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Learning needs about the condition and care plan Perioperative anxiety

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: Worried about anesthesia, pain and being away from family.

Objective findings and required checks: Alert and able to consent; anxious expression and repeated questions.

Physical examination and investigations: Assess concerns, understanding, consent status, allergies and preoperative checklist completion.

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

Clinical focus and pathophysiology

Perioperative anxiety: Uncertainty and perceived threat can increase distress and reduce information retention.

Medical / surgical management

Provide clear information, privacy, reassurance grounded in facts and referral for unanswered consent questions.

Illustrative drug and treatment study

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Medicine / treatment	Purpose	Nursing checks
Prescribed premedication	Use only when ordered as part of the anesthesia plan	Check consent timing, monitoring and sedation risk
no self-medication	Avoid unapproved medicines before surgery	Reconcile all products with the team.

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 what the learner already knows and wants to understand. Assess: Use teach-back or demonstration to identify specific gaps.	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Short-term: At the next patient-specific reassessment: Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Provide clear information, privacy, reassurance grounded in facts and referral for unanswered consent questions. Rationale: Uncertainty and perceived threat can increase distress and reduce information retention. 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

Explain preparation, fasting according to the anesthesia instructions, postoperative care and how to ask for help.

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

New chest pain, breathing difficulty, allergy symptoms or withdrawal of consent requires immediate communication.

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

- Uncertainty and perceived threat can increase distress and reduce information retention.
- Priority concerns: Learning needs about the condition and care plan.
- New chest pain, breathing difficulty, allergy symptoms or withdrawal of consent requires immediate communication.
- Explain preparation, fasting according to the anesthesia instructions, postoperative care and how to ask for help.

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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