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Daily self-care needs exceed current ability Oral care for a dependent patient

Nursing Foundation | Focused diagnosis-based template

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Clinical assessment

Subjective: Dry mouth and discomfort with eating; caregiver requests help.

Objective findings and required checks: Dry oral mucosa and plaque; swallowing and airway protection need assessment.

Physical examination and investigations: Inspect mouth, dentures, pain, hydration and swallowing safety.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Oral care for a dependent patient: Poor oral hygiene and dry mucosa increase discomfort and may contribute to infection and aspiration-related harm.

Medical / surgical management

Provide assisted toothbrushing and oral moisturization; use appropriate positioning and suction assistance if indicated.

Illustrative drug and treatment study

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Medicine / treatment	Purpose	Nursing checks
Prescribed oral treatment	Treat a diagnosed oral condition	Verify indication and application
saliva substitute	Support dry-mouth comfort when appropriate	Check tolerance and aspiration considerations.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

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Focused nursing-problem template

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask which activities the person can do and where help is wanted. Assess: Assess personal-care tasks, cognition, mobility and available support.	Daily self-care needs exceed current ability. Possible factors: weakness, symptoms or reduced confidence. Validate against the patient's assessment.	Short-term: At the next patient-specific reassessment: Completes a chosen self-care activity with the agreed level of assistance. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver demonstrates essential care skills and knows support options.	1. Assess ability task by task and respect preferences and privacy. Rationale: Specific assessment prevents unnecessary dependence. 2. Provide only the assistance required and use suitable aids. Rationale: Supported participation protects dignity and builds independence. 3. Teach caregivers with consent and confirm realistic support at home. Rationale: Continuity depends on available skills and resources. 4. Provide assisted toothbrushing and oral moisturization; use appropriate positioning and suction assistance if indicated. Rationale: Poor oral hygiene and dry mucosa increase discomfort and may contribute to infection and aspiration-related harm. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Apply this template

Complete with verified data: assessment cues; supported actual problem or risk; measurable outcome and review time; selected authorized interventions and rationale; observed response and next action.

Subjective / objective cues: _____

Patient-specific target and review time: _____

Evaluation evidence and next action: _____

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Health education and continuing care

Demonstrate safe mouth and denture care; avoid excessive fluid in the mouth of a patient with poor airway protection.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Oral bleeding, severe pain, new swallowing difficulty or respiratory deterioration needs review.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Poor oral hygiene and dry mucosa increase discomfort and may contribute to infection and aspiration-related harm.
- Priority concerns: Daily self-care needs exceed current ability.
- Oral bleeding, severe pain, new swallowing difficulty or respiratory deterioration needs review.
- Demonstrate safe mouth and denture care; avoid excessive fluid in the mouth of a patient with poor airway protection.

Exam / viva: What assessment evidence supports this problem, and what measurable result would demonstrate improvement?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023
https://wtcs.pressbooks.pub/pharmacology2e/

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B.Sc. Nursing curriculum and regulatory notifications - Indian Nursing Council

https://www.indiannursingcouncil.org/gazette-notification

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