

CONCEPT MAP CARE PLAN

WHAT ARE CONCEPT MAP CARE PLANS?

A concept map care plan is a diagram of patient problems, supporting data, interventions and evaluations. Your ideas about patient problems are the “concepts” that will be diagrammed. These maps are used to organize patient data, analyze relationships in the data, and enable you to take a holistic view of the patient’s situation.

Concept mapping requires critical thinking to analyze relationships in clinical data. Critical thinking and clinical reasoning are used to formulate clinical judgments and decisions about nursing care. The important ideas that must be linked together during concept map care planning are the **medical and nursing diagnoses**, along with all the **pertinent clinical data**. Through concept mapping of diagnoses and clinical data, you can evaluate what you know about the care of your patient and what further information you need in order to provide safe and effective nursing care.

STEPS IN CONCEPT MAP CARE PLANNING

The steps of the nursing process (assessing, diagnosing, planning, implementing, and evaluating nursing care) are related to the development of concept map care plans. Before developing a concept map, the first thing you must do is gather clinical data. This step corresponds to the assessment phase of the nursing process. You must review the patient’s chart to **determine his current health problem(s), medical history, physical assessment findings, prescribed medications, diagnostic measures, and treatments**. In order to collect this data, the Patient Data Base form should be completed. This assessment tool becomes the basis for your concept map.

STEP 1: DEVELOP A BASIC SKELETON DIAGRAM

The initial diagram is composed of clinical impressions you make after reviewing all of the data. Write the patient’s reason for admission (usually a medical diagnosis) in the circle at the top of the page. Next think of the general problems that represent the patient’s responses to his medical diagnosis, such as problems breathing. Once you have decided the top five problems, formulate a nursing diagnosis and write them in the boxes below the central medical diagnosis. In the small box above each nursing diagnosis, prioritize the problems by writing the appropriate number.

STEP 2: ANALYZE AND CATEGORIZE DATA

In this step you must analyze and categorize the patient data you have collected. This categorization provides evidence to support the medical diagnosis and general nursing diagnosis. Group the most important data related to the patient’s medical diagnosis in the top circle. This would include data such as past medical history. Then group clinical assessment data, treatments, medications, diagnostic data, and medical history data

related to the nursing diagnosis in the appropriate nursing diagnosis box. If you do not know where a piece of data should go but think it is important, list it off to the side of the map and ask for clarification from your peers or instructor. If a piece of data is relevant to more than one problem area, you may repeat that data in different boxes.

STEP 3: IDENTIFY GOALS AND INTERVENTIONS

Below each nursing diagnosis, formulate a realistic goal that can be achieved within your 2-day clinical experience. Make sure the goal is measurable. In the boxes labeled “intervention”, write down 4-6 nursing interventions, which will lead to goal achievement. This step corresponds to **the planning phase** of the nursing process. You should list the interventions you plan to provide for the patient during the time you are caring for him. The interventions include key areas of assessment and other therapeutic interventions such as teaching or therapeutic communication. While you do not need to write down rationales for each intervention, you should be prepared to state them verbally if asked.

STEP 4 EVALUATE PATIENT RESPONSES

After you have carried out your therapeutic nursing interventions, evaluate how effective this plan has been and whether your goals have been achieved. Be sure to include the data that supports whether or not you have achieved your goal. Include any revisions or recommendations you would make to achieve the desired goal.

STEP 5 LINKING THE DATA

In this last step you must link nursing diagnoses together to show their interrelatedness, thus providing a holistic view of the patient. This can be done by drawing dotted lines between the nursing diagnoses that impact one another. When the same assessment data is placed under more than one nursing diagnosis, these concepts are related. Upon completion, this tool will allow you to look at your patient in a holistic way, utilizing critical thinking.