacks lets her choose a method that fits her health and wishes instead of being steered.
Respect choices.	Respecting her choices supports her right to decide about her own body, and she is more likely to use a method she chose.
Explain options.	Explaining options, including which are safe while breastfeeding, answers her question and helps her avoid methods that may affect milk or health.
Refer.	Referral to a family planning clinic or clinician gives access to methods needing a prescription or procedure, and to follow-up.

Expected outcomes

- Chooses a method suitable for her.
- Understands its use.
- Attends follow-up.

Linking the data to the diagnosis

The mother, who recently delivered, asks, "Which method is safe while I'm breastfeeding?" She asks about contraception, is unsure and is motivated. This fits family planning questions because she wants information to space her births and lacks the knowledge to choose, and she is ready to learn. The need is present now, so it is an actual diagnosis, but it is a request for teaching rather than a health problem. The plan aims for her to choose a method suitable for her, understand its use and attend follow-up, by giving balanced information and respecting her choices.

K - Child and teen

Recommended assessment tools

CarePath tool: **CP-CHILD** Child & Teen Check (p. 277)

Validated scales: PEWS, FLACC

K1 Slow growth

Group: Child and teen | Type: Actual problem

- **Definition:** Height or weight is below what is expected for age.
- **Possible causes:** Poor nutrition; chronic illness; hormone problems; neglect
- **Signs and symptoms:** Below the growth chart; thin; short; poor appetite

Scenario

A toddler's weight falls below the expected curve.

Subjective (S): (Parent) "He's small for his age."

Objective (O): Weight below the 3rd percentile; thin; poor appetite; growth chart falling.

Assessment tools for this scenario: **CP-CHILD** Child & Teen Check (p. 277) · **CP-SAFE** Safety & Falls Score (p. 269) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: PEWS, FLACC, Morse Fall Scale, MUST, fluid chart, glucose

CarePath diagnosis: Slow growth related to poor nutrition, as evidenced by below the growth chart and thin.

Interventions and rationale

Intervention	Rationale
Measure growth.	Accurate height and weight plotted on a growth chart show the pattern and whether the child is catching up or falling further behind.
Make a feeding plan.	A practical feeding plan gives the family clear steps to raise calories and nutrients, which are the likely cause of poor growth.
Involve a dietitian.	A dietitian can tailor foods and calories to the child's needs and find barriers to eating that the family may not notice.
Treat the cause.	Poor growth can come from illness or hormone problems, so finding and treating the cause is needed for lasting improvement.
Follow up.	Follow-up lets the team check progress and change the plan, since growth is judged over time and not from one visit.

Expected outcomes

- Within 3 months: weight gain follows the expected curve, family follows the feeding plan, causes assessed.

Linking the data to the diagnosis

The toddler's parent says, "He's small for his age." His weight is below the 3rd percentile, he is thin, has a poor appetite and his growth chart is falling. This fits slow growth because the measurements are already below what is expected for his age and are still dropping, so it is actual, not risk. The plan aims for weight gain to follow the expected curve within 3 months, for the family to follow the feeding plan and for the cause to be assessed, using regular measurement, a dietitian and treatment of any underlying problem.

K2 Delayed development

Group: Child and teen | Type: Actual problem

- **Definition:** The child may be slower in movement, speech, or social skills than expected.
- **Possible causes:** Prematurity; illness; neglect; genetic conditions
- **Signs and symptoms:** Late sitting, walking, or speech; poor play

Scenario

A two-year-old does not say any words.

Subjective (S): (Parent) "She doesn't say words yet."

Objective (O): Age 2; no words; limited play; passes hearing screen.

Assessment tools for this scenario: CP-CHILD Child & Teen Check (p. 277)

Validated scales to consider: PEWS, FLACC

CarePath diagnosis: Delayed development related to an unknown cause under assessment (hearing screen passed), as evidenced by no words at age 2 and limited play.

Interventions and rationale

Intervention	Rationale
Screen development.	Screening with a standard tool shows how far her skills are from expected and helps decide how urgent further help is.
Encourage stimulation.	Talking, reading, singing and play give the brain the input it needs to build language, and early stimulation can improve progress.
Refer for therapy.	Therapy from a speech or developmental specialist gives targeted help that parents alone cannot provide, and early help works best.
Teach parents.	Parents spend the most time with her, so teaching them activities lets practice continue every day at home.

Expected outcomes

- Receives referral and therapy.
- Uses new words or signs within 3 months.
- Parents practice activities.

Linking the data to the diagnosis

The child is two years old, says no words, and plays very little, although she passes the hearing screen. Because the delay can already be seen, the statement is actual. The cause is not yet known, so the nurse screens development and refers early. A hearing problem has been ruled out, which narrows the search. The plan aims for a referral and therapy, new words or signs within 3 months, and parents who can practice stimulation activities at home.

K3 Fear of hospital or procedures

Group: Child and teen | Type: Actual problem

- **Definition:** The child is frightened of staff, needles, or unfamiliar surroundings.
- **Possible causes:** Past experience; strange place; pain; separation
- **Signs and symptoms:** Crying; clinging; refusal; nightmares

Scenario

A child cries at the sight of a white coat.

Subjective (S): "I don't want to be here."

Objective (O): Child cries at the white coat; clings to parent; refuses exam.

Assessment tools for this scenario: **CP-CHILD** Child & Teen Check (p. 277)

Validated scales to consider: PEWS, FLACC

CarePath diagnosis: Fear of hospital or procedures related to past experience, as evidenced by crying and clinging.

Interventions and rationale

Intervention	Rationale
Explain simply.	Simple, age-appropriate words reduce fear of the unknown, since children imagine frightening things when they do not understand.
Allow play.	Play, including toy equipment, lets him handle and understand tools in a safe way and express fears he cannot say.
Let a parent stay.	A parent's presence gives security and comfort, and children cope better with strange people and places when a trusted adult is near.
Be honest.	Honesty about what will happen, including pain, builds trust, while false promises can increase fear at the next procedure.
Praise.	Praise rewards cooperation and builds his confidence, making him more likely to cope well in future visits.

Expected outcomes

- Allows the exam with play support.
- Cries less.
- Says he felt brave.

Linking the data to the diagnosis

The child says, "I don't want to be here." He cries at the white coat, clings to his parent and refuses the exam. This fits fear of hospital or procedures because the fear is set off by staff and the setting, and it is already blocking care, so it is actual. It differs from distress when separated from parents because he is frightened of the people and the place, not only of being left. The plan aims for him to allow the exam with play support, cry less and say he felt brave.

K4 Child cannot express pain **URGENT**

Group: Child and teen | Type: Actual problem

- **Definition:** The child is too young or unable to say where or how much they hurt.
- **Possible causes:** Young age; developmental delay; fear; language barrier
- **Signs and symptoms:** Crying; guarding; irritability; changes in sleep or play

Scenario

A toddler cries and clutches his belly but cannot say where it hurts.

Subjective (S): (Cannot speak.) Cries and clutches belly.

Objective (O): Toddler cries; guards abdomen; faces pain scale 8/10; fever 38.1 C.

Assessment tools for this scenario: **CP-CHILD** Child & Teen Check (p. 277) · **CP-PAIN** Pain & Comfort Score (p. 268) · **CP-INFECT** Infection Check (p. 281)

Validated scales to consider: PEWS, FLACC, NRS 0-10, PAINAD, qSOFA / sepsis screen

CarePath diagnosis: Child cannot express pain related to young age, as evidenced by crying and guarding.

Interventions and rationale

Intervention	Rationale
Use a faces pain scale.	A faces scale lets a toddler point to how he feels without needing words, so pain can be measured and tracked.
Observe behavior.	Crying, guarding, sleep and play changes are the main pain clues in a child who cannot speak, so careful observation finds pain and its location.
Comfort.	Comfort such as holding, soothing words and a familiar object calms him, and calming lowers pain from fear and tension.
Tell the doctor promptly about the fever and abdominal guarding; give pain relief as ordered.	Abdominal pain with fever can signal a serious problem such as appendicitis, so the doctor assesses the cause before or alongside pain relief.

Expected outcomes

- Within 1 hour: pain 3/10 or lower, settles and sleeps, feeds.

Linking the data to the diagnosis

The toddler cannot speak but cries and clutches his belly. He guards his abdomen, rates 8/10 on a faces pain scale and has a fever of 38.1 C. This fits child cannot express pain because pain is clearly present but he is too young to say where or how much, so observation and a faces scale are needed. The problem is actual. The plan aims for pain of 3/10 or lower within 1 hour, for him to settle and sleep and to feed, using pain tools, observation, comfort and ordered pain relief.

K5 Accident risk at home

Group: Child and teen | Type: Risk problem

- **Definition:** Hazards such as stairs, water, or hot items raise injury risk.
- **Risk factors:** Curious children; hot items; stairs; water; poisons
- **Warning signs to watch for:** Frequent bumps; unsafe toys; open medicines

Scenario

A toddler climbs the stairs without a gate.

Subjective (S): (Parent) "He climbs everything."

Objective (O): Toddler at the top of stairs; no gate; bumps and bruises; hot kettle within reach.

Assessment tools for this scenario: **CP-CHILD** Child & Teen Check (p. 277)

Validated scales to consider: PEWS, FLACC

CarePath diagnosis: Accident risk at home related to curious children and hot items (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Child-proof the home.	Removing hazards such as hot kettles and open stairs prevents injury before it happens, which is more reliable than depending on a toddler to stay safe.
Teach parents.	Parents who know common dangers and what children can do at each age are better able to spot and fix hazards themselves.
Supervise.	Toddlers have no sense of danger and move fast, so close adult supervision is needed even in a child-proofed home.
Use safety devices.	Gates, cooker guards, locks and similar devices act as physical barriers that work even when a parent is distracted for a moment.

Expected outcomes

- Home made safer within 1 week.
- No injury.
- Parent states 3 safety changes.

Linking the data to the diagnosis

The parent says, "He climbs everything." The toddler is at the top of the stairs with no gate, has bumps and bruises, and a hot kettle is within reach. This is a risk diagnosis because no serious injury has occurred; the hazards and his curiosity make one likely. The bruises show he is active, not that the risk has become an injury. The plan aims for the home to be made safer within 1 week, for no injury to occur and for the parent to state 3 safety changes, using child-proofing, teaching, supervision and safety devices.

K6 Distress when separated from parents

Group: Child and teen | Type: Actual problem

- **Definition:** The child is upset or anxious when caregivers are away.
- **Possible causes:** Strange place; bonding; fear; young age
- **Signs and symptoms:** Screaming; clinging; refusing care; sleep disturbance

Scenario

A child cries whenever her parents leave.

Subjective (S): "Mommy don't go!"

Objective (O): Child screams and clings; poor sleep; refuses care without parent.

Assessment tools for this scenario: CP-CHILD Child & Teen Check (p. 277)

Validated scales to consider: PEWS, FLACC

CarePath diagnosis: Distress when separated from parents related to strange place, as evidenced by screaming and clinging.

Interventions and rationale

Intervention	Rationale
Encourage a parent to stay.	A parent's presence is the strongest source of security for a child and reduces panic, so staying helps her accept care.
Keep routines.	Familiar routines such as meals and bedtime give predictability, which makes a strange place feel safer.
Offer a comfort object.	A favorite toy or blanket gives comfort and a link to home when the parent must be away.

Intervention	Rationale
Play.	Play distracts her, helps her express feelings and builds trust with staff, which makes separations easier.
Reassure.	Calm reassurance, including telling her when the parent will return, helps her feel safe and understand that she is not abandoned.

Expected outcomes

- Settles within 10 minutes of parent leaving.
- Accepts routine.
- Sleeps well.

Linking the data to the diagnosis

The child screams, "Mommy don't go!" She clings, sleeps poorly and refuses care without a parent. This fits distress when separated from parents because the distress appears when her parents leave and is already affecting care and sleep, so it is actual. It differs from fear of hospital or procedures, which is about the staff and treatments. The plan aims for her to settle within 10 minutes of the parent leaving, accept routine care and sleep well, using parent presence, routines, a comfort object, play and reassurance.

K7 Behavior problems

Group: Child and teen | Type: Actual problem

- **Definition:** Ongoing tantrums, defiance, or aggression that disrupt care and family life.
- **Possible causes:** Stress; developmental disorders; poor parenting skills; illness
- **Signs and symptoms:** Tantrums; aggression; defiance; withdrawal

Scenario

A hospitalized child hits staff.

Subjective (S): "No! I won't!"

Objective (O): Hitting staff; refuses care; tantrums; irritable.

Assessment tools for this scenario: CP-CHILD Child & Teen Check (p. 277)

Validated scales to consider: PEWS, FLACC

CarePath diagnosis: Behavior problems related to stress, as evidenced by tantrums and aggression.

Interventions and rationale

Intervention	Rationale
Set limits.	Clear, consistent limits help a stressed child know what is expected and feel safe, and they protect staff and other patients from harm.
Praise good behavior.	Praise for good behavior rewards what the child does right, and children tend to repeat behavior that gets attention.
Distract.	Distraction shifts his attention from what is upsetting him and can stop a tantrum before it grows.
Involve parents.	Parents know the child best and can use the same approaches, so involving them keeps responses consistent and helps him feel secure.
Refer if it persists.	Persistent problems may have a cause such as illness or a developmental condition, so referral gets specialist assessment and support.

Expected outcomes

- Within 48 hours: behavior improves, cooperates with care.
- Parent uses limit setting.

Linking the data to the diagnosis

The hospitalized child shouts, "No! I won't!" He hits staff, refuses care, has tantrums and is irritable. This fits behavior problems because the aggression and defiance are already disrupting care, so it is an actual diagnosis. The behavior seems to come from stress, but it is more than fear alone. The plan aims for behavior to improve within 48 hours, for him to cooperate with care and for the parent to use limit setting, through clear limits, praise, distraction, parent involvement and referral if the behavior continues.

K8 Missing school due to illness

Group: Child and teen | Type: Actual problem

- **Definition:** Illness or treatment interrupts schooling and learning.
- **Possible causes:** Chronic illness; hospital stays; fatigue; stigma
- **Signs and symptoms:** Gaps in learning; falling behind; isolation

Scenario

A child with leukemia misses months of school.

Subjective (S): "I'm behind in class."

Objective (O): Child with leukemia; missed 3 months; grades falling; low mood.

Assessment tools for this scenario: **CP-CHILD** Child & Teen Check (p. 277) · **CP-SAFE** Safety & Falls Score (p. 269)

Validated scales to consider: PEWS, FLACC, Morse Fall Scale

CarePath diagnosis: Missing school due to illness related to chronic illness, as evidenced by gaps in learning and falling behind.

Interventions and rationale

Intervention	Rationale
Liaise with the school.	Contact with the school allows teachers to know his condition, share lessons and plan how he returns, so he is not left behind.
Arrange hospital teaching.	Hospital teaching keeps learning going during treatment and helps him feel normal when he cannot attend class.
Plan catch-up.	A catch-up plan sets realistic steps so he can recover lost learning without being overwhelmed, which protects his confidence.
Encourage friendships.	Friendships reduce isolation and low mood, and staying in touch with classmates helps him feel he still belongs at school.

Expected outcomes

- Has a teaching plan.
- Catches up gradually.
- Attends when possible.
- Mood improves.

Linking the data to the diagnosis

The child with leukemia says, "I'm behind in class." He has missed 3 months of school, his grades are falling and his mood is low. This fits missing school due to illness because treatment and chronic illness have caused the gaps, and the problem is already present, so it is actual. It is about education rather

than only mood. The plan aims for him to have a teaching plan, catch up gradually, attend when possible and have better mood, through links with the school, hospital teaching, a catch-up plan and support for friendships.

K9 Risk-taking behavior in teens

Group: Child and teen | Type: Actual problem

- **Definition:** Teens may take risks with substances, sex, or safety.
- **Possible causes:** Peer pressure; curiosity; poor self-control; family issues
- **Signs and symptoms:** Substance experimenting; unsafe sex; reckless driving; secrecy

Scenario

A teenager drinks and drives with friends.

Subjective (S): "I only had a few drinks."

Objective (O): Teen drinks and drives; secretive; peer influence; no safe plan.

Assessment tools for this scenario: CP-CHILD Child & Teen Check (p. 277)

Validated scales to consider: PEWS, FLACC

CarePath diagnosis: Risk-taking behavior in teens related to peer pressure and curiosity, as evidenced by drinking and driving, secrecy, and having no safe plan.

Interventions and rationale

Intervention	Rationale
Talk without judging.	Talking without judgment keeps the teen willing to speak honestly, whereas criticism often leads to secrecy and defensiveness.
Teach the risks.	Clear facts about alcohol, driving and consequences help him weigh the real dangers, which may be underestimated by teens.
Encourage support.	Supportive people such as friends, mentors or school staff give him positive influences and counter peer pressure.
Involve family.	Family involvement allows consistent rules and monitoring at home, with his understanding where possible.
Refer.	Referral to a counselor or substance service gives skilled help with behavior that he may not be able to change alone.

Expected outcomes

- States risks and safe alternatives.
- No risky driving.
- Engages with a counselor.

Linking the data to the diagnosis

The teenager drinks and drives with friends, keeps it secret, and has no safe plan, and peer influence is clear. The behavior is happening now, so the statement is actual, and it needs prompt, non-judging safety counseling because drink driving can cause death. The plan aims for the teen to state the risks and safe alternatives, stop risky driving, and work with a counselor and his family.

K10 Infant dehydration risk

Group: Child and teen | Type: Risk problem

- **Definition:** Infants can lose body water quickly through vomiting, diarrhea, or poor feeding.
- **Risk factors:** Vomiting; diarrhea; fever; poor feeding; heat

- **Warning signs to watch for:** Sunken soft spot; dry mouth; fewer wet diapers; lethargy

Scenario

A 10-month-old with one day of vomiting is feeding poorly.

Subjective (S): Parent: "She vomits after every feed."

Objective (O): Vomiting 5 times today; breastfeeds poorly; 4 wet diapers in 24 hours; soft spot flat; mouth moist; temperature 37.9 C.

Assessment tools for this scenario: **CP-CHILD** Child & Teen Check (p. 277) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: PEWS, FLACC, MUST, fluid chart, glucose

CarePath diagnosis: Infant dehydration risk related to vomiting, poor feeding and fever (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Give oral rehydration.	Small, frequent sips of oral rehydration solution replace water and salts lost in vomiting without overloading the stomach, so fluid is more likely to stay down.
Breastfeed.	Breast milk is easily digested and gives fluid and nutrition, and continued feeding keeps intake up and comforts the baby while she is unwell.
Monitor diapers.	Counting wet diapers is a simple, reliable way to see whether enough fluid is going in, so falling urine output is caught early.
Seek urgent care for lethargy.	Lethargy means dehydration may be becoming serious, and infants worsen quickly, so prompt medical assessment and possible intravenous fluids are needed.

Expected outcomes

- Wet diapers return to at least 6 per day.
- Takes fluids.
- Alert and active.
- No dehydration.

Linking the data to the diagnosis

The parent says the 10-month-old vomits after every feed. She has vomited 5 times today, breastfeeds poorly and has a temperature of 37.9 C. However, she has 4 wet diapers in 24 hours, a flat soft spot and a moist mouth, so dehydration has not occurred. This is why a risk statement fits, not an actual dehydration diagnosis, and it rests on vomiting, poor feeding and fever. The plan aims to replace fluid before loss builds up, bringing wet diapers back to at least 6 per day, keeping her taking fluids and alert, and preventing dehydration.

K11 Unsafe infant sleep

Group: Child and teen | Type: Risk problem

- **Definition:** Sleep position or setting may raise the chance of suffocation or sudden infant death.
- **Risk factors:** Soft bedding; tummy sleeping; smoking; overheating; bed sharing
- **Warning signs to watch for:** Found face down; sweating; heavy blankets

Scenario

A baby is put down to sleep on his stomach on a pillow in a home where adults smoke.

Subjective (S): Parent: "He sleeps best on his stomach."

Objective (O): Baby on a pillow face down; heavy blankets; smoke in the home; baby breathing normally and pink.

Assessment tools for this scenario: CP-CHILD Child & Teen Check (p. 277)

Validated scales to consider: PEWS, FLACC

CarePath diagnosis: Unsafe infant sleep related to soft bedding and tummy sleeping (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Turn the baby onto his back and remove the pillow and loose bedding now.	A baby face down on a soft pillow can rebreathe exhaled air or have the nose and mouth blocked, so moving him to his back removes the immediate suffocation danger.
Teach safe sleep: on the back, firm flat mattress, nothing soft in the cot.	Sleeping on the back on a firm, flat surface with nothing soft nearby is the safest arrangement and lowers the chance of suffocation and sudden infant death.
Keep the baby cool and avoid heavy blankets.	Babies cannot easily lose heat, and overheating is linked to sudden infant death, so light bedding and a cool room reduce the risk.
Advise a smoke-free home and car, and room-sharing without bed-sharing.	Tobacco smoke raises sudden infant death risk, and sleeping in the same room but on a separate surface keeps the baby close without the danger of adult bedding or overlying.
Check understanding by asking parents to show how they will settle him.	Asking parents to show what they will do confirms they understand and can carry out the advice, rather than only hearing it.

Expected outcomes

- Immediately: baby on his back on a firm mattress with no pillow.
- Parents state safe sleep rules in their own words.
- Home smoke-free; follow-up check completed.

Linking the data to the diagnosis

The parent says he sleeps best on his stomach. The baby was found face down on a pillow with heavy blankets, in a home with smoke. He is breathing normally and is pink, so no harm has occurred. For that reason a risk statement fits, and it rests on soft bedding and tummy sleeping. The nurse corrects the hazard first, by turning him onto his back and removing the pillow and loose bedding now. The plan aims to leave him on his back on a firm mattress with no pillow, help parents state the safe sleep rules in their own words, and make the home smoke-free with a follow-up check.

K12 Missed vaccinations

Group: Child and teen | Type: Actual problem

- **Definition:** Recommended vaccines have not been given on schedule.
- **Possible causes:** Missed visits; fear; misinformation; access problems
- **Signs and symptoms:** No vaccine record; outbreak risk; delay

Scenario

A child is behind on immunizations.

Subjective (S): (Parent) "We forgot the vaccines."

Objective (O): Child's record shows missed doses; school age; no illness.

Assessment tools for this scenario: **CP-CHILD** Child & Teen Check (p. 277)

Validated scales to consider: PEWS, FLACC

CarePath diagnosis: Missed vaccinations related to missed visits, as evidenced by no vaccine record and outbreak risk.

Interventions and rationale

Intervention	Rationale
Check records.	Looking at the immunization record shows exactly which doses are missing, so the catch-up plan is accurate and nothing is repeated or overlooked.
Explain benefits.	When parents understand how vaccines prevent serious disease and protect others, they are more willing to agree to them.
Address fears.	Fear and misinformation are common reasons for delay, and listening to concerns and answering them honestly builds trust and cooperation.
Schedule catch-up.	A booked catch-up schedule turns agreement into action and brings the child to full protection as soon as safely possible.

Expected outcomes

- Catch-up schedule agreed.
- Vaccines given.
- Parent states benefits.

Linking the data to the diagnosis

The parent says, 'We forgot the vaccines.' The child's record shows missed doses, the child is of school age and has no illness. Because the vaccines are already overdue, this is an actual problem and not a risk, and the evidence is the missed doses and the lack of a complete vaccine record. The cause is missed visits, so the plan focuses on the visits. The nurse checks the record, explains the benefits, addresses any fears and books catch-up. The plan aims for an agreed catch-up schedule, vaccines given, and a parent who can state the benefits.

A - Older adult

Recommended assessment tools

CarePath tool: **CP-OLDER Older Adult Check** (p. 278)

Validated scales: 4AT / CAM, Mini-Cog

A1 Frailty

Group: Older adult | Type: Actual problem

- **Definition:** General weakness, low energy, and slow recovery that raise the chance of falls and illness.
- **Possible causes:** Aging; poor nutrition; inactivity; chronic disease; low reserves
- **Signs and symptoms:** Weakness; slowness; tiredness; weight loss; falls

Scenario

An older woman has a slow walk, exhaustion, and unintended weight loss.

Subjective (S): "I'm weak and tired all the time."

Objective (O): Slow walk; lost 5 kg; weak grip; one fall in 6 months.

Assessment tools for this scenario: **CP-OLDER Older Adult Check** (p. 278) · **CP-SAFE Safety & Falls Score** (p. 269) · **CP-FLUID Fluid Balance & Nutrition Score** (p. 266)

Validated scales to consider: 4AT / CAM, Mini-Cog, Morse Fall Scale, MUST, fluid chart, glucose

CarePath diagnosis: Frailty related to aging, as evidenced by weakness and slowness.

Interventions and rationale

Intervention	Rationale
Assess strength and nutrition.	Measuring grip, walking speed and weight and reviewing food intake shows how frail she is and which causes can be treated, so the plan fits her needs.
Start an exercise program.	Regular, gentle exercise rebuilds muscle strength and balance, which improves walking speed and lowers the chance of falling.
Prevent falls.	Weak muscles and slow walking raise fall risk, and a fall can cause fractures and loss of independence, so safe surroundings and aids matter.
Review medicines.	Some medicines cause dizziness, drowsiness or poor appetite, so a review can find and reduce those that add to weakness or falls.
Involve the team.	Dietitians, physiotherapists and doctors each address a different cause of frailty, so a team approach gives more complete care.

Expected outcomes

- Gains strength.
- No falls.
- Walking speed improves in 4-8 weeks.
- Nutrition improves.

Linking the data to the diagnosis

The patient says, 'I'm weak and tired all the time.' The nurse finds a slow walk, a weak grip, a 5 kg weight loss and one fall in 6 months. Together these show ongoing low reserves, so this is an actual problem and not a risk of falls alone, and it is also more than a single fall or one tired spell. Frailty is the

best fit because weakness, slowness and weight loss occur together. The plan aims to build strength, prevent further falls, improve walking speed over 4 to 8 weeks and improve nutrition.

A2 Memory loss

Group: Older adult | Type: Actual problem

- **Definition:** Noticeable forgetfulness that affects daily life.
- **Possible causes:** Dementia; stroke; medicines; depression; vitamin B12 deficiency
- **Signs and symptoms:** Forgets names; repeats; misplaces items; gets lost

Scenario

An older man forgets to turn off the stove.

Subjective (S): "Did I turn off the stove?"

Objective (O): Forgets names and tasks; leaves the stove on; repeats questions.

Assessment tools for this scenario: CP-OLDER Older Adult Check (p. 278)

Validated scales to consider: 4AT / CAM, Mini-Cog

CarePath diagnosis: Memory loss related to suspected dementia (not yet confirmed), as evidenced by forgetting names and tasks, leaving the stove on, and repeating questions.

Interventions and rationale

Intervention	Rationale
Assess.	A structured assessment shows how much memory is affected and what could be treated, such as medicines, depression or low vitamin B12, so care matches the cause.
Use reminders.	Notes, labels and alarms support a failing memory so daily tasks are done and missed steps are less likely.
Keep routines.	Familiar, predictable routines reduce confusion and stress and rely on habit memory, which often lasts longer than recent memory.
Make the home safe.	Safety steps such as stove shut-off devices and removing hazards reduce the chance of fire or injury when he forgets.
Support the family.	Family members are the main support, and teaching them what to expect and how to help prevents exhaustion and unsafe situations.
Refer.	A specialist referral allows diagnosis, treatment of reversible causes and access to long-term services so the cause can be treated and the family linked to long-term help.

Expected outcomes

- Safe routines.
- Supervision or reminders in place.
- Family trained.
- Assessment completed.

Linking the data to the diagnosis

The patient asks, 'Did I turn off the stove?' The nurse notes that he forgets names and tasks, repeats questions and has left the stove on. Forgetfulness already affects daily life and safety, so this is an actual problem and not a risk, and it rests on these observed memory failures. The plan aims for safe routines, reminders or supervision in place, trained family and a completed assessment, so the stove danger is controlled while the cause is found.

A3 Too many medicines

Group: Older adult | Type: Risk problem

- **Definition:** Many medicines at once raise the chance of interactions and side effects.
- **Risk factors:** Many conditions; multiple doctors; no medicine review
- **Warning signs to watch for:** Side effects; confusion; falls; interactions

Scenario

An older woman takes twelve medicines prescribed by four different doctors.

Subjective (S): "I take lots of pills and I do not know why."

Objective (O): 12 medicines; 4 prescribers; no recent medicine review; keeps old tablets at home; no side effects reported yet.

Assessment tools for this scenario: CP-OLDER Older Adult Check (p. 278)

Validated scales to consider: 4AT / CAM, Mini-Cog

CarePath diagnosis: Too many medicines related to many medicines and several prescribers (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Review the list.	Going through every medicine shows what is taken, why, and whether each is still needed, which is the first step in finding interactions or unnecessary drugs.
Involve a pharmacist.	Pharmacists are experts in interactions and side effects and can advise prescribers on safer combinations and doses.
Ask the prescriber or pharmacist to remove duplicate medicines.	Only the prescriber can stop or change medicines; the nurse makes sure the review happens and records the changes.
Teach.	When she knows what each medicine is for and how to take it, she is more likely to take them correctly and report side effects early.

Expected outcomes

- Medicine list reviewed.
- Unnecessary medicines stopped only by the prescriber after review.
- No adverse effects.
- Patient names main medicines.

Linking the data to the diagnosis

The patient says, 'I take lots of pills and I do not know why.' She takes 12 medicines from 4 prescribers, has had no recent medicine review and keeps old tablets at home. No side effects have been reported yet, so harm has not occurred. For this reason a risk statement fits, and it rests on the number of medicines and prescribers. The plan aims to review the list, stop unnecessary drugs through the prescribers, avoid adverse effects and help her name her main medicines.

A4 Loneliness at home

Group: Older adult | Type: Risk problem

- **Definition:** Living alone with little contact may lead to loneliness and low mood.
- **Risk factors:** Widowhood; mobility loss; isolation; no contacts
- **Warning signs to watch for:** Says he is lonely; no visitors; low mood

Scenario

A widower speaks only to the television.

Subjective (S): "I only talk to the television."

Objective (O): Widowed; lives alone; few visits; speaks mainly to the television.

Assessment tools for this scenario: **CP-OLDER** Older Adult Check (p. 278)

Validated scales to consider: 4AT / CAM, Mini-Cog

CarePath diagnosis: Loneliness at home related to widowhood and living alone (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Encourage visits.	Regular contact with family and friends gives social connection, which lessens loneliness and protects mood.
Link to community groups.	Community groups offer shared interests and routine company beyond family, so he builds new relationships.
Arrange phone calls.	Scheduled calls give predictable contact on days when visits are not possible, especially with reduced mobility.
Consider a pet.	A pet can give companionship and a reason for daily activity, but only if he wants one and can care for it safely.
Screen mood.	Mood screening finds low mood or depression early so treatment can start before it worsens.

Expected outcomes

- Contacts at least 3 times a week.
- Joins one group.
- Mood improves.

Linking the data to the diagnosis

The patient is widowed, lives alone, has few visits, and speaks mainly to the television. These are risk factors for loneliness, but no low mood or other harm is recorded yet, so the statement is a risk and not an actual problem. The nurse acts early to prevent isolation from leading to depression. The plan aims for contact at least three times a week, joining one group, and checking his mood regularly so that any change is caught early.

A5 Neglect or money exploitation risk

Group: Older adult | Type: Risk problem

- **Definition:** The older person may be neglected or taken advantage of by others.
- **Risk factors:** Dependence; dementia; abusers; isolation
- **Warning signs to watch for:** Missing money; unpaid bills; poor hygiene; fear

Scenario

An older woman with early dementia lets a relative manage her bank card.

Subjective (S): "My son handles my money."

Objective (O): Early dementia; lives with a relative who manages her bank card; cannot say her balance; clean and well fed; no missing money found yet.

Assessment tools for this scenario: CP-OLDER Older Adult Check (p. 278)

Validated scales to consider: 4AT / CAM, Mini-Cog

CarePath diagnosis: Neglect or money exploitation risk related to dependence and memory problems (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Ask privately.	Speaking alone lets her answer without pressure from the person who may be controlling her, so she can speak freely and safely.
Document.	Accurate, dated and factual records protect the patient and support any later investigation and clear notes give a reliable record if the concern is investigated later.
Report per policy.	Reporting through the agreed policy brings in people with legal authority to investigate and protect vulnerable adults.
Involve a social worker.	A social worker can assess her finances and care, and arrange independent help and protective measures.
Ensure safety.	Making sure she is safe comes first, so no further harm can occur while concerns are looked into.

Expected outcomes

- Patient safe.
- Concerns reported per policy.
- Independent help arranged.
- Finances protected.

Linking the data to the diagnosis

The patient says, 'My son handles my money.' She has early dementia, lives with a relative who manages her bank card and cannot say her balance. She is clean and well fed, and no missing money has been found yet, so neglect or exploitation has not been shown. This is why a risk statement fits, and it rests on dependence and memory problems. The plan aims for the patient to be safe, concerns reported per policy, independent help arranged and finances protected.

A6 Unsafe to live alone

Group: Older adult | Type: Actual problem

- **Definition:** Health or memory problems make independent living risky.
- **Possible causes:** Dementia; falls; poor mobility; no help
- **Signs and symptoms:** Unsafe cooking; wandering; unpaid bills; poor hygiene

Scenario

An older man leaves the gas on.

Subjective (S): "I can manage on my own."

Objective (O): Dementia; left the gas on; wandering; unpaid bills.

Assessment tools for this scenario: CP-OLDER Older Adult Check (p. 278)

Validated scales to consider: 4AT / CAM, Mini-Cog

CarePath diagnosis: Unsafe to live alone related to dementia, as evidenced by leaving the gas on, wandering, and unpaid bills.

Interventions and rationale

Intervention	Rationale
Assess abilities.	Assessing what he can and cannot do, such as cooking, managing money and moving safely, shows where the real dangers are.
Make the home safe.	Removing hazards like gas and fitting safety devices lowers the chance of fire, falls and injury.
Arrange services.	Home care, meals, alarms and visits support him in daily tasks and reduce the need to manage alone.
Plan for care.	Planning ahead with him and his family prepares for further decline so decisions are not made in a crisis.

Expected outcomes

- Safe living plan agreed.
- Supports in place.
- No incidents.
- Family involved.

Linking the data to the diagnosis

The patient has dementia, has left the gas on, has wandered, and has unpaid bills. These events show that unsafe living is already happening, so the statement is actual. The nurse does not assume the cause is only memory loss and also checks falls and mobility. The plan aims to assess his abilities, make the home safe, arrange services, and agree a living plan with the family and no further incidents.

A7 Difficulty adjusting to a care home

Group: Older adult | Type: Actual problem

- **Definition:** Moving to a new setting causes stress, confusion, or sadness.
- **Possible causes:** Loss of home; unfamiliar setting; change; reduced freedom
- **Signs and symptoms:** Withdrawn; sad; refuses help; confusion

Scenario

A woman cries after moving to a care home.

Subjective (S): "I want to go home."

Objective (O): New care home resident; tearful; withdrawn; refuses meals.

Assessment tools for this scenario: CP-OLDER Older Adult Check (p. 278)

Validated scales to consider: 4AT / CAM, Mini-Cog

CarePath diagnosis: Difficulty adjusting to a care home related to loss of home, as evidenced by withdrawn and sad.

Interventions and rationale

Intervention	Rationale
Orient her.	Showing her the layout, routine and staff reduces fear of the unknown and helps her feel in control of her new surroundings.
Allow personal belongings.	Familiar items such as photos and a favorite blanket give comfort and a link to her old home and identity.
Involve family.	Family visits and involvement keep her relationships strong and help her feel less alone and abandoned.
Keep routines.	Keeping routines she is used to, such as meal and wake times, gives a sense of normal life and lessens confusion.
Give emotional support.	Listening and acknowledging her sadness shows respect, lowers distress and builds trust with staff and a trusting relationship helps her accept help and settle in.

Expected outcomes

- Settles within weeks.
- Joins activities.
- Eats well.
- Says she feels more at home.

Linking the data to the diagnosis

The patient says, 'I want to go home.' She is a new resident, tearful, withdrawn and refusing meals. She is already showing distress, so this is an actual problem, not a risk, and the evidence is her withdrawn, sad behavior. It fits better than a general low mood statement because it began with the move. The plan aims for her to settle within weeks, join activities, eat well and say she feels more at home.

A8 Loss of independence

Group: Older adult | Type: Actual problem

- **Definition:** The person can no longer do tasks they once managed alone and feels reduced control.
- **Possible causes:** Illness; weakness; fear; cognitive decline
- **Signs and symptoms:** Frustration; withdrawal; refuses help; dependence

Scenario

A former driver cannot go out alone after a stroke.

Subjective (S): "I used to drive myself everywhere."

Objective (O): After stroke; cannot go out alone; frustrated; refuses help.

Assessment tools for this scenario: CP-OLDER Older Adult Check (p. 278)

Validated scales to consider: 4AT / CAM, Mini-Cog

CarePath diagnosis: Loss of independence related to illness, as evidenced by frustration and withdrawal.

Interventions and rationale

Intervention	Rationale
Respect choices.	Respecting his choices keeps his dignity and sense of control, which reduces frustration and the urge to refuse help.
Encourage independence.	Letting him do what he can safely helps rebuild skills and confidence and prevents avoidable dependence.

Intervention	Rationale
Use adaptive aids.	Aids such as walking supports, adapted tools or transport options let him do more for himself and go out more.
Set goals.	Goals that he helps set give direction and show progress, which supports motivation after a stroke.

Expected outcomes

- Uses adaptive aids.
- Takes part in decisions.
- Sets achievable independence goals.

Linking the data to the diagnosis

The patient says, 'I used to drive myself everywhere.' Since his stroke he cannot go out alone, and he is frustrated and refuses help. The loss has already happened, so this is an actual problem, and it rests on illness with frustration and withdrawal. It fits better than a mobility statement because the main issue is his loss of control and independence. The plan aims for him to use adaptive aids, take part in decisions and set achievable independence goals.

W - Wounds and skin

Recommended assessment tools

CarePath tool: **CP-SKIN Skin & Wound Score** (p. 270)

Validated scales: Braden Scale, TIME wound chart

W1 Wound not healing

Group: Wounds and skin | Type: Actual problem

- **Definition:** A wound stays open or shows little progress over the expected time.
- **Possible causes:** Poor blood flow; infection; diabetes; poor nutrition; pressure
- **Signs and symptoms:** No change in size; pale base; dead tissue; foul smell

Scenario

A leg ulcer stays open after six weeks.

Subjective (S): "This ulcer won't heal."

Objective (O): Leg ulcer for 6 weeks; 4 cm; pale base; slough; foul odor.

Assessment tools for this scenario: **CP-SKIN Skin & Wound Score** (p. 270)

Validated scales to consider: Braden Scale, TIME wound chart

CarePath diagnosis: Wound not healing related to poor blood flow, as evidenced by no change in size and pale base.

Interventions and rationale

Intervention	Rationale
Assess the wound.	Measuring size, depth, tissue type, drainage and odor shows whether the wound is improving and what is blocking healing.
Treat the cause.	Healing needs blood flow and a controlled cause, so treating poor circulation, infection or pressure addresses why it is not healing.
Dress as ordered.	The right dressing keeps the wound moist and clean, protects it and manages drainage and odor, supporting tissue repair.
Support nutrition.	Protein, calories and vitamins are needed to build new tissue, so good nutrition supports closure.
Refer to a wound specialist.	A wound specialist can offer advanced treatments and a plan for a wound that has not responded for weeks.

Expected outcomes

- Within 2-4 weeks: wound size reduced by 20-30%, no infection, care plan followed.

Linking the data to the diagnosis

The patient says, 'This ulcer won't heal.' The leg ulcer has been open for 6 weeks, measures 4 cm, has a pale base, slough and a foul odor. Healing should show progress by now, and there is none, so the problem is actual. The statement rests on poor blood flow, with no change in size and a pale base. The plan aims, within 2 to 4 weeks, for the wound to shrink by 20 to 30 percent, stay free of infection and follow the agreed care plan.

W2 Heavy wound drainage

Group: Wounds and skin | Type: Actual problem

- **Definition:** A wound leaks large amounts of fluid and needs frequent dressing care.
- **Possible causes:** Infection; large wound; swelling; fistula
- **Signs and symptoms:** Soaked dressings; odor; damaged skin around the wound

Scenario

A surgical wound soaks its dressings every few hours.

Subjective (S): "The dressing is soaked again."

Objective (O): Large wound; drainage soaks the dressing every 3 hours; surrounding skin red.

Assessment tools for this scenario: **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: Braden Scale, TIME wound chart

CarePath diagnosis: Heavy wound drainage related to infection, as evidenced by soaked dressings and odor.

Interventions and rationale

Intervention	Rationale
Use absorbent dressings.	Absorbent dressings hold large amounts of fluid away from the wound and skin, which keeps the area cleaner and reduces odor.
Protect surrounding skin.	Constant moisture softens skin and causes breakdown, so a barrier or protective product keeps the red skin around the wound from worsening.
Measure drainage.	Measuring or estimating drainage shows whether it is rising or falling, which guides dressing choice and shows whether treatment works.
Report increases.	A rise in drainage may mean infection or other complications, so telling the team quickly allows early treatment.

Expected outcomes

- Drainage reduced.
- Dressing changed on schedule.
- Skin around the wound intact.

Linking the data to the diagnosis

The patient says, 'The dressing is soaked again.' The wound is large, the dressing is soaked every 3 hours and the surrounding skin is red. The excess drainage is already occurring, so an actual statement fits, and the evidence is soaked dressings and odor. It is chosen over a general wound statement because the main task is managing fluid and protecting skin. The plan aims for drainage to reduce, dressings to be changed on schedule and the skin around the wound to stay intact.

W3 Pressure sore present

Group: Wounds and skin | Type: Actual problem

- **Definition:** Skin and tissue over a bony area has broken down from pressure.
- **Possible causes:** Prolonged pressure; moisture; friction; poor nutrition
- **Signs and symptoms:** Open sore over a bony area; pain; discharge

Scenario

A bedbound patient has an open sore on the tailbone.

Subjective (S): "My tailbone is open."

Objective (O): Open sore on the sacrum, 4 cm; bedbound; moist skin.

Assessment tools for this scenario: **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: Braden Scale, TIME wound chart

CarePath diagnosis: Pressure sore present related to prolonged pressure, as evidenced by a 4 cm open sore over the sacrum and moist skin.

Interventions and rationale

Intervention	Rationale
Relieve pressure.	Pressure is what caused the damage, so taking it off the area allows blood to reach the tissue and healing to begin.
Dress as ordered.	The ordered dressing protects the wound, keeps it moist and clean, and lowers the chance of infection.
Turn regularly.	Changing position regularly stops pressure from building over the same bony area and protects other skin.
Support nutrition.	Protein, calories, fluids and vitamins supply what the body needs to repair damaged tissue. Good intake also helps the skin resist further damage.
Monitor.	Regular checks of size, color, drainage and pain show whether the wound is healing or getting worse.

Expected outcomes

- Wound size reduces.
- No infection.
- Pressure relieved.
- Nutrition improves.

Linking the data to the diagnosis

The patient says, 'My tailbone is open.' There is an open sore on the sacrum measuring 4 cm, and he is bedbound with moist skin. Skin has already broken down, so this is an actual problem and not a risk of pressure injury. It rests on prolonged pressure and an open sore over a bony area. The plan aims for the wound to reduce in size, stay free of infection, keep pressure relieved and improve nutrition.

W4 Difficulty caring for a stoma

Group: Wounds and skin | Type: Actual problem

- **Definition:** The person or carer struggles to manage a stoma and its appliance.
- **Possible causes:** New ostomy; low confidence; skin problems; poor appliance fit
- **Signs and symptoms:** Leaks; skin irritation; fear; poor technique

Scenario

A new colostomy patient cannot change the bag.

Subjective (S): "I don't know how to change the bag."

Objective (O): New colostomy; leaks; skin irritation; afraid.

Assessment tools for this scenario: **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: Braden Scale, TIME wound chart

CarePath diagnosis: Difficulty caring for a stoma related to new ostomy, as evidenced by leaks and skin irritation.

Interventions and rationale

Intervention	Rationale
Teach and practice.	Showing the steps and letting her practice with guidance builds skill and confidence and prepares her for care at home.
Check skin.	Checking the skin around the stoma finds irritation early so it can be treated before it breaks down.
Use a skin barrier.	A skin barrier protects the skin from stool and adhesive, which reduces irritation and helps the appliance seal.
Support emotionally.	Fear and shame are common with a new stoma, and emotional support helps her accept it and take part in care.
Refer to a stoma nurse.	A stoma nurse has specialist knowledge to check fit, solve leaks and give ongoing advice.

Expected outcomes

- Within 1 week: changes the bag correctly, skin intact, says she feels confident.

Linking the data to the diagnosis

The patient says, 'I don't know how to change the bag.' She has a new colostomy, leaks, skin irritation and is afraid. The difficulty is already present and causing skin harm, so this is an actual problem. It rests on the new ostomy, with leaks and skin irritation as evidence. The plan aims, within 1 week, for her to change the bag correctly, keep the skin intact and say she feels confident.

W5 Fragile skin or skin tears

Group: Wounds and skin | Type: Risk problem

- **Definition:** Thin or dry skin tears or bruises easily.
- **Risk factors:** Aging; steroids; dehydration; poor nutrition
- **Warning signs to watch for:** Thin shiny skin; tears; bruises

Scenario

An 82-year-old on long-term steroids has thin, dry skin on her forearms and needs help dressing.

Subjective (S): "My skin is so thin."

Objective (O): Thin dry skin; purple patches on the forearms; on steroid tablets; skin intact; sleeves pulled over her arms during dressing.

Assessment tools for this scenario: CP-SKIN Skin & Wound Score (p. 270)

Validated scales to consider: Braden Scale, TIME wound chart

CarePath diagnosis: Fragile skin or skin tears related to aging, steroids and dry skin (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Handle gently.	Thin skin tears from shearing, pulling and friction, so slow, careful handling and lifting instead of dragging lowers the chance of injury.
Keep skin moist.	Moisturized skin is more flexible and less likely to split, and it helps repair the dry surface.

Intervention	Rationale
Protect limbs.	Padding or sleeves on arms and legs guard against knocks, rubbing and catching on furniture or equipment.
Avoid strong adhesives.	Strong adhesives can pull off the top layer of fragile skin, so gentler dressings or tapes avoid causing a tear.
Pad edges.	Padding hard edges on beds, chairs and rails reduces bumps that can tear or bruise thin skin.

Expected outcomes

- No new tears.
- Skin moisturized.
- Patient states protective measures.

Linking the data to the diagnosis

The patient says, 'My skin is so thin.' She is 82, takes steroid tablets, and has thin dry skin and purple patches on her forearms. The skin is intact, with no tears, so the problem has not occurred. This is why a risk statement fits, and it rests on aging, steroids and dry skin. The nurse notes that her sleeves are pulled over her arms during dressing, a clear risk of injury. The plan aims for no new tears, moisturized skin and for her to state protective measures.

W6 Skin reaction to cancer treatment

Group: Wounds and skin | Type: Actual problem

- **Definition:** Radiation or drugs cause redness, peeling, or soreness of the skin.
- **Possible causes:** Radiation; chemotherapy; sun; friction
- **Signs and symptoms:** Redness; dryness; peeling; itching; pain

Scenario

A patient has red peeling skin in the radiation area.

Subjective (S): "My skin is burning and peeling."

Objective (O): Red peeling skin in the radiation area; itching; pain 4/10.

Assessment tools for this scenario: **CP-SKIN** Skin & Wound Score (p. 270) · **CP-PAIN** Pain & Comfort Score (p. 268)

Validated scales to consider: Braden Scale, TIME wound chart, NRS 0-10, FLACC, PAINAD

CarePath diagnosis: Skin reaction to cancer treatment related to radiation, as evidenced by redness and dryness.

Interventions and rationale

Intervention	Rationale
Clean gently.	Gentle cleaning with mild products avoids rubbing and chemical irritation that can worsen already sore skin.
Apply moisturizer as ordered.	Moisturizer helps relieve dryness and itching and supports the skin barrier, and ordered products are used to avoid interfering with treatment.
Advise loose cotton clothes.	Loose cotton clothing reduces friction and trapped heat, which lessens irritation and discomfort over the treated area.
Avoid sun.	Treated skin burns easily and heals poorly, so shielding it from sun prevents further damage.

Intervention	Rationale
Report breakdown.	Broken skin can become infected or need a different treatment, so early reporting allows prompt care.

Expected outcomes

- Skin heals.
- Pain 2/10 or lower.
- Patient follows the skin care plan.

Linking the data to the diagnosis

The patient says, 'My skin is burning and peeling.' The skin in the radiation area is red and peeling, with itching and pain of 4/10. The reaction is already present, so this is an actual problem and not a risk. It rests on radiation, with redness and dryness as evidence. It is chosen over a general rash statement because the cause is cancer treatment. The plan aims for the skin to heal, pain of 2/10 or lower and for the patient to follow the skin care plan.

W7 Rash or skin infection

Group: Wounds and skin | Type: Actual problem

- **Definition:** Skin shows rash, redness, warmth, or pus from irritation or infection.
- **Possible causes:** Bacteria; fungus; allergy; poor hygiene; scratching
- **Signs and symptoms:** Redness; heat; swelling; pus; itching; fever

Scenario

A child has red crusted sores on his face.

Subjective (S): "These sores are spreading."

Objective (O): Child with crusted red sores on the face; itching; no fever.

Assessment tools for this scenario: **CP-SKIN** Skin & Wound Score (p. 270) · **CP-INFECT** Infection Check (p. 281)

Validated scales to consider: Braden Scale, TIME wound chart, qSOFA / sepsis screen

CarePath diagnosis: Rash or skin infection related to bacteria, as evidenced by crusted red sores on the face and itching.

Interventions and rationale

Intervention	Rationale
Wash hands.	Hand washing before and after care stops germs passing from the sores to other people and to other areas of the child's skin.
Clean skin.	Gentle cleaning removes crusts and bacteria, which helps medicine reach the skin and reduces spread.
Give medicine as ordered.	Ordered antibiotic cream or tablets treat the bacteria causing the infection, so they are given at the right dose and for the full course.
Prevent spread.	These sores are contagious, so separate towels and covering the sores lower the chance of passing them to others.
Teach hygiene.	Teaching the family about hygiene and not scratching helps stop spread and prevents the infection returning.

Expected outcomes

- Sores heal within 7-10 days.
- Spread prevented.

- Handwashing taught.

Linking the data to the diagnosis

The parent says, 'These sores are spreading.' The child has crusted red sores on the face with itching and no fever. The sores are present, so this is an actual problem and not a risk, and the focus is on the infection and spread. The statement rests on bacteria, though redness and heat are not recorded and the evidence is better described by crusted sores and itching. The plan aims for the sores to heal within 7 to 10 days, spread to be prevented and handwashing to be taught.

O - Surgery and intensive care

Recommended assessment tools

CarePath tool: **CP-SURG Post-op & Critical Care Check** (p. 279)

Validated scales: RASS, CPOT, Aldrete

01 Fear before surgery

Group: Surgery and intensive care | Type: Actual problem

- **Definition:** Worry about pain, anaesthesia, outcomes, or loss of control before an operation.
- **Possible causes:** Anesthesia; pain; the unknown; outcomes; loss of control
- **Signs and symptoms:** Tense; many questions; sleeplessness; sweating

Scenario

A patient is afraid he will not wake up after anesthesia.

Subjective (S): "I'm afraid I won't wake up."

Objective (O): Before surgery; heart rate 102/min; sweating; asks repeated questions.

Assessment tools for this scenario: **CP-SURG Post-op & Critical Care Check** (p. 279)

Validated scales to consider: RASS, CPOT, Aldrete

CarePath diagnosis: Fear before surgery related to anesthesia, as evidenced by tense and many questions.

Interventions and rationale

Intervention	Rationale
Explain the steps.	Knowing what will happen and when lowers fear of the unknown and gives him a sense of control.
Allow questions.	Answering his questions fully corrects wrong ideas and shows that his worries are taken seriously.
Teach breathing.	Slow, deep breathing lowers heart rate and muscle tension and helps him cope with anxiety, and it is useful after surgery too.
Reassure.	Calm, honest reassurance, including that the anesthetist monitors him throughout, eases fear without making promises that cannot be kept.
Involve family.	Familiar family members give emotional comfort and help him feel safe and supported and their presence can make the hospital setting feel less threatening.

Expected outcomes

- Anxiety 3/10 or lower before surgery.
- States understanding.
- Calm entering theater.

Linking the data to the diagnosis

The patient says, 'I'm afraid I won't wake up.' Before surgery, his heart rate is 102/min, he is sweating and asks repeated questions. Fear is already present and affecting his body, so this is an actual problem and not a risk. It rests on fear of anesthesia, with tension and many questions as evidence. It is chosen over a general anxiety statement because the fear is tied to the operation. The plan aims for anxiety of 3/10 or lower, a stated understanding of what will happen and a calm patient entering theater.

02 Breathing problems after anaesthesia **URGENT**

Group: Surgery and intensive care | Type: Actual problem

- **Definition:** Shallow breathing, low oxygen, or airway problems after an operation.
- **Possible causes:** Anesthesia drugs; pain; obesity; lung disease; sedation
- **Signs and symptoms:** Shallow breathing; low oxygen; snoring; drowsiness; blue lips

Scenario

A patient in recovery has an oxygen saturation of 88% and is hard to wake.

Subjective (S): (Drowsy, mumbling.)

Objective (O): Oxygen saturation 88%; shallow breathing; snoring; hard to wake in recovery.

Assessment tools for this scenario: **CP-SURG** Post-op & Critical Care Check (p. 279) · **CP-BREATH** Breathing & Circulation Check (p. 265) · **CP-NEURO** Brain & Senses Check (p. 280)
Validated scales to consider: RASS, CPOT, Aldrete, NEWS2, SpO₂, ECG, GCS, pupils, NIHSS

CarePath diagnosis: Breathing problems after anaesthesia related to anesthesia drugs, as evidenced by shallow breathing and low oxygen.

Interventions and rationale

Intervention	Rationale
Open the airway.	Tilting the head back and lifting the jaw lifts the tongue off the back of the throat, which clears the blockage that causes snoring and low oxygen.
Give oxygen.	Extra oxygen raises the oxygen level in the blood while the cause is corrected, protecting the brain and heart.
Stimulate.	Calling his name and gentle touch rouse him so he breathes more deeply and responds, and show how awake he is.
Position.	Positioning, such as head up or on his side as appropriate, keeps the airway open and lowers the chance of vomit being inhaled.
Monitor.	Close monitoring of oxygen level, breathing and alertness shows whether treatment is working or he is worsening.
Call for help.	Anesthesia effects can need drugs, suction or airway devices that the nurse cannot provide alone, so skilled help is needed quickly.

Expected outcomes

- Within minutes: oxygen saturation 94% or higher, airway open, patient awake and breathing normally.

Linking the data to the diagnosis

The patient is drowsy and mumbling. In recovery his oxygen saturation is 88%, with shallow breathing and snoring, and he is hard to wake. This is a life-threatening emergency, so help is called first while the airway is opened and oxygen is given. The problem has already occurred, so an actual statement fits and not a risk, and the evidence is shallow breathing and low oxygen after anesthesia drugs. The plan aims, within minutes, for oxygen saturation of 94% or higher, an open airway and a patient who is awake and breathing normally.

03 Risk of internal bleeding after surgery **URGENT**

Group: Surgery and intensive care | Type: Risk problem

- **Definition:** Hidden bleeding may occur and show as low blood pressure, fast pulse, or pain.
- **Risk factors:** Slipped clamp; clotting problems; injured large vessel

- **Warning signs to watch for:** Falling blood pressure; fast pulse; pale skin; swollen belly

Scenario

A patient is six hours after major abdominal surgery and has a mildly raised clotting time.

Subjective (S): "I am sore but alright."

Objective (O): Six hours after abdominal surgery; pulse 84/min; blood pressure 118/72; abdomen soft; INR 1.6; on blood-thinning injections.

Assessment tools for this scenario: **CP-SURG** Post-op & Critical Care Check (p. 279) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-BREATH** Breathing & Circulation Check (p. 265)

Validated scales to consider: RASS, CPOT, Aldrete, Braden Scale, TIME wound chart, NEWS2, SpO₂, ECG

CarePath diagnosis: Risk of internal bleeding after surgery related to major surgery and clotting problems (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Check vital signs, abdomen and dressings at ordered times.	Changes in pulse, blood pressure, abdomen and dressings are the earliest signs of hidden blood loss, so checking them regularly allows early detection.
Report a rising pulse, falling blood pressure, pallor, abdominal swelling or new pain at once.	Fast reporting matters because internal bleeding can worsen quickly and delay can lead to shock.
Call the surgeon if bleeding is suspected.	The surgeon can examine, order tests and decide on treatment, so being called early lets bleeding be controlled sooner.
If bleeding is confirmed, give intravenous fluids and prepare for return to theater as ordered.	Fluids support blood pressure while the cause is found, and preparing for theater means a bleed that needs repair is not delayed.

Expected outcomes

- Pulse and blood pressure stay in the doctor's range.
- Abdomen stays soft.
- Any sign of bleeding is reported within minutes.

Linking the data to the diagnosis

The patient says, 'I am sore but alright.' Six hours after abdominal surgery his pulse is 84/min, blood pressure 118/72 and abdomen soft, so no bleeding has been found. He has an INR of 1.6 and takes blood-thinning injections, and these are the risk factors. This is why a risk statement fits, and it is not an actual hemorrhage statement. If signs appear, help is called first, as this is urgent. The plan aims for pulse and blood pressure to stay in range, a soft abdomen and any sign of bleeding reported within minutes.

O4 Drain, tube, or line problems

Group: Surgery and intensive care | Type: Risk problem

- **Definition:** Tubes and lines may block, slip out, kink, or be pulled.
- **Risk factors:** Patient movement; poor securing; blockage; kinks
- **Warning signs to watch for:** Pulled-out tube; no drainage; leaking; pain

Scenario

A restless patient with a chest drain and IV lines is about to be turned.

Subjective (S): "I will be careful."

Objective (O): Chest drain and IV line in place; restless; drain tubing not secured; no kinks seen yet; dressing dry.

Assessment tools for this scenario: CP-SURG Post-op & Critical Care Check (p. 279)

Validated scales to consider: RASS, CPOT, Aldrete

CarePath diagnosis: Drain, tube, or line problems related to patient movement and poor securing (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Secure tubes.	Secure tubes cannot be dragged, pulled out or kinked during turning or restless movement, which protects the drain and lines.
Check they are open.	A drain that is open and draining properly removes air or fluid, and a blocked tube can harm his breathing.
Teach the patient not to pull.	When he understands why the tubes matter, he is less likely to pull on them, especially when restless.
Keep drainage below the site.	Keeping the drainage system below the site lets fluid and air flow out and stops fluid running back into the chest.
Report problems.	Early reporting of kinks, leaks, blockages or displacement allows quick correction before harm occurs so a blocked or displaced drain does not harm the patient.

Expected outcomes

- Drain and lines stay secured with no accidental removal.
- No infection or leakage.
- Patient states not to pull on it.

Linking the data to the diagnosis

The patient says, 'I will be careful.' He has a chest drain and an IV line, is restless, and the drain tubing is not secured. No kinks are seen yet and the dressing is dry, so no problem has occurred. This is why a risk statement fits, and it rests on patient movement and poor securing. It is chosen over a tube discomfort statement because no harm or distress is documented. The plan aims for the drain to be secure, no infection or leakage, and for the patient to state he will not pull on it.

05 Infection from lines

Group: Surgery and intensive care | Type: Risk problem

- **Definition:** Intravenous lines and other devices can carry germs into the body.
- **Risk factors:** Long dwell time; poor hygiene; contaminated hubs; weak immunity
- **Warning signs to watch for:** Redness; pus at the site; fever; chills

Scenario

A patient has had a central line for nine days, and hub care has been inconsistent.

Subjective (S): "My line site is fine."

Objective (O): Central line day 9; site clean and dry; temperature 36.9 C; hub handled without gloves twice; low white cell count.

Assessment tools for this scenario: CP-SURG Post-op & Critical Care Check (p. 279)

Validated scales to consider: RASS, CPOT, Aldrete

CarePath diagnosis: Infection from lines related to long dwell time and poor hygiene (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Use aseptic technique.	Sterile technique and clean hands keep germs from entering the bloodstream through the line. Strict hygiene every time the line is handled is the most important protection.
Clean hubs.	Cleaning hubs before each use removes germs that can be pushed into the line. Gloves and a thorough scrub of the hub before each access stop contaminated hubs causing bloodstream infection.
Check the site.	Regular site checks find redness, swelling, pus or pain early, before infection spreads. This matters more because his low white cell count weakens defenses.
Remove unneeded lines.	The longer a line stays in, the higher the infection risk, so removing lines that are not needed removes the pathway for germs.
Report infection.	Reporting fever, chills or site changes quickly allows early cultures and treatment, which is important with a low white cell count.

Expected outcomes

- No fever, redness, or pus at the line site.
- Hub cleaned with the correct technique every time.
- Any early sign of infection reported at once.
- Line removed as soon as it is no longer needed.

Linking the data to the diagnosis

The patient says, 'My line site is fine.' The central line is on day 9, the site is clean and dry, temperature is 36.9 C, but the hub was handled without gloves twice and the white cell count is low. There is no infection, so a risk statement fits, not an actual infection. It rests on long dwell time and poor hygiene, with weak defenses adding to the danger. The plan aims to prevent infection, and if signs appear, to recognize them early, take cultures, start treatment and remove the line if needed.

O6 Slow gut recovery after surgery

Group: Surgery and intensive care | Type: Actual problem

- **Definition:** Bowel movement is slow to return, causing bloating, nausea, or constipation.
- **Possible causes:** Anesthesia; pain medicines; bowel handling; immobility
- **Signs and symptoms:** Bloating; vomiting; no gas; absent bowel sounds

Scenario

A patient on day 2 after bowel surgery has not passed gas.

Subjective (S): "I'm bloated and haven't passed gas."

Objective (O): Day 2 after bowel surgery; abdomen distended; vomited once; absent bowel sounds.

Assessment tools for this scenario: **CP-SURG** Post-op & Critical Care Check (p. 279) · **CP-ELIM**

Elimination Check (p. 267) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: RASS, CPOT, Aldrete, Bristol Stool Chart, bladder scan, MUST, fluid chart, glucose

CarePath diagnosis: Slow gut recovery after surgery related to anesthesia, as evidenced by bloating and vomiting.

Interventions and rationale

Intervention	Rationale
Encourage walking.	Walking stimulates the bowel to start moving again, and it also lowers the risk of clots and chest problems.
Limit opioids.	Opioids slow the bowel, so using the lowest effective dose, with other pain relief as ordered, helps movement return.
Give intravenous fluids as ordered, and keep nothing by mouth if instructed.	Vomiting and a distended gut mean oral fluids may be vomited or inhaled, so the doctor decides the route.
Listen to bowel sounds.	Bowel sounds and the abdomen show whether movement is returning or a blockage is developing.
Report vomiting.	Vomiting with a distended abdomen may mean obstruction or a leak, so the surgical team needs to know promptly.

Expected outcomes

- By day 3-4: passes gas and stool, vomiting stops, tolerates diet, walks daily.

Linking the data to the diagnosis

The patient says, 'I'm bloated and haven't passed gas.' On day 2 after bowel surgery his abdomen is distended, he has vomited once and bowel sounds are absent. The slow recovery is already present, so this is an actual problem and not a risk. It rests on anesthesia, with bloating and vomiting as evidence. It fits better than a constipation statement because it follows surgery and includes vomiting. The plan aims, by day 3 to 4, for gas and stool to pass, vomiting to stop, diet to be tolerated and daily walking.

07 Needs of sedated or unconscious patient

Group: Surgery and intensive care | Type: Risk problem

- **Definition:** The person cannot protect their own airway, skin, eyes, or position.
- **Risk factors:** Sedatives; coma; paralysis; ventilator
- **Warning signs to watch for:** Cannot move; no cough; eyes unprotected; skin at risk

Scenario

An ICU patient on a ventilator and sedation cannot turn or protect his airway.

Subjective (S): (Sedated; cannot speak.)

Objective (O): Ventilated and sedated; no cough or gag reflex; eyes partly open; skin intact; cannot turn himself.

Assessment tools for this scenario: **CP-SURG** Post-op & Critical Care Check (p. 279) · **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: RASS, CPOT, Aldrete, Braden Scale, TIME wound chart

CarePath diagnosis: Needs of sedated or unconscious patient related to sedatives and loss of protective reflexes (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Turn regularly.	Changing position regularly relieves pressure on the skin, helps the lungs expand and prevents joint stiffness.
Give eye and mouth care.	Without blinking or normal saliva, eyes and mouth dry out and become infected, so regular cleaning and lubrication protects them.
Suction.	Without a cough or gag, secretions collect in the airway, so suction clears them and helps prevent chest infection.
Monitor.	Continuous monitoring finds changes in breathing, heart rate, sedation level or ventilator function early so problems are treated before they become dangerous.
Protect skin.	Keeping skin clean, dry and free from pressure lowers the chance of breakdown in a patient who cannot move himself.
Keep communicating.	Hearing may still be present, so speaking to him explains care, supports dignity and may reduce distress.

Expected outcomes

- Airway protected.
- Skin intact.
- Eyes protected.
- Repositioned every 2 hours.
- No complications.

Linking the data to the diagnosis

The patient is sedated and cannot speak. He is on a ventilator with no cough or gag reflex, his eyes are partly open, his skin is intact and he cannot turn himself. He has not yet come to harm, so a risk statement fits, and it rests on sedatives and loss of protective reflexes. The nurse acts for him because he cannot protect his airway, eyes and skin. The plan aims for a protected airway, intact skin, protected eyes, repositioning every 2 hours and no complications.

08 Discomfort from tubes

Group: Surgery and intensive care | Type: Actual problem

- **Definition:** Tubes and devices cause soreness, irritation, or restlessness.
- **Possible causes:** Tubes; ventilator; catheters; dressings; noise
- **Signs and symptoms:** Restlessness; pulling at tubes; grimacing; sleeplessness

Scenario

A ventilated patient bites the tube and grimaces.

Subjective (S): (Tries to speak.) Grimaces.

Objective (O): Bites the ventilator tube; restless; pulls at lines; heart rate 118/min.

Assessment tools for this scenario: **CP-SURG** Post-op & Critical Care Check (p. 279) · **CP-PAIN** Pain & Comfort Score (p. 268)

Validated scales to consider: RASS, CPOT, Aldrete, NRS 0-10, FLACC, PAINAD

CarePath diagnosis: Discomfort from tubes related to tubes, as evidenced by restlessness and pulling at tubes.

Interventions and rationale

Intervention	Rationale
Give comfort.	Comfort measures such as mouth care, repositioning and pain relief reduce the irritation that makes him restless.
Secure the tube.	A secure tube is less likely to move, rub or be pulled out, which protects his airway and reduces discomfort.
Give sedation as ordered.	Ordered sedation or pain relief eases distress and prevents him from harming himself or removing the tube.
Talk reassuringly.	A calm voice and explanation lower fear and agitation, even when he cannot answer. Hearing a familiar, steady voice helps him feel safe.
Check the tube position.	Checking the tube position confirms it is correctly placed and not causing pain, leaks or poor ventilation.

Expected outcomes

- Settles with comfort.
- Tube secure.
- No self-removal.
- Sedation adjusted by plan.

Linking the data to the diagnosis

The patient tries to speak and grimaces. He is ventilated, bites the tube, is restless, pulls at lines and has a heart rate of 118/min. The distress is already present, so this is an actual problem, and it rests on the tubes, with restlessness and pulling as evidence. It is chosen over a risk of line problems because discomfort is happening now. The plan aims for him to settle with comfort measures, the tube to stay secure, no self-removal and sedation adjusted by plan.

09 Sleep loss in ICU

Group: Surgery and intensive care | Type: Actual problem

- **Definition:** Noise, light, and care routines prevent restful sleep.
- **Possible causes:** Alarms; lights; noise; pain; routines
- **Signs and symptoms:** Poor sleep; confusion; irritability

Scenario

An ICU patient sleeps only 2 hours at night.

Subjective (S): "I never get to sleep in here."

Objective (O): Sleeps 2 hours; confused at night; noise and lights constant.

Assessment tools for this scenario: CP-SURG Post-op & Critical Care Check (p. 279) · CP-OLDER Older Adult Check (p. 278)

Validated scales to consider: RASS, CPOT, Aldrete, 4AT / CAM, Mini-Cog

CarePath diagnosis: Sleep loss in ICU related to alarms, as evidenced by poor sleep and confusion.

Interventions and rationale

Intervention	Rationale
Group care.	Doing several tasks at one visit leaves longer uninterrupted periods in which he can sleep.
Dim lights.	Dim lights at night help the body clock tell night from day, which supports sleep and reduces night-time confusion.
Reduce noise.	Noise and alarms wake patients repeatedly, so lowering sound levels and responding quickly to alarms protects sleep.
Offer earplugs.	Earplugs block some noise and help him fall asleep, if he agrees and it is safe to use them.
Keep a routine.	A regular night routine signals bedtime and supports a natural sleep pattern. Keeping the same pattern each night also helps him feel settled.

Expected outcomes

- Sleeps 4-6 hours with grouped care.
- Orientation improves.
- Less agitated.

Linking the data to the diagnosis

The patient says, 'I never get to sleep in here.' He sleeps only 2 hours, is confused at night, and noise and lights are constant. The sleep loss has already happened, so this is an actual problem and not a risk. It rests on alarms, with poor sleep and confusion as evidence. It is chosen over a general confusion statement because the main driver is the environment. The plan aims for 4 to 6 hours of sleep with grouped care, improved orientation and less agitation.

O10 Family distress in ICU

Group: Surgery and intensive care | Type: Actual problem

- **Definition:** Relatives feel fear, shock, or helplessness while the patient is critically ill.
- **Possible causes:** Fear; uncertainty; unfamiliar environment; lack of information
- **Signs and symptoms:** Anxiety; crying; sleeplessness; constant questions

Scenario

A wife stays beside her husband in ICU, shaking.

Subjective (S): "Is he going to die?"

Objective (O): Wife shaking; no sleep for 2 days; asks questions repeatedly.

Assessment tools for this scenario: CP-SURG Post-op & Critical Care Check (p. 279)

Validated scales to consider: RASS, CPOT, Aldrete

CarePath diagnosis: Family distress in ICU related to fear, as evidenced by anxiety and crying.

Interventions and rationale

Intervention	Rationale
Give updates.	Regular honest updates reduce fear of the unknown and help relatives feel included and trusted.
Explain equipment.	Explaining monitors, alarms and tubes makes the environment less frightening and helps her understand what she sees.
Allow visits.	Being near the patient comforts both of them, so visits are allowed within safe unit rules.
Offer support.	Showing care, listening and encouraging rest and food help her cope with stress and exhaustion.
Refer to a counselor.	A counselor can give ongoing emotional help beyond what the bedside nurse can offer. This is useful when her distress continues beyond what ordinary updates can ease.

Expected outcomes

- Receives regular updates.
- Understands the equipment.
- Rests.
- Feels supported.

Linking the data to the diagnosis

The wife asks, 'Is he going to die?' She is shaking, has had no sleep for 2 days and asks questions repeatedly. Her distress is already present, so this is an actual problem. It concerns the family, not the patient, and it rests on fear, with anxiety and crying as evidence. The plan aims for regular updates, an understanding of the equipment, rest and a feeling of being supported, so her fear lessens and she can cope.

Z - Brain and senses

Recommended assessment tools

CarePath tool: **CP-NEURO Brain & Senses Check** (p. 280)

Validated scales: GCS, pupils, NIHSS

Z1 Difficulty understanding speech

Group: Brain and senses | Type: Actual problem

- **Definition:** The person hears but struggles to make sense of spoken language.
- **Possible causes:** Stroke; brain injury; dementia; hearing problems
- **Signs and symptoms:** Cannot follow commands; wrong answers; confusion

Scenario

After a stroke, a patient cannot understand simple instructions.

Subjective (S): "I... what?"

Objective (O): Cannot follow commands; wrong answers; hears well; after stroke.

Assessment tools for this scenario: **CP-NEURO Brain & Senses Check** (p. 280)

Validated scales to consider: GCS, pupils, NIHSS

CarePath diagnosis: Difficulty understanding speech related to stroke, as evidenced by cannot follow commands and wrong answers.

Interventions and rationale

Intervention	Rationale
Use short sentences.	Short, simple sentences are easier to process when understanding is impaired, so he is more likely to follow what is said.
Use gestures and pictures.	Gestures and pictures give meaning through another route, supporting words he cannot understand. Pointing, objects and pictures help him show what he needs too.
Repeat.	Repeating the same words gives more time to process and builds familiarity, rather than changing the message each time.
Refer to speech therapy.	A speech therapist can assess the type of difficulty and offer exercises and strategies that improve communication.
Be patient.	Patience keeps him calm and encouraged, whereas rushing or frustration makes understanding harder. A relaxed, unhurried approach gives him time to respond.

Expected outcomes

- Within days: follows one-step commands, uses gestures, speech therapy started.

Linking the data to the diagnosis

The patient says, 'I... what?' After a stroke he cannot follow commands, gives wrong answers, and hears well. Because hearing is normal, the problem is with understanding, not hearing loss, so this statement fits better than a hearing statement. The difficulty is present now, so it is actual and not a risk, and it rests on the stroke. The plan aims, within days, for him to follow one-step commands, use gestures and have speech therapy started.

Z2 Ignoring one side of the body

Group: Brain and senses | Type: Actual problem

- **Definition:** After brain injury the person may not notice one side of the body or space.
- **Possible causes:** Stroke in one side of the brain
- **Signs and symptoms:** Ignores one side; bumps into things; eats from one side of the plate; neglects a limb

Scenario

A stroke patient eats only the right half of his plate.

Subjective (S): "I finished eating."

Objective (O): Eats only the right half of the plate; ignores the left side; neglects the left arm.

Assessment tools for this scenario: CP-NEURO Brain & Senses Check (p. 280)

Validated scales to consider: GCS, pupils, NIHSS

CarePath diagnosis: Ignoring one side of the body related to stroke affecting one side of the brain, as evidenced by eating only the right half of the plate and ignoring the left arm.

Interventions and rationale

Intervention	Rationale
Approach from the affected side.	Approaching from the affected side draws attention toward the neglected side and helps him notice people and objects there.
Cue him to scan.	Cueing him to look across the whole space trains the habit of scanning toward the neglected side.
Arrange items.	Placing food and items where he can see them, and moving them gradually toward the left, helps him use what he is not noticing.
Teach awareness.	Helping him learn about the problem makes him more likely to protect the neglected side and use strategies.
Refer to therapy.	A therapist can provide specialist retraining to improve attention to the neglected side. This gives structured practice in a safe setting.

Expected outcomes

- Scans the left side.
- Eats the whole meal with a cue.
- No injuries on the left side.
- Therapy started.

Linking the data to the diagnosis

The patient says, 'I finished eating.' After a stroke he eats only the right half of the plate, ignores the left side and neglects the left arm. He is not aware of what he is missing, so this is an actual problem and not a risk, and it differs from simple weakness because he does not notice the left side. It rests on a stroke on one side of the brain. The plan aims for him to scan the left side, eat the whole meal with a cue, avoid left-sided injuries and have therapy started.

Z3 Risk of seizures **URGENT**

Group: Brain and senses | Type: Risk problem

- **Definition:** Sudden bursts of abnormal brain activity that may cause injury.
- **Risk factors:** Epilepsy; head injury; fever in children; missed medicine
- **Warning signs to watch for:** Sudden jerking; loss of awareness; confusion afterwards

Scenario

A patient with epilepsy has vomited for two days and has missed her anti-seizure medicine.

Subjective (S): "I cannot keep my tablets down."

Objective (O): Epilepsy; two doses missed because of vomiting; last seizure 6 months ago; no seizure now; sleep deprived.

Assessment tools for this scenario: **CP-NEURO** Brain & Senses Check (p. 280) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: GCS, pupils, NIHSS, MUST, fluid chart, glucose

CarePath diagnosis: Risk of seizures related to epilepsy and missed medicine (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Give anti-seizure medicine on time, and tell the doctor at once if vomiting stops tablets staying down.	Missed doses are a common trigger for seizures; vomiting can stop tablets from being absorbed, so another route may be needed.
Keep the bed low, padded, and the area clear.	A low padded bed and clear space reduce injury if a seizure does happen.
Teach seizure precautions to the patient and family.	Knowing the warning signs and first aid helps them act early and stay safe.
During a seizure: protect the head, time it, put nothing in the mouth, and turn to the side afterward.	Protecting the head and turning to the side prevent injury and keep the airway clear; objects in the mouth can injure the teeth and block breathing.
Support regular sleep and avoid known triggers.	Sleep loss lowers the seizure threshold, so regular sleep helps prevent seizures.

Expected outcomes

- No seizure during the stay.
- No missed doses, or any missed dose reported at once.
- Patient and family state seizure precautions.
- If a seizure occurs: no injury, airway kept clear, and doctor informed.

Linking the data to the diagnosis

This is a risk diagnosis, because no seizure is happening now. The patient has epilepsy, has vomited for two days, and says, "I cannot keep my tablets down," so two doses were missed. She is also sleep deprived. Her last seizure was 6 months ago, so an actual seizure diagnosis would not fit; the risk factors carry the statement. Because a seizure could start without warning, help is called first and the prescriber is told about the missed doses. The plan aims for no injury, safe recovery if a seizure does occur, a review of her medicines, and the patient stating her seizure precautions.

Z4 Adjusting to vision loss

Group: Brain and senses | Type: Actual problem

- **Definition:** The person struggles with safety, independence, or feelings after losing sight.
- **Possible causes:** Eye disease; injury; diabetes; aging
- **Signs and symptoms:** Bumping into things; missing steps; anxiety; withdrawal

Scenario

A man who is newly blind cannot move safely at home.

Subjective (S): "I can't see anything now."

Objective (O): Newly blind; bumps into things; anxious; withdrawn.

Assessment tools for this scenario: **CP-NEURO** Brain & Senses Check (p. 280) · **CP-MIND** Mood & Mind Screen (p. 272)

Validated scales to consider: GCS, pupils, NIHSS, PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Adjusting to vision loss related to eye disease, as evidenced by bumping into things and missing steps.

Interventions and rationale

Intervention	Rationale
Orient him to the space.	A newly blind person has lost the mental map of the room. Walking through the layout with him builds a new map, so he can find furniture and exits and bump into things less.
Label items.	Labels in large print, raised letters or texture let him identify belongings by touch or with help, which supports independence and cuts down on mistakes and frustration.
Teach safe mobility.	Learning cane use and sighted-guide technique lets him detect obstacles and steps before he hits them, which lowers the risk of falls and rebuilds confidence in moving around.
Offer counseling.	Sudden sight loss often brings fear, grief and withdrawal. Counseling gives him a safe place to talk about these feelings and learn coping skills, which supports adjustment.
Refer to rehabilitation.	Rehabilitation services offer trained mobility, daily living and technology teaching that a ward cannot provide, helping him regain long-term independence and connect with others in the same situation.

Expected outcomes

- Within 1 week: moves safely in the room, uses a cane, states coping steps, joins rehabilitation.

Linking the data to the diagnosis

This is an actual problem because the difficulty is already present. The man is newly blind, says, "I can't see anything now," bumps into things, is anxious and is withdrawn. These are the signs of struggling to adjust, and they fit better than a risk of injury statement because he is already moving unsafely. The diagnosis covers both safety and feelings, so the plan works on both. The nurse orients him to the room, teaches safe movement and offers counseling. The aim is that within 1 week he moves safely in the room, uses a cane, states coping steps and joins rehabilitation.

Z5 Adjusting to hearing loss

Group: Brain and senses | Type: Actual problem

- **Definition:** The person struggles with communication, safety, or feelings after losing hearing.
- **Possible causes:** Aging; infection; noise; injury
- **Signs and symptoms:** Asks people to repeat; withdrawn; misses safety cues

Scenario

An older woman answers conversation questions wrongly.

Subjective (S): "What did you say?"

Objective (O): Asks people to repeat; withdrawn; hearing test shows loss; misses alarms.

Assessment tools for this scenario: **CP-NEURO Brain & Senses Check** (p. 280)

Validated scales to consider: GCS, pupils, NIHSS

CarePath diagnosis: Adjusting to hearing loss related to aging, as evidenced by asks people to repeat and withdrawn.

Interventions and rationale

Intervention	Rationale
Face the patient.	Facing the patient lets her see lip movements and facial expressions, which give extra clues to the words and help her follow the conversation.
Reduce noise.	Background noise from televisions, machines and other voices makes it harder to pick speech out of sound. Lowering it helps her hear and answer correctly.
Speak clearly.	Speaking slowly and clearly at a normal volume, without shouting, keeps words distinct. Shouting distorts speech and can feel demeaning, while clear speech is easier to understand.
Check hearing aids.	A hearing aid that is dirty, flat or fitted badly gives poor sound. Checking it makes sure she gets the full benefit of the device she already has.
Refer.	A hearing specialist can assess the loss, adjust or supply aids and teach communication skills, giving her longer-term help than ward care can give.

Expected outcomes

- Uses hearing aid effectively.
- Communicates clearly.
- Safe.
- Says she feels less isolated.

Linking the data to the diagnosis

This is an actual problem because hearing loss is already affecting her daily life. The older woman says, "What did you say?", asks people to repeat, withdraws, misses alarms and answers questions wrongly. The hearing test confirms loss, and missing alarms adds a safety concern. The statement is about adjusting to the loss, not only the loss itself, because communication and mood are affected. The nurse improves how people speak to her, checks her aids and refers her. The aim is that she uses her hearing aid well, communicates clearly, stays safe and says she feels less isolated.

Z6 Risk of injury from numbness

Group: Brain and senses | Type: Risk problem

- **Definition:** Loss of feeling raises the chance of unnoticed injury.
- **Risk factors:** Diabetes; nerve damage; spinal injury; pressure
- **Warning signs to watch for:** Cannot feel touch or pain; injuries unnoticed; tingling

Scenario

A diabetic with reduced feeling in both feet walks barefoot at home.

Subjective (S): "I cannot feel my feet very well."

Objective (O): Reduced feeling to light touch in both feet; diabetic; walks barefoot; skin intact; no injuries seen.

Assessment tools for this scenario: CP-NEURO Brain & Senses Check (p. 280) · CP-SKIN Skin & Wound Score (p. 270)

Validated scales to consider: GCS, pupils, NIHSS, Braden Scale, TIME wound chart

CarePath diagnosis: Risk of injury from numbness related to diabetes and nerve damage (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Check both feet daily for cuts, blisters and color change.	With reduced feeling she will not notice small injuries. Daily checks of both feet find cuts, blisters and color change early, before they become infected ulcers.
Protect from heat and cold; test bath water with the elbow.	Numb skin cannot sense dangerous temperatures, so burns and frostbite can happen without pain. The elbow is more sensitive and gives a better warning than the feet.
Teach to wear shoes and socks at all times and check shoes before wearing.	Shoes and socks protect numb feet from sharp objects, hot ground and friction. Checking inside shoes finds stones or rough seams she could not feel.
Refer to a foot specialist (podiatry).	A podiatrist can assess nerve and circulation changes, trim nails and calluses safely, and advise on footwear, which lowers the chance of a hidden foot problem.
Report any new sore, blister or color change the same day.	In diabetes, small foot wounds can worsen quickly because of poor healing and infection risk. Same-day reporting allows early treatment and helps prevent ulcers and serious complications.

Expected outcomes

- No new foot injury during the follow-up period.
- Patient states and demonstrates a daily foot-check routine.
- Patient wears shoes and socks outdoors and indoors.

Linking the data to the diagnosis

This is a risk diagnosis because no injury has happened yet. The patient is diabetic, says, "I cannot feel my feet very well," and has reduced feeling to light touch in both feet. She also walks barefoot at home. Her skin is intact and no injuries were seen, so an actual injury statement would be wrong; the risk factors are the numbness and the barefoot habit. Protecting the feet matters because she cannot feel damage as it happens. The plan aims for no new foot injury, a daily foot check she can state and demonstrate, and shoes and socks worn both outdoors and indoors.

27 Raised pressure in the brain URGENT

Group: Brain and senses | Type: Actual problem

- **Definition:** Increasing pressure inside the skull may cause headache, vomiting, confusion, or drowsiness.
- **Possible causes:** Head injury; tumor; bleeding; swelling; infection
- **Signs and symptoms:** Headache; vomiting; drowsiness; confusion; slow pulse; unequal pupils

Scenario

A head-injured patient becomes drowsy and vomits.

Subjective (S): "My head is pounding."

Objective (O): After head injury; vomiting; drowsy; slow pulse; unequal pupils.

Assessment tools for this scenario: **CP-NEURO** Brain & Senses Check (p. 280) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: GCS, pupils, NIHSS, MUST, fluid chart, glucose

CarePath diagnosis: Raised pressure in the brain related to head injury, as evidenced by headache and vomiting.

Interventions and rationale

Intervention	Rationale
Call for help urgently.	Early help brings a team able to confirm the problem and start treatment. Raised pressure in the brain can worsen fast and cause permanent damage or death.
Raise the head to 30 degrees and keep the neck straight.	A 30 degree head-up position with the neck straight helps blood drain from the head through the neck veins, which can lower pressure inside the skull.
Do neurological checks (alertness, pupils, limb movement) as ordered.	Changes in alertness, pupils and limb movement show whether pressure is rising. Regular checks let the team notice decline early and act quickly.
Avoid straining and keep the airway clear.	Straining and coughing raise pressure inside the skull, and a blocked airway raises carbon dioxide, which widens brain blood vessels. Both can worsen pressure.
Prepare for urgent scan or treatment.	Scans can find the cause, such as bleeding, and treatment may be needed quickly. Being ready saves time when the brain is at risk.

Expected outcomes

- Help arrives within minutes.
- Neurological status checked as ordered.
- Treatment started promptly as ordered.

Linking the data to the diagnosis

This is an actual and urgent problem, so help is called first. After a head injury the patient is drowsy, vomiting, and says, "My head is pounding." The nurse also finds a slow pulse and unequal pupils. These together point to rising pressure in the skull, not just a headache or a stomach upset. The nurse calls for help, positions the head and neck, and watches neurological signs while preparing for urgent scan or treatment. The aim is that help arrives within minutes, neurological status is checked as ordered, and treatment is started promptly as ordered.

H - Infection and community health

Recommended assessment tools

CarePath tool: **CP-INFECT Infection Check** (p. 281)

Validated scales: qSOFA / sepsis screen

H1 Exposed to an infectious disease

Group: Infection and community health | Type: Risk problem

- **Definition:** The person has had contact with someone who has a contagious illness.
- **Risk factors:** Close contact; shared room; travel; crowds
- **Warning signs to watch for:** Fever; cough; rash; known contact history

Scenario

A nurse treats a patient later found to have tuberculosis.

Subjective (S): "I was near him when he coughed."

Objective (O): Contact with a tuberculosis case; no symptoms yet; staff exposed.

Assessment tools for this scenario: **CP-INFECT Infection Check** (p. 281)

Validated scales to consider: qSOFA / sepsis screen

CarePath diagnosis: Exposed to an infectious disease related to close contact and shared room (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Do hand hygiene.	Hands carry germs between people and surfaces. Cleaning hands before and after contact reduces the chance of spreading infection to others or to yourself.
Wear masks.	A suitable mask, such as a fitted respirator for tuberculosis, filters the tiny airborne droplets that carry the bacteria and protects the person wearing it.
Isolate the source patient.	Placing the infectious patient in isolation prevents the germs reaching other people while exposed staff are monitored and tested.
Trace contacts.	Finding everyone who shared air with the case lets them be assessed and tested, so any early infection is caught and treated and further spread is stopped.
Test.	Testing shows whether the exposed person has been infected, even before symptoms start, so treatment can begin early and others are protected.
Follow protocol.	Following the local protocol makes sure that exposure is managed in a consistent, evidence-based way, with the right tests, reporting and follow-up.

Expected outcomes

- Contact assessed.
- Tests done.
- No infection develops.
- Precautions followed.

Linking the data to the diagnosis

This is a risk diagnosis because the nurse has been exposed but is not ill. She treated a patient later found to have tuberculosis, and the statement says, "I was near him when he coughed." She has no

symptoms yet, so an actual infection diagnosis would be wrong; the risk rests on close contact and exposed staff. The plan stops spread and finds infection early through precautions, contact tracing and testing. The aim is that the contact is assessed, tests are done, precautions are followed and no infection develops.

H2 Distress from isolation

Group: Infection and community health | Type: Actual problem

- **Definition:** Isolation for infection control leaves the person lonely or anxious.
- **Possible causes:** Isolation room; lack of visitors; fear; boredom
- **Signs and symptoms:** Loneliness; tearfulness; restlessness; low mood

Scenario

A patient in isolation feels abandoned.

Subjective (S): "I feel so alone in this room."

Objective (O): Isolation room; no visitors; tearful; restless.

Assessment tools for this scenario: CP-INFECT Infection Check (p. 281)

Validated scales to consider: qSOFA / sepsis screen

CarePath diagnosis: Distress from isolation related to isolation room, as evidenced by loneliness and tearfulness.

Interventions and rationale

Intervention	Rationale
Explain the reasons.	Understanding why isolation is needed helps him accept it as protection, not punishment, and lowers fear and feelings of abandonment.
Allow calls.	Phone or video calls keep him in touch with family and friends, which lessens loneliness while keeping the infection-control barrier in place.
Keep routines.	Familiar daily routines give a sense of normality and control, which supports mood and helps against restlessness and low mood.
Provide activities.	Books, music, television or other activities occupy the mind and reduce boredom, which is a major source of distress during isolation.
Visit regularly.	Regular, planned visits show that he has not been forgotten, give a chance to talk and let the nurse notice early signs of worsening mood.

Expected outcomes

- Within 2 days: says he feels less lonely.
- Has contact by phone.
- Routine kept.
- Activities provided.

Linking the data to the diagnosis

This is an actual problem because distress is already present. The patient is in an isolation room with no visitors, is tearful and restless, and says, "I feel so alone in this room." The cause is the isolation itself, which fits this statement better than a general mood problem. The nurse cannot remove the isolation, so the plan lessens its emotional cost through explanation, calls, routines, activities and regular visits. The aim is that within 2 days he says he feels less lonely, has phone contact, keeps his routine and has activities provided.

H3 Outbreak risk in community

Group: Infection and community health | Type: Risk problem

- **Definition:** Conditions in the community raise the chance of a disease spreading.
- **Risk factors:** Poor sanitation; lack of vaccines; crowding; travel
- **Warning signs to watch for:** Cluster of cases; rapid spread; alerts

Scenario

A school has low measles vaccine coverage and a case of measles has been reported in the neighboring town.

Subjective (S): Teacher: "Many parents have not vaccinated their children."

Objective (O): Vaccine coverage 60%; measles reported in the neighboring town; crowded classrooms; no cases at the school yet.

Assessment tools for this scenario: **CP-INFECT Infection Check** (p. 281)

Validated scales to consider: qSOFA / sepsis screen

CarePath diagnosis: Outbreak risk in community related to low vaccine coverage and crowding (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Report.	Early reporting lets health authorities check the risk, offer support and organize a response before measles spreads in the school.
Isolate.	Measles spreads easily through the air, so separating anyone with symptoms quickly limits how many others are exposed.
Trace contacts.	Finding children and staff who were in contact shows who may be infected or unprotected, so they can be watched, advised or vaccinated in time.
Vaccinate.	Vaccination builds immunity so that fewer children can catch and pass on measles. Raising coverage from 60% protects both individuals and the group.
Educate.	Clear information about measles and vaccine safety answers parents' concerns, which helps them accept vaccination and recognize early signs.
Follow health authority advice.	Health authorities have current local rules, supplies and outbreak plans, so following their advice makes the response consistent and effective.

Expected outcomes

- Outbreak identified and reported.
- Cases isolated.
- Vaccination done.
- No new cases within the incubation period.

Linking the data to the diagnosis

This is a risk diagnosis, because no measles case has occurred at the school yet. Vaccine coverage is 60%, measles was reported in the neighboring town, classrooms are crowded, and a teacher says, "Many parents have not vaccinated their children." These are risk factors, so an actual outbreak statement would be premature. The nurse reports, prepares to isolate and trace any cases, vaccinates and educates, following health authority advice. The aim is that any outbreak is identified and reported, cases are isolated, vaccination is done and no new cases appear within the incubation period.

H4 Unsafe water or sanitation

Group: Infection and community health | Type: Risk problem

- **Definition:** Poor water or waste disposal raises the chance of illness.
- **Risk factors:** Contaminated sources; poor waste disposal; flooding
- **Warning signs to watch for:** Diarrhea outbreaks; skin disease; dirty water

Scenario

A village uses an open well close to a pit latrine.

Subjective (S): Villager: "We drink from the well."

Objective (O): Open well 5 meters from a pit latrine; water cloudy; no water treatment; no diarrhea cases reported yet.

Assessment tools for this scenario: CP-INFECT Infection Check (p. 281)

Validated scales to consider: qSOFA / sepsis screen

CarePath diagnosis: Unsafe water or sanitation related to a contaminated source and poor waste disposal (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Teach boiling and treatment of water.	Boiling or treating water kills or removes germs that cause diarrhea and other diseases, giving households a safe drink even if the source stays contaminated.
Improve sanitation.	Moving waste away from drinking sources, for example by safer latrine placement, stops germs from seeping into the water supply.
Report.	Reporting tells the health and water authorities about the hazard so they can test the well and give resources or enforce safer practices.
Educate the community.	Community understanding of how water spreads disease helps people keep safe habits, support changes and teach others, which lasts longer than a one-time intervention.

Expected outcomes

- No diarrhea cases develop.
- Diarrhea cases fall.
- Community states hygiene steps.

Linking the data to the diagnosis

This is a risk diagnosis, because no one has fallen ill yet. The open well is 5 meters from a pit latrine, the water is cloudy, there is no water treatment, and a villager says, "We drink from the well." No diarrhea cases are reported, so an actual outbreak statement would not fit; the contaminated source and poor waste disposal are the risk factors. The plan prevents illness by making water safe and improving sanitation. The aim is that safe water is supplied, diarrhea cases fall or stay low and the community states hygiene steps.

H5 Crowded living conditions

Group: Infection and community health | Type: Risk problem

- **Definition:** Overcrowding raises the chance of spreading infection and stress.
- **Risk factors:** Poverty; large households; lack of housing
- **Warning signs to watch for:** Shared beds; poor ventilation; frequent infections

Scenario

Ten people share two rooms.

Subjective (S): "Ten of us live in two rooms."

Objective (O): Poor ventilation; shared beds; windows rarely opened; no cough or fever at present.

Assessment tools for this scenario: **CP-INFECT Infection Check** (p. 281)

Validated scales to consider: qSOFA / sepsis screen

CarePath diagnosis: Crowded living conditions related to crowding and poor ventilation (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Teach hygiene.	Handwashing and covering coughs reduce the spread of germs in close quarters, where one sick person can quickly infect many others.
Improve ventilation.	Fresh air dilutes airborne germs, so opening windows and improving airflow lowers the chance of breathing in infectious droplets in a crowded room.
Screen.	Screening for cough, fever or other signs finds infection early, so it can be treated and the sick person separated before others catch it.
Link to services.	Housing, social and health services can help with longer-term causes of crowding, which hygiene teaching alone cannot fix.

Expected outcomes

- Hygiene and ventilation improved.
- Infection spread reduced.
- Referral to housing services.

Linking the data to the diagnosis

This is a risk diagnosis, because nobody is sick yet. Ten people share two rooms, beds are shared, ventilation is poor and windows are rarely opened. One resident says, "Ten of us live in two rooms." There is no cough or fever at present, so an actual infection diagnosis would be wrong; crowding and poor ventilation are the risk factors. The plan reduces spread through hygiene teaching, better ventilation, screening and links to services. The aim is improved hygiene and ventilation, less spread of infection and referral to housing services.

H6 Poor hygiene practices

Group: Infection and community health | Type: Actual problem

- **Definition:** Handwashing, bathing, or food handling habits put health at risk.
- **Possible causes:** Lack of facilities; low knowledge; habits
- **Signs and symptoms:** Dirty hands; body odor; infections

Scenario

A child often has diarrhea and does not wash his hands.

Subjective (S): "I don't always wash my hands."

Objective (O): Child with frequent diarrhea; dirty nails; no soap at home.

Assessment tools for this scenario: **CP-INFECT Infection Check** (p. 281)

Validated scales to consider: qSOFA / sepsis screen

CarePath diagnosis: Poor hygiene practices related to lack of facilities, as evidenced by dirty hands and body odor.

Interventions and rationale

Intervention	Rationale
Teach handwashing.	Handwashing with soap at key times, such as after toilet use and before eating, removes germs that cause diarrhea and breaks the route from hands to mouth.
Provide soap.	Without soap, handwashing is much less effective. Providing it removes a practical barrier that teaching alone cannot overcome.
Model good habits.	Children copy what they see, so seeing adults wash hands correctly shows the habit in action and makes it more likely to be adopted.
Educate the community.	Hygiene is shared across households, so teaching the wider community spreads the habit and lowers the number of people who can pass germs to the child.

Expected outcomes

- Washes hands at key times.
- Fewer diarrhea episodes.
- Soap available.

Linking the data to the diagnosis

This is an actual problem because hygiene habits are already harming the child's health. He often has diarrhea, has dirty nails, has no soap at home and says, "I don't always wash my hands." The cause is a lack of facilities and habit, which fits this statement better than a risk of infection, because illness is already happening. The plan teaches handwashing, supplies soap and models the habit. The aim is that he washes his hands at key times, has fewer diarrhea episodes and has soap available.

D - End of life

Recommended assessment tools

CarePath tool: **CP-END** End-of-Life Comfort Check (p. 282)

Validated scales: ESAS

D1 Needs comfort near death

Group: End of life | Type: Actual problem

- **Definition:** The dying person needs relief of symptoms and calm, dignified care.
- **Possible causes:** Terminal illness; pain; breathlessness; anxiety
- **Signs and symptoms:** Moaning; restlessness; grimacing; fear

Scenario

A dying patient needs comfort and calm.

Subjective (S): "I'm so tired. I just want to be comfortable."

Objective (O): Terminal illness; restless; pain 6/10; shortness of breath.

Assessment tools for this scenario: **CP-END** End-of-Life Comfort Check (p. 282) · **CP-PAIN** Pain & Comfort Score (p. 268)

Validated scales to consider: ESAS, NRS 0–10, FLACC, PAINAD

CarePath diagnosis: Needs comfort near death related to terminal illness, as evidenced by moaning and restlessness.

Interventions and rationale

Intervention	Rationale
Control symptoms.	Untreated pain and breathlessness cause suffering and fear near death. Giving ordered medicines and measures promptly relieves symptoms and keeps him comfortable.
Give mouth care.	A dry mouth is common near death and very uncomfortable. Regular mouth care keeps the lips and mouth moist, clean and more comfortable.
Reposition gently.	Gentle position changes ease pressure and stiffness and can help breathing, but slow, supported movement avoids causing extra pain.
Keep the room calm.	A quiet, softly lit room with few interruptions reduces stress and agitation, and helps him rest peacefully.
Stay present.	Staying present reassures him that he is not alone, which eases fear and anxiety and honors his dignity.
Involve the family.	Family involvement gives comfort to both patient and relatives, and helps them take part in care and feel they can still do something meaningful.

Expected outcomes

- Comfortable and peaceful.
- Symptoms controlled.
- Family present.
- Pain 3/10 or lower.

Linking the data to the diagnosis

This is an actual problem because he is already suffering. The dying patient has a terminal illness, is restless, reports pain 6/10 and has shortness of breath. He says, "I'm so tired. I just want to be

comfortable." The focus is comfort and dignity, not cure, which is why this statement fits better than a treatment-focused problem. The plan controls symptoms, gives mouth care, repositions gently, keeps the room calm, stays present and involves the family. The aim is that he is comfortable and peaceful, symptoms are controlled, family are present and pain is 3/10 or lower.

D2 Family grief before death

Group: End of life | Type: Actual problem

- **Definition:** Relatives are grieving while the person is still alive.
- **Possible causes:** Expected death; fear; guilt; anticipatory loss
- **Signs and symptoms:** Crying; sleeplessness; withdrawal; sadness

Scenario

A family weeps at the bedside of a patient with days to live.

Subjective (S): "I can't bear to see him like this."

Objective (O): Family weeping; not sleeping; asks what to expect.

Assessment tools for this scenario: CP-END End-of-Life Comfort Check (p. 282)

Validated scales to consider: ESAS

CarePath diagnosis: Family grief before death related to expected death, as evidenced by crying and sleeplessness.

Interventions and rationale

Intervention	Rationale
Listen.	Listening lets family express fear, guilt and sadness without judgment, which eases emotional pain and shows that their feelings are valid.
Encourage goodbyes.	Saying goodbye, thanks and sorry while the patient is alive can reduce later regret and help the family begin to find peace.
Explain changes.	Knowing what changes to expect, such as sleepiness or altered breathing, lowers fear and helps them recognize these as normal parts of dying.
Allow presence.	Being able to stay at the bedside lets the family feel useful and close to him, which supports their grieving and the patient's comfort.
Offer a chaplain.	A chaplain can offer spiritual and emotional support and rituals that matter to the family, which many people find a comfort during loss.

Expected outcomes

- Understands what to expect.
- Says goodbyes.
- Feels supported.

Linking the data to the diagnosis

This is an actual problem because the family is already grieving while the patient is alive. They are weeping at the bedside, are not sleeping and ask what to expect. A relative says, "I can't bear to see him like this." This fits family grief before death, rather than bereavement support, because the patient has not died. The plan gives them a chance to talk, say goodbye, understand changes and receive spiritual support. The aim is that they understand what to expect, say their goodbyes and feel supported.

D3 Unfinished affairs or wishes

Group: End of life | Type: Actual problem

- **Definition:** The person has legal, family, or personal matters to settle.
- **Possible causes:** Short time left; unresolved conflicts; legal matters
- **Signs and symptoms:** Asks to see family; wants to make a will; restlessness

Scenario

A dying father wants to speak with his estranged son.

Subjective (S): "I want to see my son before I die."

Objective (O): Wants to settle family matters; restless; legal matters unfinished.

Assessment tools for this scenario: CP-END End-of-Life Comfort Check (p. 282)

Validated scales to consider: ESAS

CarePath diagnosis: Unfinished affairs or wishes related to short time left, as evidenced by asks to see family and wants to make a will.

Interventions and rationale

Intervention	Rationale
Listen.	Listening shows respect and lets him say what matters most, so the team understands his wishes and fears before time runs out.
Help plan visits.	Dying people often have limited time and energy, so planning visits quickly helps a meeting with his son happen while he can still take part.
Involve a social worker and chaplain.	A social worker can help with family contact and legal matters, and a chaplain with spiritual peace, covering needs the nurse cannot meet alone.
Document wishes.	Recorded wishes make sure that others know and respect what he wants, which gives him reassurance and avoids confusion or disputes later.

Expected outcomes

- Meets his son or arranges contact.
- Wishes documented.
- Reports peace.

Linking the data to the diagnosis

This is an actual problem because his unfinished matters are already weighing on him. He is restless, has unfinished legal matters, wants to settle family issues and says, "I want to see my son before I die." His time is short, so delay could mean the chance is lost. This fits better than general distress because the concern is specific: reconciliation and legal affairs. The plan listens, arranges contact, involves a social worker and chaplain and records his wishes. The aim is that he meets his son or arranges contact, his wishes are documented and he reports peace.

D4 Distressing symptoms near death

Group: End of life | Type: Actual problem

- **Definition:** Breathlessness, agitation, pain, or secretions cause distress near the end.
- **Possible causes:** Advanced disease; secretions; organ failure
- **Signs and symptoms:** Noisy breathing; agitation; pain; nausea

Scenario

A patient has rattling breaths and is restless.

Subjective (S): (Unable to speak.) Rattling breaths.

Objective (O): Noisy breathing; agitated; observed pain 7/10; poor intake.

Assessment tools for this scenario: **CP-END** End-of-Life Comfort Check (p. 282) · **CP-PAIN** Pain & Comfort Score (p. 268)

Validated scales to consider: ESAS, NRS 0–10, FLACC, PAINAD

CarePath diagnosis: Distressing symptoms near death related to advanced disease, as evidenced by noisy breathing and agitation.

Interventions and rationale

Intervention	Rationale
Give comfort medicines as ordered.	Medicines for pain, breathlessness, agitation and secretions, given as ordered, relieve distress quickly when he cannot ask for help himself.
Reposition.	Changing position helps secretions drain and eases pressure and discomfort, though movement should be gentle to avoid worsening pain.
Give mouth care.	Mouth care keeps the mouth moist and clean, which relieves dryness and discomfort that he cannot report.
Keep calm.	A calm, quiet environment lowers agitation and helps him rest more comfortably.
Reassure the family.	Explaining that noisy breathing is usually not painful to the patient, and what is being done, eases the family's fear and distress.

Expected outcomes

- Calm and comfortable.
- Secretions managed.
- Family reassured.
- No distress.

Linking the data to the diagnosis

This is an actual problem because distress is already present. The patient cannot speak, has rattling breaths, noisy breathing, agitation and observed pain 7/10, and intake is poor. Because he cannot say how he feels, the nurse relies on what is seen and heard. This fits better than a general comfort need because specific symptoms need targeted relief. The plan gives comfort medicines as ordered, repositions, gives mouth care, keeps the room calm and reassures the family. The aim is that he is calm and comfortable, secretions are managed, the family is reassured and there is no distress.

D5 Needs bereavement support

Group: End of life | Type: Actual problem

- **Definition:** Family members need support after a death.
- **Possible causes:** Loss of a loved one; family; grief
- **Signs and symptoms:** Crying; sleeplessness; guilt; isolation

Scenario

A widow cannot cope with funeral decisions.

Subjective (S): "I can't think. I don't know what to do."

Objective (O): Widow cannot decide on funeral; tearful; sleepless.

Assessment tools for this scenario: CP-END End-of-Life Comfort Check (p. 282)

Validated scales to consider: ESAS

CarePath diagnosis: Needs bereavement support related to loss of a loved one, as evidenced by crying and sleeplessness.

Interventions and rationale

Intervention	Rationale
Offer condolences.	Expressing sympathy acknowledges her loss and shows that the nurse cares, which helps her feel supported when she is overwhelmed.
Give information on grief.	Knowing that sleeplessness, tears and poor concentration are normal in grief helps her feel less frightened about her reactions.
Refer to counseling.	Trained counselors give ongoing help with grief that goes beyond what a nurse can offer in a short contact.
Follow up.	Follow-up checks how she is coping over time and allows early help if grief becomes severe or she is struggling with daily tasks.

Expected outcomes

- Receives support.
- Decisions made with help.
- Follows up with a bereavement service.

Linking the data to the diagnosis

This is an actual problem because the loss has already happened and she is struggling. The widow cannot decide on the funeral, is tearful and sleepless, and says, "I can't think. I don't know what to do." This fits bereavement support, not family grief before death, because her husband has already died. The plan offers condolences, information about grief, referral to counseling and follow-up. The aim is that she receives support, makes decisions with help and follows up with a bereavement service.

T - Long-term illness

Recommended assessment tools

CarePath tool: **CP-LONG Long-Term Condition Check** (p. 283)

Validated scales: Self-management review

T1 Uncontrolled high blood pressure

Group: Long-term illness | Type: Actual problem

- **Definition:** Blood pressure stays high despite treatment, raising the risk of stroke and heart disease.
- **Possible causes:** High salt intake; stress; obesity; missed medicine; kidney disease
- **Signs and symptoms:** Readings above target; headaches; dizziness; sometimes no symptoms

Scenario

A patient's pressure stays above 160/100 despite medicine.

Subjective (S): "I don't get headaches so I'm fine."

Objective (O): Blood pressure 168/102; misses medicines; high-salt diet.

Assessment tools for this scenario: **CP-LONG Long-Term Condition Check** (p. 283) · **CP-PAIN Pain & Comfort Score** (p. 268) · **CP-SKIN Skin & Wound Score** (p. 270)

Validated scales to consider: Self-management review, NRS 0-10, FLACC, PAINAD, Braden Scale, TIME wound chart

CarePath diagnosis: Uncontrolled high blood pressure related to high salt intake and missed medicines, as evidenced by a blood pressure of 168/102.

Interventions and rationale

Intervention	Rationale
Check technique.	Wrong cuff size, arm position or rushed measurement can give false readings. Checking technique makes sure treatment decisions are based on accurate numbers.
Encourage taking medicine.	Missed doses let blood pressure rise again. Regular medicine gives steady control, which lowers the risk of stroke, heart disease and kidney damage.
Reduce salt.	Salt makes the body hold water, which raises blood pressure. Cutting salt helps lower readings and can make medicines work better.
Encourage exercise.	Regular physical activity strengthens the heart and helps lower blood pressure over time, and it helps weight control.
Follow up.	Follow-up lets the team see whether readings are improving and adjust treatment, and it reinforces the habit of ongoing care.
Report severe symptoms.	Severe headache, chest pain, vision change or weakness can signal stroke or a dangerous rise in pressure and need urgent medical attention.

Expected outcomes

- Blood pressure within target.
- Takes medicine regularly.
- Reduces salt.
- Follows up.

Linking the data to the diagnosis

This is an actual problem because the blood pressure is already above target. The patient's reading is 168/102, he misses medicines and eats a high-salt diet. He says, "I don't get headaches so I'm fine," which shows he does not realize that high pressure can be silent. Raised pressure despite treatment fits this statement better than a simple knowledge need. The plan checks measurement technique, encourages regular medicine, reduces salt, encourages exercise and follows up. The aim is blood pressure within target, regular medicine use, less salt and attendance at follow-up.

T2 Foot problems in diabetes

Group: Long-term illness | Type: Risk problem

- **Definition:** Reduced feeling and blood flow raise the chance of ulcers and infection.
- **Risk factors:** Nerve damage; poor circulation; poor foot care; ill-fitting shoes
- **Warning signs to watch for:** Numb feet; ulcers; calluses; slow healing

Scenario

A diabetic with numb feet wears tight shoes and has dry, cracked heels.

Subjective (S): "I cannot feel my feet."

Objective (O): Numb feet; dry cracked heels; tight shoes; weak foot pulses; no ulcer or open skin; blood sugar 14 mmol/L.

Assessment tools for this scenario: **CP-LONG** Long-Term Condition Check (p. 283) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: Self-management review, Braden Scale, TIME wound chart, MUST, fluid chart, glucose

CarePath diagnosis: Foot problems in diabetes related to nerve damage and poor foot care (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Check feet daily.	Numb feet cannot sense injury, so daily inspection finds cuts, blisters and pressure marks early, before they become ulcers or infections.
Use proper shoes.	Tight or poorly fitting shoes rub and press on numb skin and cause sores. Well-fitting protective shoes spread pressure and prevent damage.
Keep feet clean and dry.	Moist skin between the toes encourages fungal infection, and dry cracked heels allow germs in. Clean, dry and moisturized skin keeps the barrier intact.
Refer to podiatry.	A podiatrist can assess nerve and blood flow, treat calluses and advise on footwear, which lowers the chance of ulcers in a high-risk foot.
Control sugar.	High blood sugar damages nerves and blood vessels and slows healing. Better control lowers the risk of further nerve damage and infection.

Expected outcomes

- No ulcer or open skin develops.
- No infection.
- Daily foot checks.
- Proper shoes.

Linking the data to the diagnosis

This is a risk diagnosis because there is no ulcer yet. The patient has numb feet, says, "I cannot feel my feet," and has dry cracked heels, tight shoes, weak foot pulses and a blood sugar of 14 mmol/L. There is no open skin, so an actual foot ulcer diagnosis would be wrong; nerve damage and poor foot care are

the risk factors. The plan protects the skin and improves control of sugar. The aim is no infection, daily foot checks and proper shoes.

T3 Lung disease flare-ups

Group: Long-term illness | Type: Actual problem

- **Definition:** Breathing worsens suddenly in chronic lung disease.
- **Possible causes:** Infection; smoking; pollution; missed inhalers
- **Signs and symptoms:** Cough; wheeze; breathlessness; change in sputum

Scenario

A COPD patient becomes more breathless and coughs more.

Subjective (S): "I'm more breathless and coughing more."

Objective (O): Wheeze; sputum increased and green; oxygen saturation 90%.

Assessment tools for this scenario: **CP-LONG** Long-Term Condition Check (p. 283) · **CP-BREATH** Breathing & Circulation Check (p. 265)

Validated scales to consider: Self-management review, NEWS2, SpO₂, ECG

CarePath diagnosis: Lung disease flare-ups related to infection, as evidenced by cough and wheeze.

Interventions and rationale

Intervention	Rationale
Give medications as ordered.	Bronchodilators open narrowed airways and steroids or antibiotics, if ordered, treat inflammation or infection, which eases breathlessness and shortens the flare-up.
Give oxygen.	Oxygen raises low blood oxygen levels. In COPD it is given carefully to reach the ordered target, because too much can cause carbon dioxide to build up.
Position.	Sitting upright or leaning forward lets the lungs expand more easily and the breathing muscles work better, which relieves breathlessness.
Teach early signs.	Spotting early signs such as more cough, a change in sputum or more breathlessness allows treatment sooner, which can prevent hospital admission.
Vaccinate.	Vaccines such as those for influenza and pneumonia lower the chance of infections that trigger flare-ups.
Support stopping smoking.	Smoking damages the airways and triggers flare-ups. Support to stop slows lung damage and lowers the number of future flare-ups.

Expected outcomes

- Breathing returns to baseline.
- Oxygen at target.
- Flare-up resolves.
- Patient knows early signs.

Linking the data to the diagnosis

This is an actual problem because the flare-up has already begun. The patient with COPD says, "I'm more breathless and coughing more." The nurse finds wheeze, increased green sputum and oxygen saturation of 90%. The green sputum suggests infection as the trigger. This fits a flare-up, not a stable chronic condition, because breathing has worsened suddenly. The plan gives medicines and oxygen as ordered, positions him to ease breathing and teaches early signs. The aim is that breathing returns to baseline, oxygen is at target, the flare-up resolves and the patient knows early signs.

T4 Difficulty following fluid limits

Group: Long-term illness | Type: Actual problem

- **Definition:** The person struggles to keep to fluid restrictions set for heart or kidney problems.
- **Possible causes:** Thirst; habit; lack of understanding; salty food
- **Signs and symptoms:** Weight gain; swelling; breathlessness

Scenario

A dialysis patient drinks beyond his limit.

Subjective (S): "I can't stop drinking. I'm thirsty."

Objective (O): Weight up 3 kg; swelling; breathless; on dialysis.

Assessment tools for this scenario: **CP-LONG** Long-Term Condition Check (p. 283) · **CP-FLUID** Fluid Balance & Nutrition Score (p. 266)

Validated scales to consider: Self-management review, MUST, fluid chart, glucose

CarePath diagnosis: Difficulty following fluid limits related to thirst, as evidenced by weight gain and swelling.

Interventions and rationale

Intervention	Rationale
Teach limits.	When kidneys or the heart cannot clear fluid, extra intake builds up in the body. Knowing the limit and why helps him stay within it.
Offer ice chips or sugar-free candy.	Ice chips and sugar-free candy keep the mouth moist and ease thirst with little fluid. Ice counts toward the limit because it melts into water.
Measure intake.	Recording what he drinks shows how close he is to his limit and helps spot patterns, so the team can give targeted advice.
Support.	Thirst is hard to resist, so encouragement and practical help improve his chance of keeping to the limit over time.

Expected outcomes

- Keeps within the fluid limit.
- Weight gain under target.
- States strategies for thirst.

Linking the data to the diagnosis

This is an actual problem because he is already going over his limit. The dialysis patient says, "I can't stop drinking. I'm thirsty." His weight is up 3 kg, he has swelling and is breathless, which are signs of fluid overload. The difficulty lies in keeping to the limit, not in lacking fluid. The plan teaches the limit, offers thirst-relief options, measures intake and gives support. The aim is that he keeps within the fluid limit, his weight gain stays under target and he states strategies for thirst.

T5 Dialysis access care

Group: Long-term illness | Type: Risk problem

- **Definition:** The dialysis access site may become infected, blocked, or damaged.
- **Risk factors:** Needle sites; poor care; infection; clotting
- **Warning signs to watch for:** Redness; swelling; no buzzing feel; fever

Scenario

A dialysis patient with a new fistula carries a heavy shopping bag on that arm.

Subjective (S): "I carry my shopping on that arm."

Objective (O): Fistula arm: pulse buzz present; skin clean, cool, no redness; carries a heavy bag on that arm; blood pressure was taken on that arm at the last visit.

Assessment tools for this scenario: **CP-LONG** Long-Term Condition Check (p. 283) · **CP-SKIN** Skin & Wound Score (p. 270) · **CP-BREATH** Breathing & Circulation Check (p. 265)

Validated scales to consider: Self-management review, Braden Scale, TIME wound chart, NEWS2, SpO₂, ECG

CarePath diagnosis: Dialysis access care related to poor care and pressure on the access arm (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Protect the arm.	Pressure, heavy loads or tight items on the access arm can squeeze the fistula and reduce blood flow, causing clotting and loss of the access.
No blood pressure or needles on that arm.	Pressure from a cuff or needle puncture can damage or block the fistula, so these are kept to the other arm.
Check the thrill.	Feeling the thrill, the buzz of blood flow, shows that the fistula is working. Loss of the thrill means a clot may have formed and needs urgent attention.
Keep clean.	Washing the arm, especially before dialysis, lowers germs on the skin and reduces the risk of infection at needle sites.
Report the blood pressure taken on that arm and any sign of infection.	The access arm must not have blood pressure cuffs or needles because it can damage the fistula, so the error is recorded and corrected.

Expected outcomes

- No infection develops at the access site.
- Fistula keeps working.
- No complications.
- Patient protects the arm.

Linking the data to the diagnosis

This is a risk diagnosis because the fistula is working and no problem has occurred. The thrill is present and the skin is clean, cool and not red. However, the patient says, "I carry my shopping on that arm," carries a heavy bag on it, and had blood pressure taken on that arm at the last visit. These behaviors and poor care are the risk factors, so an actual infection or blockage statement would be wrong. The plan protects the arm, checks the thrill, keeps it clean and reports infection. The aim is that the fistula keeps working, there are no complications and the patient protects the arm.

T6 Cancer treatment side effects

Group: Long-term illness | Type: Actual problem

- **Definition:** Nausea, tiredness, sore mouth, or hair loss from treatment.
- **Possible causes:** Chemotherapy; radiation; immune suppression
- **Signs and symptoms:** Nausea; fatigue; hair loss; mouth sores; infection

Scenario

A patient on chemotherapy has mouth sores and extreme tiredness.

Subjective (S): "My mouth is sore and I'm so tired."

Objective (O): Mouth ulcers; fatigue; nausea; on chemotherapy.

Assessment tools for this scenario: **CP-LONG** Long-Term Condition Check (p. 283) · **CP-SKIN** Skin & Wound Score (p. 270)

Validated scales to consider: Self-management review, Braden Scale, TIME wound chart

CarePath diagnosis: Cancer treatment side effects related to chemotherapy, as evidenced by nausea and fatigue.

Interventions and rationale

Intervention	Rationale
Give anti-sickness medicine.	Anti-sickness medicine blocks the signals that cause nausea and vomiting, which lets him eat and drink and helps prevent dehydration and weight loss.
Mouth care.	Chemotherapy damages the lining of the mouth. Gentle, regular mouth care eases soreness, keeps the mouth clean and lowers the chance of infection.
Rest.	Treatment drains energy. Planned rest periods help him conserve strength and recover, and pacing activities helps him manage tiredness.
Hydration.	Vomiting and a sore mouth make drinking difficult, and fluid is needed to keep kidneys and circulation working well.
Infection precautions.	Chemotherapy lowers white cells, so infections can develop quickly. Hand hygiene and avoiding sick contacts lower the risk of serious infection.
Report fever.	Fever during chemotherapy can signal serious infection that needs urgent treatment, so reporting it quickly can be life-saving.

Expected outcomes

- Side effects controlled.
- Eats and drinks.
- No fever.
- Patient states when to call.

Linking the data to the diagnosis

This is an actual problem because the side effects are already present. The patient on chemotherapy says, "My mouth is sore and I'm so tired." The nurse finds mouth ulcers, fatigue and nausea. These are expected effects of treatment, which fits better than a problem caused by the cancer itself. The plan controls symptoms and protects against complications such as dehydration and infection. The aim is that side effects are controlled, he eats and drinks, he has no fever and he states when to call for help.

T7 Difficulty accepting long-term illness

Group: Long-term illness | Type: Actual problem

- **Definition:** The person struggles emotionally with a permanent condition.
- **Possible causes:** New diagnosis; fear; denial; losses
- **Signs and symptoms:** Anger; sadness; refusal; withdrawal

Scenario

A newly diagnosed diabetic denies the illness.

Subjective (S): "I don't have diabetes."

Objective (O): Newly diagnosed; denies the illness; misses checks.

Assessment tools for this scenario: **CP-LONG** Long-Term Condition Check (p. 283)

Validated scales to consider: Self-management review

CarePath diagnosis: Difficulty accepting long-term illness related to a new diagnosis, as evidenced by denial of the illness and missed checks.

Interventions and rationale

Intervention	Rationale
Listen.	Listening without judgment lets him express fear, anger or denial and helps him feel understood, which is the first step toward acceptance.
Give information.	Clear, simple information in small amounts corrects misunderstandings and lets him see that diabetes can be managed, without overwhelming him.
Suggest support groups.	Meeting others with the same condition shows that people live well with it, and offers practical tips and emotional support.
Offer a counselor.	A counselor can help him work through grief, denial and fear in more depth than ward staff can offer.
Set small goals.	Small, achievable goals build confidence and a sense of control, which makes it easier to take the next step in managing his illness.

Expected outcomes

- Acknowledges the illness.
- Attends education.
- Sets goals.
- Joins support.

Linking the data to the diagnosis

This is an actual problem because he is already refusing to accept the diagnosis. He is newly diagnosed with diabetes, says, "I don't have diabetes," denies the illness and misses checks. This is about emotional acceptance, which fits better than a knowledge deficit, because information alone will not work while he is denying the illness. The plan listens, gives information gradually, suggests support groups, offers counseling and sets small goals. The aim is that he acknowledges the illness, attends education, sets goals and joins support.

T8 Weak immune system

Group: Long-term illness | Type: Risk problem

- **Definition:** Illness or treatment lowers the body's defenses against infection.
- **Risk factors:** Chemotherapy; HIV; steroids; poor nutrition; diabetes
- **Warning signs to watch for:** Frequent infections; slow healing; fevers

Scenario

A patient starting steroids and chemotherapy lives with a school-age child who has a cold.

Subjective (S): "My child has a cold."

Objective (O): On steroids and chemotherapy; white cell count 2.1; temperature 36.8 C; no signs of infection; lives with a school-age child.

Assessment tools for this scenario: **CP-LONG** Long-Term Condition Check (p. 283) · **CP-INFECT**

Infection Check (p. 281)

Validated scales to consider: Self-management review, qSOFA / sepsis screen

CarePath diagnosis: Weak immune system related to chemotherapy and steroids (risk factors); no signs of the problem are present yet.

Interventions and rationale

Intervention	Rationale
Protect from infection.	Chemotherapy and steroids reduce the body's defenses, so keeping germs away, such as avoiding sick contacts, lowers the chance of a serious infection.
Hygiene.	Clean hands, mouth and skin reduce the germs that can enter the body, which matters when white cell counts are low.
Vaccines as advised.	Some vaccines are safe and helpful, but live vaccines can be harmful with a weak immune system, so only those advised by the team are given.
Monitor.	Regular checks of temperature and signs of infection find problems early, when treatment works best and before the infection spreads.
Teach.	Understanding precautions and warning signs helps the patient and household act early and consistently, and report a fever promptly.

Expected outcomes

- No new infection.
- Follows precautions.
- Vaccines updated.
- Monitoring done.

Linking the data to the diagnosis

This is a risk diagnosis because no infection has developed. The patient is on steroids and chemotherapy, the white cell count is 2.1, and her temperature is 36.8 C with no signs of infection. She says, "My child has a cold," and lives with a school-age child, which raises exposure. An actual infection statement would be wrong; the weak defenses and exposure are the risk factors. The plan protects her, supports hygiene, updates vaccines as advised, monitors and teaches. The aim is no new infection, precautions followed, vaccines updated and monitoring done.

X - Sexual and reproductive health

Recommended assessment tools

CarePath tool: **CP-SEX Sexual & Reproductive Health Check** (p. 284)

Validated scales: PLISSIT

X1 Concern about sexual function

Group: Sexual and reproductive health | Type: Actual problem

- **Definition:** The person is worried about changes in sexual ability or desire.
- **Possible causes:** Illness; medicines; fear; relationship strain; pain
- **Signs and symptoms:** Loss of desire; difficulty with function; worry; avoidance

Scenario

A man after prostate surgery is worried about erections.

Subjective (S): "I'm worried about sex after surgery."

Objective (O): After prostate surgery; avoids partner; embarrassed; asks quietly.

Assessment tools for this scenario: **CP-SEX Sexual & Reproductive Health Check** (p. 284)

Validated scales to consider: PLISSIT

CarePath diagnosis: Concern about sexual function related to illness, as evidenced by loss of desire and difficulty with function.

Interventions and rationale

Intervention	Rationale
Provide privacy.	Sexual concerns are private and embarrassing. A private, unhurried setting helps him speak openly and feel respected.
Give information.	Accurate information about recovery after prostate surgery corrects myths and fears, and shows what to expect and which treatments can help.
Include the partner.	Sexual function affects both partners. Involving his partner, with his consent, supports communication and reduces misunderstanding and avoidance.
Refer to a specialist.	A specialist such as a urologist or sexual health counselor can offer treatments and advice beyond a nurse's scope, which improves his chance of recovery.
Respect values.	Personal, cultural and religious values shape how people see sexuality. Respecting them builds trust and keeps advice acceptable to him.

Expected outcomes

- Receives accurate information.
- Discusses with partner.
- Referred to a specialist.
- Reports less worry.

Linking the data to the diagnosis

This is an actual problem because worry is already affecting him. The man is after prostate surgery and says, "I'm worried about sex after surgery." He avoids his partner, is embarrassed and asks quietly. The statement is about concern, not a confirmed loss of function, so it fits better than a diagnosis of sexual dysfunction. The plan gives privacy, accurate information, partner involvement and referral, while

respecting his values. The aim is that he receives accurate information, discusses it with his partner, is referred to a specialist and reports less worry.

X2 Concern about fertility

Group: Sexual and reproductive health | Type: Actual problem

- **Definition:** The person is worried about the ability to have children.
- **Possible causes:** Hormone problems; surgery; infection; age
- **Signs and symptoms:** Anxiety; sadness; questions; failed conception

Scenario

A couple has tried for two years without pregnancy.

Subjective (S): "We've been trying for two years."

Objective (O): Couple tearful; anxious; failed conception; no known cause.

Assessment tools for this scenario: **CP-SEX** Sexual & Reproductive Health Check (p. 284) · **CP-MIND** Mood & Mind Screen (p. 272)

Validated scales to consider: PLISSIT, PHQ-9, GAD-7, C-SSRS

CarePath diagnosis: Concern about fertility related to hormone problems, as evidenced by anxiety and sadness.

Interventions and rationale

Intervention	Rationale
Listen.	Listening gives the couple a safe place to share grief and anxiety, which can ease emotional strain and strengthen their relationship.
Give information.	Clear facts about normal conception times and common causes correct myths and reduce self-blame, helping them make decisions.
Refer for testing.	Testing can find a treatable cause in either partner, so referral gives them a path forward and answers the question of why they have not conceived.
Offer counseling.	Counseling helps them manage sadness, stress and strain on the relationship, which are common during fertility problems.
Support.	Continued support shows they are not alone and helps them cope with waiting, tests and uncertain results.

Expected outcomes

- Referred for testing.
- Receives counseling.
- Understands options.
- Copes with stress.

Linking the data to the diagnosis

This is an actual problem because the couple is already distressed. They have tried for two years without pregnancy, are tearful and anxious, and say, "We've been trying for two years." No cause is known, so the statement is about worry and coping, not a diagnosed fertility disorder. The plan listens, informs, arranges testing, offers counseling and supports them. The aim is that they are referred for testing, receive counseling, understand their options and cope with stress.

X3 Needs safe-sex knowledge

Group: Sexual and reproductive health | Type: Actual problem

- **Definition:** The person needs information on preventing infection and unplanned pregnancy.
- **Possible causes:** Low knowledge; taboo; peer pressure
- **Signs and symptoms:** Unprotected sex; unplanned pregnancy; infections

Scenario

A teenager does not know how condoms protect against infection.

Subjective (S): "I didn't know condoms protect me."

Objective (O): Teen; unprotected sex; risk of unplanned pregnancy; embarrassed.

Assessment tools for this scenario: CP-SEX Sexual & Reproductive Health Check (p. 284) · CP-INFECT Infection Check (p. 281)

Validated scales to consider: PLISSIT, qSOFA / sepsis screen

CarePath diagnosis: Needs safe-sex knowledge related to low knowledge, as evidenced by not knowing how condoms protect against infection and unprotected sex.

Interventions and rationale

Intervention	Rationale
Give clear information.	Plain, accurate information corrects myths and fills gaps, so the teenager can understand how condoms prevent infection and pregnancy.
Discuss protection and testing.	Knowing how to protect herself and why testing matters lets her make safer choices and find infections early, when they are easier to treat.
Keep confidentiality.	Teenagers may avoid care if they fear being judged or exposed. Confidentiality builds trust and makes it more likely she will return and ask for help.
Refer.	A youth clinic or sexual health service can provide testing, contraception and ongoing advice that go beyond one conversation.

Expected outcomes

- States how to protect herself.
- Accesses testing.
- Confidentiality kept.
- Reports intended safe practice.

Linking the data to the diagnosis

This is an actual problem because the knowledge gap is already leading to risk. The teenager says, "I didn't know condoms protect me," has had unprotected sex, is embarrassed and faces a risk of unplanned pregnancy. The need is for knowledge, which fits better than a diagnosis of infection or pregnancy, because neither is confirmed. The plan gives clear information, discusses protection and testing, keeps confidentiality and refers. The aim is that she states how to protect herself, accesses testing, has confidentiality kept and reports intended safe practice.

X4 Menopause symptoms

Group: Sexual and reproductive health | Type: Actual problem

- **Definition:** Hot flushes, sleep trouble, mood changes, or other symptoms linked to menopause.
- **Possible causes:** Falling hormones; age; surgery
- **Signs and symptoms:** Hot flushes; sleep trouble; dryness; mood changes

Scenario

A 52-year-old has night sweats.

Subjective (S): "I wake up drenched."

Objective (O): Night sweats; hot flushes; aged 52; disturbed sleep; mood changes.

Assessment tools for this scenario: **CP-SEX Sexual & Reproductive Health Check** (p. 284)

Validated scales to consider: PLISSIT

CarePath diagnosis: Menopause symptoms related to falling hormones, as evidenced by hot flushes and sleep trouble.

Interventions and rationale

Intervention	Rationale
Reassure.	Knowing that menopause is a normal stage and that symptoms usually ease lowers anxiety and helps her feel in control.
Give lifestyle advice.	Steps such as avoiding triggers like caffeine and alcohol, staying active and keeping the bedroom cool can reduce hot flushes and improve sleep.
Suggest layered clothes.	Layers can be removed quickly during a flush or night sweat, which keeps her comfortable and helps her sleep.
Refer for treatment options.	A health professional can discuss options such as hormone therapy or other treatments, weighing benefits and risks for her.
Check mood.	Mood changes and poor sleep can lead to low mood or anxiety, so checking mood finds problems that need extra support.

Expected outcomes

- Symptoms reduced.
- Sleep improves.
- Uses coping steps.
- Discusses treatment options.

Linking the data to the diagnosis

This is an actual problem because symptoms are already present. The 52-year-old woman says, "I wake up drenched," and has night sweats, hot flushes, disturbed sleep and mood changes. Her age and symptom pattern point to menopause, which fits better than an unrelated sleep problem. The plan reassures her, gives practical advice, suggests layers, refers for treatment options and checks mood. The aim is that symptoms are reduced, sleep improves, she uses coping steps and she discusses treatment options.

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About the author

Hamza Aradi, RN, BSN

I am a nurse because I love people and I love taking care of them. Over my time at the bedside I learned that good nursing is not only knowing the right procedure. It is noticing the person in front of you, listening, and acting with kindness and skill.

I also learned how hard professional nursing can feel when the language is complicated and the steps are scattered. I wrote CarePath to change that. My goal is to make professional nursing easier to understand and practice, so that students, new nurses, caregivers, and anyone who cares for others can learn it and use it with confidence.

I wrote each statement in plain words, with a real situation, clear actions, and the reason behind each action, because care is best when people understand why they do what they do. I want everyone who cares for others to have a clear path.

This book is not finished the day it is printed. I want it to keep improving with every reader and every patient. If you find a way to make it clearer, safer, or more useful, I would be glad to hear it.

Thank you for reading, and for caring.

Appendix A: CarePath Assessment Tools

20 original bedside scoring tools, one for each CarePath group. Each tool is on its own page for printing. Click a group or a diagnosis code to jump to it.

How to use

1. Score each item 0, 1 or 2 (pick the column that best fits).
2. Add the total and follow the action band (green / amber / red).
3. **Any red flag = escalate at once**, whatever the total. Use SBAR.
4. Pick the matching CarePath diagnosis from the "Links to" codes.
5. Rescore after each intervention and at least once per shift.

Code	Tool	Group	Diagnoses
CP-BREATH	Breathing & Circulation Check	Group B	B1-B14
CP-FLUID	Fluid Balance & Nutrition Score	Group F	F1-F13, E9
CP-ELIM	Elimination Check	Group E	E1-E9
CP-PAIN	Pain & Comfort Score	Group C	C1-C12, K4
CP-SAFE	Safety & Falls Score	Group S	S1-S26
CP-SKIN	Skin & Wound Score	Group W	W1-W7, S5
CP-MOVE	Movement & Self-Care Score	Group M	M1-M19
CP-MIND	Mood & Mind Screen	Group P	P1-P29
CP-TALK	Communication Check	Group R	R1-R16
CP-LEARN	Learning Readiness Check	Group L	L1-L13, T1-T8
CP-SPIRIT	Spiritual & Values Check	Group V	V1-V6
CP-MOTHER	Mother & Newborn Check	Group N	N1-N14
CP-CHILD	Child & Teen Check	Group K	K1-K12
CP-OLDER	Older Adult Check	Group A	A1-A8, P18
CP-SURG	Post-op & Critical Care Check	Group O	O1-O10
CP-NEURO	Brain & Senses Check	Group Z	Z1-Z7, B13
CP-INFECT	Infection Check	Group H	H1-H6, S11
CP-END	End-of-Life Comfort Check	Group D	D1-D5
CP-LONG	Long-Term Condition Check	Group T	T1-T8
CP-SEX	Sexual & Reproductive Health Check	Group X	X1-X4

Important: These are original tools that have not yet been validated. Pilot them and have them reviewed by clinicians before using them for clinical decisions. They support, but do not replace, clinical judgment, validated scales and local policy.

CP-BREATH Breathing & Circulation Check**Group B**Quick bedside check of breathing and circulation. **Links to: B1-B14**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Breathing rate (/min)	12-20	21-24 or 9-11	≥25 or ≤8	
Oxygen saturation	≥95%	92-94%	≤91%	
Work of breathing	Normal, full sentences	Some effort, short sentences	Neck muscles, 1-3 words	
Heart rate (/min)	51-100	41-50 or 101-130	≤40 or ≥131	
Systolic BP (mmHg)	101-160	91-100 or 161-199	≤90 or ≥200	
Skin and limbs	Warm, pink	Cool or mild swelling	Cold, mottled, blue	
TOTAL				

Score	Level	Action
0-2	Low	Routine checks every shift
3-5	Medium	Recheck within 1 hour, inform nurse in charge
≥6 or any item = 2	High	Escalate now (SBAR), stay with patient

⚠ **Red flags — escalate at once regardless of score:** New chest pain; SpO₂ ≤88%; unresponsive

Nursing notes / action taken:

CP-FLUID Fluid Balance & Nutrition Score**Group F**Tracks intake, output, hydration and eating. **Links to: F1-F13, E9**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Oral intake today	Eats >75% of meals	Eats 25–75%	Eats <25% or nil by mouth	
Fluid balance (24 h)	Within ± 500 mL	± 500 –1000 mL	More than ± 1000 mL	
Urine output	≥ 0.5 mL/kg/h	Reduced, dark	<0.5 mL/kg/h for 6 h	
Hydration signs	Moist mouth, normal skin	Dry mouth, thirsty	Sunken eyes, confused	
Weight change (1 week)	No change	1–2 kg change	More than 2 kg	
Swallowing / nausea	No problem	Mild nausea or slow swallow	Vomiting or coughing on food	
TOTAL				

Score	Level	Action
0–2	Low	Continue chart, encourage fluids
3–5	Medium	Strict input/output chart, daily weight, inform doctor
≥ 6	High	Doctor review today, dietitian / swallow referral

⚠ **Red flags — escalate at once regardless of score:** Urine <0.5 mL/kg/h for 6 h; glucose <4 or >20 mmol/L

Nursing notes / action taken:

CP-ELIM Elimination Check**Group E**Bladder and bowel function. **Links to: E1-E9**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Days since bowel opened	0–2 days	3 days	4 days or more	
Stool type	Soft, formed	Hard or loose	Watery ≥ 3 times/day or blood	
Passing urine	Normal	Frequent, urgent or burning	Unable to pass or very little	
Continence	Fully continent	Occasional leaks	Frequent incontinence	
Abdomen	Soft, no pain	Bloated or mild pain	Hard, swollen bladder or severe pain	
TOTAL				

Score	Level	Action
0–2	Low	Routine
3–5	Medium	Bowel/bladder plan, fluids and fibre, recheck daily
≥ 6	High	Bladder scan or doctor review today

⚠ **Red flags — escalate at once regardless of score:** No urine for 6 h; blood in stool; hard swollen abdomen

Nursing notes / action taken:

CP-PAIN Pain & Comfort Score**Group C**Pain plus how it affects rest and function. **Links to: C1-C12, K4**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Pain now (patient says 0-10)	0-3	4-6	7-10	
Face and body (if cannot speak)	Relaxed	Frowning, guarding	Grimacing, crying, rigid	
Effect on sleep	Sleeps well	Wakes sometimes	Cannot sleep	
Effect on movement	Moves freely	Moves with care	Will not move	
Relief from last dose	Good relief	Partial relief	No relief	
Nausea / itch / drowsiness	None	Mild	Severe or hard to wake	
TOTAL				

Score	Level	Action
0-2	Comfortable	Reassess every 4 h
3-6	Moderate	Give pain relief as ordered, comfort measures, reassess in 30-60 min
≥7	Severe	Inform doctor, review plan; hard to wake = stop opioid and escalate

⚠ **Red flags — escalate at once regardless of score:** Hard to wake after opioid; breathing <8/min

Nursing notes / action taken:

CP-SAFE Safety & Falls Score**Group S**Falls, wandering, medicines and injury risk. **Links to: S1-S26**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Fall in last 3 months	No	Near miss	Yes	
Walking	Steady	Uses aid	Unsteady or needs a person	
Mental state	Alert, knows limits	Sometimes forgets	Confused or impulsive	
Risky medicines	None	1 (sedative, BP, diuretic)	2 or more	
Toilet needs	Independent	Frequent or urgent	Incontinent, gets up alone	
Sight / hearing	Good	Mild problem	Severe problem	
TOTAL				

Score	Level	Action
0-3	Low	Standard safety: bed low, bell in reach
4-7	Medium	Falls bundle: non-slip socks, toilet rounds every 2 h
≥8	High	Bed near station, bed alarm, 1-hourly checks

⚠ **Red flags — escalate at once regardless of score:** Head injury after fall; on blood thinner after fall

Nursing notes / action taken:

CP-SKIN Skin & Wound Score**Group W**Pressure injury and wound risk. **Links to: W1-W7, S5**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Moves in bed	Changes position alone	Needs help sometimes	Cannot change position	
Skin moisture	Dry	Sometimes damp	Often wet (sweat, urine)	
Nutrition	Eats well	Eats half	Eats little	
Skin over bony areas	Intact	Red but fades on pressing	Red that does not fade or broken	
Wound (if present)	Healing, clean	Slow, some drainage	Smell, pus, spreading red	
TOTAL				

Score	Level	Action
0-2	Low	Check skin daily
3-5	Medium	Turn every 2-4 h, pressure-relief mattress
≥6	High	Turn every 2 h, wound plan, tissue-viability referral

⚠ **Red flags — escalate at once regardless of score:** Spreading redness with fever

Nursing notes / action taken:

CP-MOVE Movement & Self-Care Score**Group M**Independence in daily activities. **Links to: M1-M19**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Washing	Independent	Needs some help	Fully dependent	
Dressing	Independent	Needs some help	Fully dependent	
Eating	Independent	Needs set-up or help	Fed by others	
Toileting	Independent	Needs some help	Fully dependent	
Transfer bed-chair	Independent	One person helps	Two people or hoist	
Walking	Independent	With aid or person	Cannot walk	
TOTAL				

Score	Level	Action
0-3	Independent	Encourage self-care
4-7	Partly dependent	Assist with care, physio referral
≥8	Dependent	Full care plan, physio and OT, moving-and-handling plan

⚠ **Red flags — escalate at once regardless of score:** New sudden weakness on one side

Nursing notes / action taken:

CP-MIND Mood & Mind Screen**Group P**Low mood, anxiety, confusion and self-harm risk. **Links to: P1-P29**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Mood in last 2 weeks	Fine	Low some days	Low most days	
Worry / anxiety	Calm	Worried at times	Constant worry or panic	
Sleep and appetite	Normal	Changed	Much worse	
Interest in things	Normal	Less	None	
Orientation (time, place, person)	All correct	1 wrong	2-3 wrong or new confusion	
Thoughts of self-harm	No	Passive thoughts	Plan or intent — URGENT	
TOTAL				

Score	Level	Action
0-3	Low	Support and listen
4-7	Medium	Inform doctor, consider mental-health referral
≥8 or self-harm item = 2	High	Do not leave alone, escalate now

⚠ **Red flags — escalate at once regardless of score:** Any plan or intent to self-harm; sudden confusion

Nursing notes / action taken:

CP-TALK Communication Check**Group R**Barriers to communication and support. **Links to: R1-R16**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Language	Shares a language with staff	Partly	Needs interpreter	
Hearing / speech	Clear	Some difficulty	Cannot hear or speak	
Understanding	Understands	Needs repeats	Does not understand	
Family / support	Good support	Some support	No support or conflict	
TOTAL				

Score	Level	Action
0-2	Low	Routine
3-5	Medium	Use aids, simple words, picture cards
≥6	High	Interpreter, social work referral

⚠ **Red flags — escalate at once regardless of score:** Signs of abuse or neglect

Nursing notes / action taken:

CP-LEARN Learning Readiness Check**Group L**Readiness and ability to learn self-care. **Links to: L1-L13, T1-T8**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Wants to learn	Yes	Unsure	No	
Reading level	Reads well	Some difficulty	Cannot read	
Teach-back	Explains correctly	Partly correct	Cannot explain	
Practical skill (e.g. inhaler, insulin)	Does it correctly	Needs prompts	Cannot do it	
TOTAL				

Score	Level	Action
0-2	Ready	Teach, give leaflet
3-5	Needs support	Short sessions, teach-back each time, include family
≥6	Not ready	Involve carer, delay discharge teaching, refer

⚠ **Red flags — escalate at once regardless of score: —****Nursing notes / action taken:**

CP-SPIRIT Spiritual & Values Check**Group V**Beliefs and values that affect care. **Links to: V1-V6**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Faith / beliefs important to care	No needs	Some needs	Strong needs not met	
Distress about meaning or fear	None	Some	Severe	
Care choices conflict with beliefs	No	Unsure	Yes	
TOTAL				

Score	Level	Action
0-1	Low	Respect preferences
2-3	Medium	Offer chaplain or faith leader
≥4	High	Care conference with family and faith support

⚠ **Red flags — escalate at once regardless of score: —**

Nursing notes / action taken:

CP-MOTHER Mother & Newborn Check**Group N**Post-birth mother and newborn. **Links to: N1-N14**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Mother: blood loss	Normal	Heavier than expected	Soaking pad in <1 h	
Mother: BP / pulse	Normal	Slightly abnormal	BP $\geq$ 160/110 or pulse $\geq$ 120	
Mother: uterus	Firm	Soft, firms with massage	Soft, stays soft	
Baby: breathing	30–60/min, quiet	Fast or grunting	<30 or >60, colour change	
Baby: feeding	Feeds well	Poor latch	Not feeding	
Baby: colour / temperature	Pink, warm	Mild yellow or cool	Deep yellow, blue or cold	
TOTAL				

Score	Level	Action
0–2	Low	Routine checks
3–5	Medium	Midwife / senior review within 1 h
$\geq$6 or any item = 2	High	Emergency call now

⚠ **Red flags — escalate at once regardless of score:** Heavy bleeding; newborn breathing difficulty

Nursing notes / action taken:

CP-CHILD Child & Teen Check**Group K**Child condition and pain (age-adjusted). **Links to: K1-K12**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Behaviour	Playing, normal	Irritable or sleepy	Floppy, hard to wake	
Breathing	Normal for age	Faster, some effort	Grunting, chest pulling in	
Colour / circulation	Pink	Pale	Grey or mottled	
Pain (face, crying)	Content	Crying, consolable	Inconsolable	
Family concern	None	Some	Very worried	
TOTAL				

Score	Level	Action
0-2	Low	Routine
3-5	Medium	Senior review within 1 h
≥6	High	Escalate now

⚠ **Red flags — escalate at once regardless of score:** Parent says 'not my child'; seizure

Nursing notes / action taken:

CP-OLDER Older Adult Check**Group A**Frailty, delirium and memory. **Links to: A1–A8, P18**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Alertness	Normal	Sleepy or agitated	Hard to wake	
Attention (months backwards)	No errors	1–2 errors	Cannot start	
Change from usual self	No	Mild change	Sudden change	
Frailty (daily life)	Active	Needs help outside	Needs help at home	
Medicines	<5	5–9	≥10	
TOTAL				

Score	Level	Action
0–2	Low	Routine
3–5	Medium	Delirium prevention: glasses, aids, clock, sleep, fluids
≥6 or sudden change	High	Doctor review for delirium today

⚠ **Red flags — escalate at once regardless of score:** Sudden confusion

Nursing notes / action taken:

CP-SURG Post-op & Critical Care Check**Group 0**Recovery after surgery or sedation. **Links to: 01-010**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Conscious level	Awake	Responds to voice	Responds to pain only	
Breathing / SpO₂	Normal, ≥95%	Shallow, 92-94%	≤91% or noisy	
Wound / drain	Dry	Some ooze	Soaked or fast drain output	
Pain	0-3	4-6	7-10	
Nausea / vomiting	None	Nausea	Vomiting	
Urine since surgery	Passed	Not yet, <6 h	None in 6 h	
TOTAL				

Score	Level	Action
0-2	Ready	Ward transfer / routine
3-5	Watch	15-30 min checks
≥6	High	Anaesthetist / surgeon now

⚠ **Red flags — escalate at once regardless of score:** Fast bleeding; airway noise

Nursing notes / action taken:

CP-NEURO Brain & Senses Check**Group Z**Conscious level and nerve function. **Links to: Z1-Z7, B13**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Responds	Eyes open, talks normally	Confused or to voice only	To pain only or none	
Pupils	Equal, react	Slow	Unequal or fixed	
Limbs	Equal strength	Mild weakness	One side weak	
Speech / face	Normal	Slurred	Face droop or no speech	
Headache / vomiting	None	Mild	Severe or vomiting	
TOTAL				

Score	Level	Action
0-1	Low	Neuro checks every 4 h
2-4	Medium	Hourly neuro checks, inform doctor
≥5 or new deficit	High	Stroke / emergency call now

⚠ **Red flags — escalate at once regardless of score:** Face droop, arm weakness, speech change

Nursing notes / action taken:

CP-INFECT Infection Check**Group H**Infection and sepsis warning. **Links to: H1-H6, S11**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Temperature	36.1–38.0 °C	38.1–39 °C or 35.1–36	≥39.1 or ≤35 °C	
Heart rate	≤90	91–130	≥131	
Breathing rate	≤20	21–24	≥25	
Mental state	Normal	Slightly changed	New confusion	
Infection source	None seen	Possible	Clear (wound, urine, chest)	
TOTAL				

Score	Level	Action
0–2	Low	Routine, hand hygiene
3–5	Medium	Sepsis screen, inform doctor
≥6	High	Treat as sepsis: escalate now, cultures, antibiotics within 1 h as ordered

⚠ **Red flags — escalate at once regardless of score:** Low BP with fever

Nursing notes / action taken:

CP-END End-of-Life Comfort Check**Group D**Symptoms at end of life. **Links to: D1-D5**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Pain	None	Mild	Severe	
Breathlessness	None	Mild	Severe	
Agitation	Calm	Restless	Distressed	
Noisy secretions	None	Some	Loud	
Mouth care	Moist, clean	Dry	Sore or cracked	
Family coping	Coping	Struggling	In crisis	
TOTAL				

Score	Level	Action
0-2	Comfortable	Continue comfort care
3-6	Some symptoms	As-needed medicines, palliative input
≥7	Distress	Urgent palliative review

⚠ **Red flags — escalate at once regardless of score: —**

Nursing notes / action taken:

CP-LONG Long-Term Condition Check**Group T**Self-management of chronic illness. **Links to: T1-T8**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Knows condition	Yes	Partly	No	
Takes medicines as prescribed	Always	Sometimes misses	Often misses	
Monitors self (BP, sugar, weight)	Regularly	Sometimes	Never	
Attends follow-up	Always	Sometimes	Rarely	
Lifestyle (diet, smoking, activity)	Healthy	Some risks	Many risks	
TOTAL				

Score	Level	Action
0-2	Good	Encourage
3-6	Fair	Teaching plan, set 1-2 goals
≥7	Poor	Specialist nurse / clinic referral

⚠ **Red flags — escalate at once regardless of score: —**

Nursing notes / action taken:

CP-SEX Sexual & Reproductive Health Check**Group X**Private, respectful screening. **Links to: X1-X4**

Patient: _____ ID: _____ Date/Time: _____ Nurse: _____

Item	0	1	2	Score
Concerns raised	None	Some	Major	
Effect of illness / medicine	None	Some	Major	
Needs information	No	Some	Much	
TOTAL				

Score	Level	Action
0-1	Low	Offer to talk later
2-3	Medium	Give information, privacy
≥4	High	Refer to specialist

⚠ Red flags — escalate at once regardless of score: Signs of abuse

Nursing notes / action taken:

Appendix B: CarePath Cheat Sheet

A Actual **R** Risk **URGENT** escalate per policy · → first 3 nursing actions

Priority: ABC first (Airway → Breathing → Circulation) → Safety → Comfort → Teaching & support. **Format:** Problem *related to* cause *as evidenced by* signs (risk: risk factors only). **Escalate:** SBAR · ABCDE · **Goals:** SMART.

B Breathing and circulation 14 <i>Assess: CP-BREATH · NEWS2 · SpO₂ · ECG</i>	F Food and fluids 13 <i>Assess: CP-FLUID · MUST · fluid chart · glucose</i>	E2 Frequent loose stools A → Replace fluids · Protect skin with barrier cream · Use infection precautions	C8 Pain near end of life A → Assess often, including by behavior · Give pain relief regularly as ordered · Reposition gently
B1 Struggling to breathe comfortably A → Sit him upright · Check breathing rate and oxygen level · Give oxygen or medicine as ordered	F1 Not eating enough to meet body needs A → Weigh weekly · Offer small frequent meals · Involve a dietitian	E3 Unable to empty the bladder A → Check with a bladder scan or palpation as ordered · Offer privacy and a normal position · Try running water or warm water	C9 Muscle cramps or spasms A → Stretch and massage gently · Give fluids · Check salt levels
B2 Poor oxygen exchange in the lungs A → Raise the head of the bed · Give oxygen as ordered · Check oxygen and breathing often	F2 Eating more than the body needs A → Assess eating habits · Set small realistic goals · Teach portion control and activity	E4 Leaking urine A → Teach pelvic floor exercises · Set a toileting schedule · Use pads	C10 Headache A → Assess pain and warning signs · Rest in a quiet dark room · Give pain relief as ordered
B3 Airway blocked by secretions A → Airway upright · Teach deep breathing and supported coughing · Give fluids and humidified air if ordered	F3 Dehydration A → Measure intake and output · Give oral rehydration or intravenous fluids as ordered · Weigh	E5 Unable to reach the toilet in time A → Place the bed near the toilet · Use a commode · Set regular toilet times	C11 Dry mouth or thirst A → Give frequent mouth care · Offer ice chips or sips if allowed · Use lip balm
B4 Weak heart pumping A → Check pulse, blood pressure, and weight daily · Give heart medicines as ordered · Limit fluid and salt if ordered	F4 Fluid build-up in the body A → Measure fluids in and out · Weigh daily · Limit fluids and salt as ordered	E6 Bowel leakage A → Set a bowel routine · Clean skin gently and use barrier cream · Use pads	C12 Noise or light disturbing rest A → Close doors · Lower voices and alarms · Dim lights at night
B5 Poor blood flow to hands or feet A → Check pulses, color, and warmth · Keep limbs warm but avoid heat pads · Avoid tight clothing	F5 Unsteady blood sugar R URGENT → Check blood sugar before meals and if symptoms appear · Call the kitchen and give a snack if the meal is late · Treat blood sugar below 4 mmol/L at once per protocol and recheck in 15 minutes	E7 Burning or pain passing urine A → Encourage fluids · Give antibiotics as ordered · Send a urine sample	S Safety and protection 26 <i>Assess: CP-SAFE · Morse Fall Scale</i>
B6 Unstable blood pressure R → Check blood pressure at ordered times with the right cuff size, lying and standing · Give medicines as ordered and note the time of each dose · Encourage fluids as allowed and record intake		E8 Likely to get urine infection from a catheter R → Use clean technique · Keep the bag below the bladder · Give catheter care	S1 Likely to fall R → Assess fall risk · Keep the bed low with the call bell in reach · Non-slip shoes
B7 Fluid in the lungs A URGENT → Sit upright · Give oxygen and diuretics as ordered · Monitor fluid balance and weight	F6 Trouble chewing or swallowing A → Screen swallowing · Sit upright for meals · Follow texture advice from the speech therapist	E9 Very little urine being made A URGENT → Measure output accurately · Check the catheter for kinks · Encourage fluids if allowed	S2 Likely to catch an infection R → Wash hands · Use clean technique for dressings and lines · Monitor temperature
B8 Low blood oxygen needing support A URGENT → Give oxygen at the ordered flow · Check equipment and tubing · Position upright	F7 Vomiting A → Give anti-sickness medicine as ordered · Keep upright · Offer small sips	C Comfort and rest 12 <i>Assess: CP-PAIN · NRS 0–10 · FLACC · PAINAD</i>	S3 Likely to get hurt R → Remove hazards · Supervise · Meet needs early
B9 Needs breathing machine support A → Check tube position and ventilator settings · Suction as needed · Give mouth care	F8 Needs tube feeding A → Check tube position before each feed · Keep head raised at least 30 degrees · Flush as ordered	C1 Short-term pain A → Assess pain with a scale · Give pain relief on time · Reposition	S4 Broken or damaged skin A → Assess skin daily · Clean and dress as ordered · Protect from friction and moisture
B10 Swollen legs or feet A → Raise legs when sitting · Weigh daily · Follow salt and fluid advice	F9 Breastfeeding difficulty A → Teach positions and latch · Encourage skin-to-skin contact · Treat soreness	C2 Long-lasting pain A → Assess pain and its effect on life · Give regular medicines as ordered · Teach pacing, gentle exercise, and relaxation	S5 Likely to develop pressure sores R → Turn every 2 hours or per plan · Check skin · Use a pressure-relieving mattress
B11 Irregular heartbeat A → Check pulse and blood pressure · Connect to monitor if ordered · Report symptoms	F10 Body salts out of balance R → Check blood results · Give replacements as ordered · Monitor heart rhythm	C3 Feeling sick to the stomach A → Give anti-sickness drugs as ordered · Keep the air fresh · Offer small sips	S6 Likely to bleed easily R → Check blood tests (INR) as ordered and report values above target · Check with the prescriber before each warfarin dose while the INR is above target; give at the same time each day as ordered · Use a soft toothbrush and electric razor
B12 Dizzy when standing up R → Check lying and standing blood pressure · Have him sit on the bed edge before standing · Rise slowly	F11 Poor appetite A → Find the cause · Offer favorite foods and small meals · Make meals pleasant	C4 Unable to sleep well A → Group care to allow rest · Reduce noise and light · Avoid caffeine late in the day	S7 Body temperature too high or too low A URGENT → Check temperature · Add or remove layers · Give fluids
B13 Poor blood flow to the brain R URGENT → Check blood pressure and pulse, and do a quick brain check (face, arm, speech) each shift · Give the blood thinner as ordered and explain why every dose matters · Teach the signs of stroke: face drooping, arm weakness, slurred speech	F12 Sore or damaged mouth A → Give mouth care with a soft brush · Use rinses as ordered · Avoid spicy or hot food	C5 Constant tiredness A → Plan rest periods · Space out activities · Treat causes	S8 Likely to inhale food or fluid R → Sit fully upright to eat · Supervise meals · Follow swallow advice
B14 Very low blood circulation (shock) R URGENT → Check pulse, blood pressure, breathing, skin and mental state every 15 minutes · Control any bleeding and keep the patient warm · Give oxygen and fluids or blood as ordered	F13 Unplanned weight loss A → Weigh regularly · Look for causes · Give high-energy foods and supplements	C6 Itching or skin discomfort A → Keep skin moist · Trim nails · Use cool compresses	S9 Slow wound or surgical healing R → Check the wound every shift · Support nutrition · Control blood sugar
E Elimination 9 <i>Assess: CP-ELIM · Bristol Stool Chart · bladder scan</i>	E1 Hard or infrequent bowel movements A → Encourage fluids, fiber, and movement · Offer toilet privacy · Give laxatives as ordered	C7 Side effects of pain medicine A URGENT → Check sedation level and breathing rate before and after each dose; if drowsy or breathing slowly (under 10/ min), hold the dose and call for help at once · Give oxygen and prepare an opioid antagonist (for example naloxone) as ordered · Give laxatives and anti-sickness medicine as ordered	S10 Reaction to medicine or allergen R URGENT → Check allergies before every drug · Use an allergy band · Observe after new medicines

S11 Likely to develop blood clots R

→ Give clot prevention as ordered · Encourage early movement and fluids as allowed · Check both legs each shift for swelling, pain, redness or warmth

S12 Likely to bleed heavily after surgery R URGENT

→ Check dressings, drain output and vital signs at ordered times · Keep dressings intact and mark any leaking area · Report quickly rising drain output, bright blood, rising pulse, falling blood pressure or paleness at once

S13 Wrong medicine or dose R

→ Check the patient's name band and ask the patient to state their name before every medicine · Check drug, dose, time, route and allergies against the order · Mark similar-name patients with an alert

S14 Harm from restraints R

→ Use the least restrictive option · Follow policy · Check restraints often

S15 Likely to wander or get lost R

→ Use an ID band · Place near the nursing station · Distract and redirect

S16 Burn or scald risk R

→ Test water temperature · Avoid heat packs on numb skin · Supervise baths

S17 Choking R URGENT

→ Cut food small and serve soft foods if needed · Sit upright and supervise every meal · Remind to eat slowly without talking

S18 Poisoning risk R URGENT

→ Teach parents to lock medicines and chemicals away, out of sight and reach · Use child-safe lids and keep medicines in original labelled containers · Give the poison-control number and put it near the phone

S19 Unsafe home R

→ Do a home safety check · Improve lighting · Clear clutter and secure loose items

S20 Abuse or violence exposure R

→ Ask privately and kindly · Ensure safety · Document facts

S21 Likely to harm others R

→ Stay calm · Keep a safe distance · Give space

S22 Staff exposure to needles or body fluids (workplace safety) R

→ Use safety devices · Keep a sharps bin at the point of use · Never recap

S23 Nerve or limb damage from positioning R

→ Pad and support limbs · Avoid pressure · Reposition

S24 Likely to spread infection to others R

→ Use isolation as needed · Do hand hygiene · Wear masks and gloves

S25 Eye damage in unconscious patients R

→ Clean eyes · Use lubricant · Close eyes gently or cover as ordered

S26 Injury during seizure R URGENT

→ Give anti-seizure medicine on time and as ordered · Keep the bed low and padded; clear the area · Teach the patient and family seizure first aid

M Movement and self-care

19

Assess: CP-MOVE · Barthel Index · Katz ADL

M1 Limited ability to move A

→ Give pain relief before activity · Assist with exercises · Encourage safe movement

M2 Tires quickly during activity A

→ Pace activity · Allow rest · Check pulse and breathing

M3 Cannot turn or change position in bed A

→ Use turning aids · Assist safely · Reposition regularly

M4 Difficulty walking A

→ Assess walking · Use a walking aid · Physiotherapy

M5 Needs help to wash A

→ Assist as needed · Let him do what he can · Ensure privacy

M6 Needs help to dress A

→ Offer easy-fit clothing · Dress the affected side first · Allow time

M7 Needs help to eat A

→ Set up the meal · Use adaptive cutlery · Give time

M8 Needs help to use the toilet A

→ Provide a raised seat and rails · Assist and give privacy · Schedule toileting

M9 Too little physical activity A

→ Set small goals · Teach benefits · Start gently

M10 Difficulty using a walking aid A

→ Check the fit · Teach technique · Practice with supervision

M11 Muscle weakness A

→ Encourage exercise · Physiotherapy · Give protein-rich nutrition

M12 Stiff joints or shortened muscles A

→ Do range-of-motion exercises · Position correctly · Use splints as ordered

M13 Cannot groom or care for appearance A

→ Assist with grooming · Encourage independence · Offer choices

M14 Unsafe wheelchair or transfer A

→ Use hoists or slide sheets · Use two staff when needed · Lock wheels

M15 Cannot do household tasks A

→ Assess abilities · Arrange home help · Teach safe methods

M16 Poor balance A

→ Assess balance · Use an aid · Non-slip shoes

M17 Loss of limb movement A

→ Position correctly · Do passive exercises · Protect from injury

M18 Muscle wasting from bed rest R

→ Mobilize early · Exercise · Give protein nutrition

M19 Poor body positioning A

→ Align the body · Support with pillows · Reposition often

P Emotions and mind

29

Assess: CP-MIND · PHQ-9 · GAD-7 · C-SSRS

P1 Worry or nervousness A

→ Stay calm · Listen · Explain the next steps simply

P2 Fear of a specific thing A

→ Explain in simple words · Let the child hold a toy · Show the equipment

P3 Difficulty handling stress A

→ Listen · Explore how he copes · Teach relaxation

P4 Loss of hope A

→ Show interest · Set tiny goals · Encourage hope

P5 Feeling no control over one's situation A

→ Give information · Offer choices · Involve him in the care plan

P6 Low self-worth A

→ Reflect strengths · Praise efforts · Give him a role in his care

P7 Unhappy with body appearance A

→ Allow her to express feelings · Support her at her own pace · Involve her partner

P8 Sadness after a loss A

→ Listen · Allow tears · Do not rush

P9 Risk of self-harm (needs urgent response) R URGENT

→ Take every statement seriously and stay with the patient · Ask directly and kindly about thoughts of suicide and use the structured risk tool required by local policy · Remove hazards and keep the patient under the observation level ordered

P10 Distress after a frightening event A

→ Create a safe place · Listen without pushing · Teach grounding

P11 Confusion or memory problems A

→ Reorient gently · Use clocks and calendars · Keep routines

P12 Low mood A

→ Listen · Encourage activity · Support routine

P13 Anger or aggression A

→ Stay calm · Give space · Listen

P14 Extreme mood swings A

→ Stay calm and consistent · Keep stimulation low · Teach coping

P15 Hearing or seeing things others do not A

→ Do not argue · Reassure · Ask about the voices and any commands

P16 Suspicious or distorted thinking A

→ Stay calm and honest · Do not argue · Keep routines

P17 Poor concentration A

→ Give short clear instructions · Reduce distractions · Repeat

P18 Sudden confusion A URGENT

→ Look for the cause · Check vital signs and blood sugar · Reorient

P19 Difficulty making decisions A

→ Give balanced information · Explore her values · Allow time

P20 Trouble controlling impulses A

→ Set clear limits · Teach coping · Reward self-control

P21 Dependence on alcohol or drugs A

→ Assess without judging · Monitor for withdrawal · Motivate

P22 Withdrawal symptoms A

→ Use a withdrawal scale · Give medicines as ordered · Monitor vital signs

P23 Harmful eating behaviors A

→ Build trust · Supervise meals as planned · Avoid blame

P24 Self-injury A

→ Treat wounds calmly · Do not judge · Assess safety and suicide risk

P25 Guilt or shame A

→ Listen · Correct unfair self-blame gently · Encourage forgiveness

P26 Long-lasting grief A

→ Acknowledge the pain · Offer grief counseling · Encourage support groups

P27 Stress from illness or hospital stay A

→ Explain the surroundings and routines · Encourage questions · Allow personal items

P28 Loss of sense of identity A

→ Explore values and strengths · Encourage meaningful activity · Link to peer support

P29 Ready for better coping A

→ Praise readiness · Teach skills · Set goals

R Communication and relationships

16

Assess: CP-TALK · Communication barrier checklist

R1 Difficulty speaking or being understood A

→ Speak slowly · Use yes or no questions · Use picture boards

R2 Difficulty hearing or seeing A

→ Check hearing and vision aids · Reduce noise · Face the patient

R3 Feeling alone or cut off from others A

→ Encourage contact · Arrange visits · Link to community groups

R4 Struggling with family or work roles A

→ Explore feelings · Help redefine roles · Involve family

R5 Family caregiver overwhelmed A

→ Acknowledge her effort · Teach skills · Encourage breaks

R6 Conflict or breakdown in family support A

→ Hold a family meeting · Give facts · Mediate

R7 Difficulty trusting or cooperating with care A

→ Build trust · Listen · Explain reasons

R8 Not enough help at home A

→ Assess needs · Arrange home care · Involve family and a social worker

R9 Language barrier A

→ Use a qualified interpreter · Use simple words and pictures · Give translated leaflets

R10 Trouble understanding health information A

→ Use plain words · Short steps · Teach-back

R11 Relationship or intimacy difficulty A

→ Create a private safe space · Give information · Include the partner

R12 Abuse or neglect in the family A

→ Observe and document · Speak privately · Ensure safety

R13 Parenting difficulty A

→ Teach skills · Praise efforts · Arrange support

R14 Weak bond between parent and baby R

→ Encourage touch and skin-to-skin care · Involve her in care · Explain baby's cues

R15 Loss of privacy or dignity R

→ Use curtains and screens · Knock before entering · Keep covered

R16 Care conflicts with culture A

→ Ask respectfully · Adapt where safe · Involve family and chaplain

L Learning and self-management 13

Assess: CP-LEARN · Teach-back

L1 Not enough knowledge about the condition A

→ Assess what they know · Teach simply · Use pictures

L2 Not following the treatment plan A

→ Ask kindly why · Explain benefits · Simplify the plan

L3 Difficulty managing medicines A

→ Review medicines · Use a pill box · Give a simple schedule

L4 Difficulty managing the illness at home A

→ Assess needs · Teach self-care · Set a routine

L5 Ready to learn and improve health A

→ Reinforce readiness · Give tailored teaching · Set goals

L6 Unsure how to use equipment or devices A

→ Demonstrate · Ask for a return demonstration · Give written steps

L7 Unsafe medicine use at home A

→ Review all medicines · Teach safe use · Remove expired drugs

L8 Struggling to manage long-term illness A

→ Set small goals · Teach self-monitoring · Suggest support groups

L9 Unhealthy habits (smoking, inactivity) A

→ Give nonjudgmental advice · Use motivational talk · Set goals

L10 Cannot reach health services A

→ Identify barriers · Arrange transport · Use telehealth

L11 Cannot afford care or medicines A

→ Refer to a social worker · Explore assistance programs · Consider generic options

L12 Not ready for discharge A

→ Assess readiness · Teach · Arrange equipment and home support

L13 Believes wrong health information A

→ Listen · Correct kindly with facts · Use trusted sources

V Spiritual and values 6

Assess: CP-SPIRIT · FICA spiritual screen

V1 Struggling with meaning, faith, or purpose A

→ Listen without judging · Offer presence · Offer a chaplain

V2 Conflict between care and personal beliefs A

→ Respect values · Explain options and risks · Involve the ethics team

V3 Ready to grow spiritually A

→ Support practices · Arrange a quiet space · Offer a chaplain

V4 Wishes about end of life unclear A

→ Open the conversation gently · Explain options · Document wishes

V5 Fear of dying A

→ Listen · Stay with the patient · Control symptoms

V6 Cannot practice faith or rituals A

→ Ask about needs · Provide a clean space · Adjust schedules

N Maternal and newborn 14

Assess: CP-MOTHER · MEOWS · APGAR

N1 Pregnancy discomfort A

→ Reassure · Teach comfortable positions · Suggest small meals

N2 High-risk pregnancy R

→ Arrange regular visits · Monitor vital signs and baby movement · Teach warning signs

N3 Fear of labor A

→ Explain the stages · Teach breathing and comfort methods · Tour the labor ward

N4 Labor pain A

→ Offer comfort · Massage · Position changes

N5 Risk of heavy bleeding after birth R URGENT

→ Check bleeding, uterus firmness and vital signs at ordered times · Massage the uterus if it feels soft · Check pads and weigh them if bleeding seems heavy

N6 Slow recovery after birth A

→ Give pain relief · Encourage rest and mobility · Wound care

N7 Baby feeding poorly A

→ Check the latch · Wake the baby · Set a feeding plan

N8 Baby's temperature unstable A

→ Do skin-to-skin contact · Warm the room · Use a hat

N9 Newborn jaundice A

→ Check bilirubin · Feed often · Give phototherapy as ordered

N10 Newborn breathing difficulty A URGENT

→ Call for help · Give oxygen · Keep warm

N11 Difficulty adjusting to new parenthood R

→ Teach baby care · Encourage rest · Involve the partner

N12 Sadness after childbirth A

→ Listen · Screen mood · Encourage support and rest

N13 Grief after pregnancy loss A

→ Show compassion · Allow time with the baby · Offer keepsakes

N14 Family planning questions A

→ Give balanced information · Respect choices · Explain options

K Child and teen 12

Assess: CP-CHILD · PEWS · FLACC

K1 Slow growth A

→ Measure growth · Make a feeding plan · Involve a dietitian

K2 Delayed development A

→ Screen development · Encourage stimulation · Refer for therapy

K3 Fear of hospital or procedures A

→ Explain simply · Allow play · Let a parent stay

K4 Child cannot express pain A URGENT

→ Use a faces pain scale · Observe behavior · Comfort

K5 Accident risk at home R

→ Child-proof the home · Teach parents · Supervise

K6 Distress when separated from parents A

→ Encourage a parent to stay · Keep routines · Offer a comfort object

K7 Behavior problems A

→ Set limits · Praise good behavior · Distract

K8 Missing school due to illness A

→ Liaise with the school · Arrange hospital teaching · Plan catch-up

K9 Risk-taking behavior in teens A

→ Talk without judging · Teach the risks · Encourage support

K10 Infant dehydration risk R

→ Give oral rehydration · Breastfeed · Monitor diapers

K11 Unsafe infant sleep R

→ Turn the baby onto his back and remove the pillow and loose bedding now · Teach safe sleep: on the back, firm flat mattress, nothing soft in the cot · Keep the baby cool and avoid heavy blankets

K12 Missed vaccinations A

→ Check records · Explain benefits · Address fears

A Older adult 8

Assess: CP-OLDER · 4AT / CAM · Mini-Cog

A1 Frailty A

→ Assess strength and nutrition · Start an exercise program · Prevent falls

A2 Memory loss A

→ Assess · Use reminders · Keep routines

A3 Too many medicines R

→ Review the list · Involve a pharmacist · Ask the prescriber or pharmacist to remove duplicate medicines

A4 Loneliness at home R

→ Encourage visits · Link to community groups · Arrange phone calls

A5 Neglect or money exploitation risk R

→ Ask privately · Document · Report per policy

A6 Unsafe to live alone A

→ Assess abilities · Make the home safe · Arrange services

A7 Difficulty adjusting to a care home A

→ Orient her · Allow personal belongings · Involve family

A8 Loss of independence A

→ Respect choices · Encourage independence · Use adaptive aids

W Wounds and skin 7

Assess: CP-SKIN · Braden Scale · TIME wound chart

W1 Wound not healing A

→ Assess the wound · Treat the cause · Dress as ordered

W2 Heavy wound drainage A

→ Use absorbent dressings · Protect surrounding skin · Measure drainage

W3 Pressure sore present A

→ Relieve pressure · Dress as ordered · Turn regularly

W4 Difficulty caring for a stoma A

→ Teach and practice · Check skin · Use a skin barrier

W5 Fragile skin or skin tears R

→ Handle gently · Keep skin moist · Protect limbs

W6 Skin reaction to cancer treatment A

→ Clean gently · Apply moisturizer as ordered · Advise loose cotton clothes

W7 Rash or skin infection A

→ Wash hands · Clean skin · Give medicine as ordered

O Surgery and intensive care 10

Assess: CP-SURG · RASS · CPOT · Aldrete

O1 Fear before surgery A

→ Explain the steps · Allow questions · Teach breathing

O2 Breathing problems after anaesthesia A URGENT

→ Open the airway · Give oxygen · Stimulate

O3 Risk of internal bleeding after surgery R URGENT

→ Check vital signs, abdomen and dressings at ordered times · Report a rising pulse, falling blood pressure, pallor, abdominal swelling or new pain at once · Call the surgeon if bleeding is suspected

O4 Drain, tube, or line problems R

→ Secure tubes · Check they are open · Teach the patient not to pull

O5 Infection from lines R

→ Use aseptic technique · Clean hubs · Check the site

O6 Slow gut recovery after surgery A

→ Encourage walking · Limit opioids · Give intravenous fluids as ordered, and keep nothing by mouth if instructed

O7 Needs of sedated or unconscious patient R

→ Turn regularly · Give eye and mouth care · Suction

O8 Discomfort from tubes A

→ Give comfort · Secure the tube · Give sedation as ordered

O9 Sleep loss in ICU A

→ Group care · Dim lights · Reduce noise

O10 Family distress in ICU A

→ Give updates · Explain equipment · Allow visits

Z Brain and senses 7

Assess: CP-NEURO · GCS · pupils · NIHSS

Z1 Difficulty understanding speech A

→ Use short sentences · Use gestures and pictures · Repeat

Z2 Ignoring one side of the body A

→ Approach from the affected side · Cue him to scan · Arrange items

Z3 Risk of seizures R URGENT

→ Give anti-seizure medicine on time, and tell the doctor at once if vomiting stops tablets staying down · Keep the bed low, padded, and the area clear · Teach seizure precautions to the patient and family

Z4 Adjusting to vision loss A

→ Orient him to the space · Label items · Teach safe mobility

Z5 Adjusting to hearing loss A

→ Face the patient · Reduce noise · Speak clearly

Z6 Risk of injury from numbness R

→ Check both feet daily for cuts, blisters and color change · Protect from heat and cold; test bath water with the elbow · Teach to wear shoes and socks at all times and check shoes before wearing

Z7 Raised pressure in the brain A URGENT

→ Call for help urgently · Raise the head to 30 degrees and keep the neck straight · Do neurological checks (alertness, pupils, limb movement) as ordered

H Infection and community health 6

Assess: CP-INFECT · qSOFA / sepsis screen

H1 Exposed to an infectious disease R

→ Do hand hygiene · Wear masks · Isolate the source patient

H2 Distress from isolation A

→ Explain the reasons · Allow calls · Keep routines

H3 Outbreak risk in community R

→ Report · Isolate · Trace contacts

H4 Unsafe water or sanitation R

→ Teach boiling and treatment of water · Improve sanitation · Report

H5 Crowded living conditions R

→ Teach hygiene · Improve ventilation · Screen

H6 Poor hygiene practices A

→ Teach handwashing · Provide soap · Model good habits

D End of life 5

Assess: CP-END · ESAS

D1 Needs comfort near death A

→ Control symptoms · Give mouth care · Reposition gently

D2 Family grief before death A

→ Listen · Encourage goodbyes · Explain changes

D3 Unfinished affairs or wishes A

→ Listen · Help plan visits · Involve a social worker and chaplain

D4 Distressing symptoms near death A

→ Give comfort medicines as ordered · Reposition · Give mouth care

D5 Needs bereavement support A

→ Offer condolences · Give information on grief · Refer to counseling

T Long-term illness 8

Assess: CP-LONG · Self-management review

T1 Uncontrolled high blood pressure A

→ Check technique · Encourage taking medicine · Reduce salt

T2 Foot problems in diabetes R

→ Check feet daily · Use proper shoes · Keep feet clean and dry

T3 Lung disease flare-ups A

→ Give medications as ordered · Give oxygen · Position

T4 Difficulty following fluid limits A

→ Teach limits · Offer ice chips or sugar-free candy · Measure intake

T5 Dialysis access care R

→ Protect the arm · No blood pressure or needles on that arm · Check the thrill

T6 Cancer treatment side effects A

→ Give anti-sickness medicine · Mouth care · Rest

T7 Difficulty accepting long-term illness A

→ Listen · Give information · Suggest support groups

T8 Weak immune system R

→ Protect from infection · Hygiene · Vaccines as advised

X Sexual and reproductive health 4

Assess: CP-SEX · PLISSIT

X1 Concern about sexual function A

→ Provide privacy · Give information · Include the partner

X2 Concern about fertility A

→ Listen · Give information · Refer for testing

X3 Needs safe-sex knowledge A

→ Give clear information · Discuss protection and testing · Keep confidentiality

X4 Menopause symptoms A

→ Reassure · Give lifestyle advice · Suggest layered clothes

Appendix C: Alphabetical Index

All 238 diagnoses A–Z · code · type · page number in the complete book

A			
Abuse or neglect in the family	R12	A	153
Abuse or violence exposure	S20	R	91
Accident risk at home	K5	R	194
Adjusting to hearing loss	Z5	A	230
Adjusting to vision loss	Z4	A	229
Airway blocked by secretions	B3	A	27
Anger or aggression	P13	A	128
B			
Baby feeding poorly	N7	A	182
Baby's temperature unstable	N8	A	183
Behavior problems	K7	A	196
Believes wrong health information	L13	A	169
Body salts out of balance	F10	R	47
Body temperature too high or too low	S7	A	78
URGENT			
Bowel leakage	E6	A	56
Breastfeeding difficulty	F9	A	46
Breathing problems after anaesthesia	O2	A	218
URGENT			
Broken or damaged skin	S4	A	76
Burn or scald risk	S16	R	87
Burning or pain passing urine	E7	A	57
C			
Cancer treatment side effects	T6	A	249
Cannot afford care or medicines	L11	A	168
Cannot do household tasks	M15	A	111
Cannot groom or care for appearance	M13	A	109
Cannot practice faith or rituals	V6	A	175
Cannot reach health services	L10	A	167
Cannot turn or change position in bed	M3	A	100
Care conflicts with culture	R16	A	157
Child cannot express pain	K4	A	193
URGENT			
Choking	S17	R	88
URGENT			
Concern about fertility	X2	A	254
Concern about sexual function	X1	A	253
Conflict between care and personal beliefs	V2	A	172
Conflict or breakdown in family support	R6	A	148
Confusion or memory problems	P11	A	126
Constant tiredness	C5	A	64
Crowded living conditions	H5	R	237
D			
Dehydration	F3	A	41
Delayed development	K2	A	192
Dependence on alcohol or drugs	P21	A	135
Dialysis access care	T5	R	248
Difficulty accepting long-term illness	T7	A	250
Difficulty adjusting to a care home	A7	A	207
Difficulty adjusting to new parenthood	N11	R	186
Difficulty caring for a stoma	W4	A	212
Difficulty following fluid limits	T4	A	248
Difficulty handling stress	P3	A	119
Difficulty hearing or seeing	R2	A	145
Difficulty making decisions	P19	A	133
Difficulty managing medicines	L3	A	161
Difficulty managing the illness at home	L4	A	161
Difficulty speaking or being understood	R1	A	144
Difficulty trusting or cooperating with care	R7	A	149
Difficulty understanding speech	Z1	A	227
Difficulty using a walking aid	M10	A	107
Difficulty walking	M4	A	101
Discomfort from tubes	O8	A	223
Distress after a frightening event	P10	A	125
Distress from isolation	H2	A	235
Distress when separated from parents	K6	A	195
Distressing symptoms near death	D4	A	242
Dizzy when standing up	B12	R	35
Drain, tube, or line problems	O4	R	219
Dry mouth or thirst	C11	A	70
E			
Eating more than the body needs	F2	A	40
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Extreme mood swings	P14	A	129
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F			
Family caregiver overwhelmed	R5	A	147
Family distress in ICU	O10	A	225
Family grief before death	D2	A	241
Family planning questions	N14	A	189
Fear before surgery	O1	A	217
Fear of a specific thing	P2	A	118
Fear of dying	V5	A	174
Fear of hospital or procedures	K3	A	192
Fear of labor	N3	A	179
Feeling alone or cut off from others	R3	A	146
Feeling no control over one's situation	P5	A	120
Feeling sick to the stomach	C3	A	62
Fluid build-up in the body	F4	A	41
Fluid in the lungs	B7	A	31
URGENT			
Foot problems in diabetes	T2	R	246
Fragile skin or skin tears	W5	R	213
Frailty	A1	A	202
Frequent loose stools	E2	A	53
G			
Grief after pregnancy loss	N13	A	188
Guilt or shame	P25	A	139
H			
Hard or infrequent bowel movements	E1	A	52
Harm from restraints	S14	R	85
Harmful eating behaviors	P23	A	137
Headache	C10	A	69
Hearing or seeing things others do not	P15	A	130
Heavy wound drainage	W2	A	211
High-risk pregnancy	N2	R	178

I		
Ignoring one side of the body	Z2 A	228
Infant dehydration risk	K10 R	198
Infection from lines	O5 R	220
Injury during seizure URGENT	S26 R	97
Irregular heartbeat	B11 A	34
Itching or skin discomfort	C6 A	65
L		
Labor pain	N4 A	179
Language barrier	R9 A	151
Leaking urine	E4 A	54
Likely to bleed easily	S6 R	77
Likely to bleed heavily after surgery URGENT	S12 R	83
Likely to catch an infection	S2 R	74
Likely to develop blood clots	S11 R	82
Likely to develop pressure sores	S5 R	76
Likely to fall	S1 R	73
Likely to get hurt	S3 R	75
Likely to get urine infection from a catheter	E8 R	58
Likely to harm others	S21 R	92
Likely to inhale food or fluid	S8 R	79
Likely to spread infection to others	S24 R	95
Likely to wander or get lost	S15 R	86
Limited ability to move	M1 A	99
Loneliness at home	A4 R	204
Long-lasting grief	P26 A	140
Long-lasting pain	C2 A	62
Loss of hope	P4 A	119
Loss of independence	A8 A	208
Loss of limb movement	M17 A	113
Loss of privacy or dignity	R15 R	156
Loss of sense of identity	P28 A	141
Low blood oxygen needing support URGENT	B8 A	31
Low mood	P12 A	127
Low self-worth	P6 A	121
Lung disease flare-ups	T3 A	247
M		
Memory loss	A2 A	203
Menopause symptoms	X4 A	255
Missed vaccinations	K12 A	200
Missing school due to illness	K8 A	197
Muscle cramps or spasms	C9 A	68
Muscle wasting from bed rest	M18 R	114
Muscle weakness	M11 A	108
N		
Needs bereavement support	D5 A	243
Needs breathing machine support	B9 A	32
Needs comfort near death	D1 A	240
Needs help to dress	M6 A	103
Needs help to eat	M7 A	104
Needs help to use the toilet	M8 A	105
Needs help to wash	M5 A	102
Needs of sedated or unconscious patient	O7 R	222
Needs safe-sex knowledge	X3 A	255
Needs tube feeding	F8 A	45
Neglect or money exploitation risk	A5 R	205
Nerve or limb damage from positioning	S23 R	94

Newborn breathing difficulty URGENT	N10 A	185
Newborn jaundice	N9 A	184
Noise or light disturbing rest	C12 A	71
Not eating enough to meet body needs	F1 A	39
Not enough help at home	R8 A	150
Not enough knowledge about the condition	L1 A	159
Not following the treatment plan	L2 A	160
Not ready for discharge	L12 A	168

O		
Outbreak risk in community	H3 R	236

P		
Pain near end of life	C8 A	67
Parenting difficulty	R13 A	154
Poisoning risk URGENT	S18 R	89
Poor appetite	F11 A	48
Poor balance	M16 A	112
Poor blood flow to hands or feet	B5 A	29
Poor blood flow to the brain URGENT	B13 R	36
Poor body positioning	M19 A	115
Poor concentration	P17 A	131
Poor hygiene practices	H6 A	238
Poor oxygen exchange in the lungs	B2 A	26
Pregnancy discomfort	N1 A	177
Pressure sore present	W3 A	211

R		
Raised pressure in the brain URGENT	Z7 A	232
Rash or skin infection	W7 A	215
Reaction to medicine or allergen URGENT	S10 R	81
Ready for better coping	P29 A	142
Ready to grow spiritually	V3 A	172
Ready to learn and improve health	L5 A	162
Relationship or intimacy difficulty	R11 A	153
Risk of heavy bleeding after birth URGENT	N5 R	180
Risk of injury from numbness	Z6 R	231
Risk of internal bleeding after surgery URGENT	O3 R	218
Risk of seizures URGENT	Z3 R	228
Risk of self-harm (needs urgent response) URGENT	P9 R	124
Risk-taking behavior in teens	K9 A	198

S		
Sadness after a loss	P8 A	123
Sadness after childbirth	N12 A	187
Self-injury	P24 A	138
Short-term pain	C1 A	61
Side effects of pain medicine URGENT	C7 A	66
Skin reaction to cancer treatment	W6 A	214
Sleep loss in ICU	O9 A	224
Slow growth	K1 A	191
Slow gut recovery after surgery	O6 A	221
Slow recovery after birth	N6 A	181
Slow wound or surgical healing	S9 R	80
Sore or damaged mouth	F12 A	49
Staff exposure to needles or body fluids (workplace safety)	S22 R	93
Stiff joints or shortened muscles	M12 A	108
Stress from illness or hospital stay	P27 A	140

Struggling to breathe comfortably	B1 A	25
Struggling to manage long-term illness	L8 A	165
Struggling with family or work roles	R4 A	146
Struggling with meaning, faith, or purpose	V1 A	171
Sudden confusion URGENT	P18 A	132
Suspicious or distorted thinking	P16 A	131
Swollen legs or feet	B10 A	33

T

Tires quickly during activity	M2 A	100
Too little physical activity	M9 A	106
Too many medicines	A3 R	204
Trouble chewing or swallowing	F6 A	43
Trouble controlling impulses	P20 A	134
Trouble understanding health information	R10 A	152

U

Unable to empty the bladder	E3 A	53
Unable to reach the toilet in time	E5 A	55
Unable to sleep well	C4 A	63
Uncontrolled high blood pressure	T1 A	245
Unfinished affairs or wishes	D3 A	242
Unhappy with body appearance	P7 A	122
Unhealthy habits (smoking, inactivity)	L9 A	166
Unplanned weight loss	F13 A	50

Unsafe home	S19 R	90
Unsafe infant sleep	K11 R	199
Unsafe medicine use at home	L7 A	164
Unsafe to live alone	A6 A	206
Unsafe water or sanitation	H4 R	237
Unsafe wheelchair or transfer	M14 A	110
Unstable blood pressure	B6 R	30
Unsteady blood sugar URGENT	F5 R	42
Unsure how to use equipment or devices	L6 A	163

V

Very little urine being made URGENT	E9 A	59
Very low blood circulation (shock) URGENT	B14 R	37
Vomiting	F7 A	44

W

Weak bond between parent and baby	R14 R	155
Weak heart pumping	B4 A	28
Weak immune system	T8 R	251
Wishes about end of life unclear	V4 A	173
Withdrawal symptoms	P22 A	136
Worry or nervousness	P1 A	117
Wound not healing	W1 A	210
Wrong medicine or dose	S13 R	84