Critical Thinking and the Nursing Process

Critical Thinking and Safe Care

Outline:

A. **Critical Thinking Attitudes**

1. Intellectual Humility	
2. Intellectual Courage	***3. Intellectual Empathy***
4. Intellectual Integrity	***5. Intellectual Perseverance***
6. Faith in Reason	***7. Intellectual Sense of Justice***

B. ***Knowledge*** **Base**

Concern for Patient Safety

C. Critical Thinking Skills

Problem Solving	***Other Critical Thinking Skills***

Introduction

- Think critically; means the use of knowledge and skills to make the best decisions possible in patient care situations.
- "**Critical thinking** is the ***use of those cognitive*** [knowledge] ***skills or strategies*** that ***<u>increase the probability of a desirable outcome</u>***."
- Critical thinking is sometimes called ***directed thinking*** because it ***focuses on a goal***.
- Other terms used include ***reasoning, common sense, analysis,*** and ***inquiry.***
- **Good thinking requires:**

✓ Critical thinking attitudes & skills	✓ Good knowledge base

A. Critical Thinking Attitudes

1- Intellectual Humility ***تواضع***

It is the ability to say, "***I am not sure about that***…. ***I need more information***." Patients respect nurses who can say, "***I do not know***; ***let me find out***." It is unsafe to care for patients when you are not sure of what you need to do.

2- Intellectual Courage ***جرأة، جاهر بالصواب***

It allows you to ***look at other points of view*** even ***when you do not agree with them*** at first and you will be willing to ***listen to arguments*** e.g (changing 8-hour shifts to 12-hour shifts). Maybe you will even be convinced and say, "***Okay, I see you were right after all***."

3- Intellectual Empathy ***التقمص العاطفى***

Consider the patient who snaps as you enter her room, "***I've been waiting all morning for my bath***. If you do not help me with it right now I am going to call your supervisor." first response is, "***I have five other patients***" But, if you have empathy, you will think, "***If I were this patient, who is in chronic pain & is tired of being in hospital***, ***<u>how would I feel</u>***?"

4- Intellectual Integrity **السلامة والكمال**

Your patient ***asks a hundred questions*** when you bring a ***newly prescribed medication*** for ***high BP***. But later you notice patient is taking ***herbal remedy***. With intellectual integrity you want same kind of **proof** that both medications are ***safe & effective before using them***.

5- Intellectual Perseverance **المواظبة، المثابرة**

Do not give up. You have ***concerns about some side effects*** you have noticed when you ***administer a new drug*** to your patients. You mentioned it to the physician and he said not to worry about it, but you are still concerned. With intellectual perseverance, you might do ***web research***, then go to your ***supervisor or the pharmacist*** to ***discuss your concerns***.

6- Faith in Reason **الاعتقاد او الايمان بالاسباب**

Faith in reason, means believe in your heart that ***good thinking & reason***, will ***result in the best outcomes*** for your patients. And if you really believe, you will be more likely to ***attend a seminar or read an article on critical thinking skills***.

7- Intellectual Sense of Justice **العدالة**

One of your co-workers wants to ***change the medication administration schedule*** on your unit. She says it is because it ***will be better for the patients***, but ***you think it might be because it fits her break schedule better***. With intellectual sense of justice, you will be sure that ***your thinking is not biased by something that you just want for yourself***. You should examine your own motives as well as those of others when you make decisions.

B. Knowledge Base

Nurses must have a ***good knowledge base in order to safely care*** for their patients. ***Best knowledge*** base practice ***comes from research***. Researchers ***try new methods*** for taking care of patients & ***compare them with traditional methods*** to determine what works best.

Care based on good, well-designed research studies, is called **evidence based practice**. As nurses, we need to ***use as many researched interventions*** as we can. Other interventions, until they are validated by research, have to be based on our best critical thinking skills. Some expert organizations are beginning to "**bundle حزمة**" best practice strategies together to increase their use. **Bundles** are ***groups of interventions that, when used together, have been shown to improve patient outcomes***. To find more information on bundles, go to http://www.ihi.org/ihi and type "bundles" in the search window.

Concern for Patient Safety

- ✓ Health-care providers are being held accountable for safe care by society.
- ✓ As a result, guidelines to reduce errors in health care and improve patient outcomes have been developed.
- ✓ The Joint Commission on Accreditation of Hospitals and Organizations 2006 ***patient safety goals*** can be found at http://www.jcipatientsafety.org.

These goals address important areas of concern such as:

✓ **Correctly identifying patients**	✓ **Using medications safely**
✓ **Identifying operative sites correctly**	✓ **Improving communication**
✓ **Reducing risk for infections**	✓ **Reducing fall injuries**

C. Critical Thinking Skills

Problem Solving

Problem solving is one type of critical thinking skill. Nurses solve problems on a daily basis. However, a problem can be handled in a way that may or may not help the patient. For instance, consider Mr. Frank, who is in pain and requests pain medication.

An alternative approach is to use a standard problem-solving method:

1. **Gather data.** Decide to **use a pain-rating scale** on which the patient rates pain on a scale of 0 (no pain) to 10 (the greatest pain possible). You **check his history** and find he has compression fractures of his spine. You **next go to the medication record** and find that he has no alternative pain medications ordered.
2. **Identify problem**: ➔ **use your knowledge base to draw the conclusion** that Mr. Frank is in acute pain, & current medication are not sufficient to provide pain relief.
3. **Decide what outcome** (sometimes called a **goal**) is desirable. The outcome should be determined by you **(the nurse) and the patient** working together.In this case you talk to Mr. Frank and determine that he needs pain relief now; he cannot wait until the next scheduled dose of medication. He states that he is able to tolerate a pain rating of 3 or less on a 10-point scale.
4. **Plan what to do.** ***Formulate & evaluate some alternative solutions***. For example, tell Mr. Frank to ***wait 40 minutes***; ***giving medication early*** might relieve his pain, you could decide to try ***some non–drug pain-control*** methods, such as **relaxation, distraction, or imagery**. Another alternative is to ***report to the physician*** that Mr. Frank's pain is not controlled with current pain-control regimen. Once you have several alternative courses of action, decide which will best help patient.
5. **Implement plan of care.** The RN enters the room and informs you and the patient that the physician has changed the analgesic orders. You obtain and administer the first dose of the new analgesic, being sure to explain its effects and side effects to Mr. Frank. Informs Mr. Frank that physician has ordered consultation with pain clinic.
6. **Evaluate plan of care.** Did the plan work? As you reassess Mr. Frank 30 minutes later, he rates his pain level at 2. You think back to the **desired outcome, compare it with current data collected** & **determine that interventions** were successful.

Other Critical Thinking Skills

Following are a few questions to ask yourself as you continue to develop your critical thinking. There are many more questions you might ask. These are not in any order, nor would they all be asked for a given situation.

They are just some ideas to get you started.

- Have I thought this through?
- What information do I need? How do I know?
- Is someone influencing my thinking in ways I am not aware of?

- What conclusions can I draw from the information I have?
- Am I basing this decision on assumptions that may or may not be true?
- Am I thinking creatively about this, or am I in a rut?
- Is there an expert I can consult that can help me think through this?
- Is there any research or evidence that this is true?
- Am I too stressed or tired to think carefully about this right now?

NURSING PROCESS

Components of nursing process contains five components that include: **Assessment, Diagnosis, expected outcome and planning, implementation and evaluation.**

1) Assessment

1. Conduct the health history.
2. Perform the physical assessment.
3. Interview patient's family or significant others.
4. Study the health record.
5. Organize, analyze, synthesize, and summarize the collected data.

Elements of the Assessment Process

1. Data collection	2. Data verification
3. Data organization	4. Data interpretation
5. Data documentation	

Purpose of Assessment

The purpose of assessment is to establish a database concerning a client's physical, psychosocial, and emotional health in order to identify health promoting behaviors as well as actual and/or potential health problems.

TYPES OF ASSESSMENT

There are 3 types of assessment: Comprehensive, Focused & Ongoing assessment

A. **Comprehensive Assessment**

1. Completed upon admission
2. Includes a complete health history
3. Provides a baseline data
4. Should include:
   - Assessment of physical and psychosocial aspects of the client's health,
   - The client's perception of health
   - He presence of health risk factors
   - The client's coping patterns

B. Focused Assessment

1. Limited in scope
2. Focus on a particular need or health problem or potential risks.
3. Often used in health care agencies with short stays (e.g., outpatient surgery centers & emergency departments, labor & delivery & in mental health settings).

C. Ongoing Assessment

1. Systematic follow-up is required when problems are identified during a comprehensive or focused assessment.
2. Includes systematic monitoring and observation related to specific problems
3. Allows to broaden or to confirm the validity of the initial assessment data
4. Important when problems have been identified & plan of care has been implemented to address these problems
5. Allow to determine the response to nursing interventions
6. Allow to identify any emerging problems.

DATA COLLECTION

- Nurse must possess strong cognitive, interpersonal, & technical skills to elicit appropriate information & make relevant observations at data collection process.

Types of Data

- ***Subjective data*** are data from the client's point of view and include feelings, perceptions, and concerns. The data (symptoms) are obtained through interviews.
- ***Objective data*** are observable & measurable (quantitative) data, obtained through observation, assessment techniques performed during physical examination, & lab & diagnostic testing. Data (signs) can be seen, heard, or felt by someone other than patient. Comprehensive & accurate assessments include subjective & objective data.

Sources of Data

1. Client	2. Family/significant other
3. Other health care professionals	4. Medical records
5. Results of diagnostic tests	6. Relevant literature
7. Interdisciplinary conferences, rounds, and consultations	

Methods of Data Collection

1. Observation	2. Interview
3. Health history	4. Symptom analysis
5. Physical examination	6. Laboratory and diagnostic data

1) Observation

It includes ***client mood, interactions with others, physical & emotional responses, & safety considerations***. Nurse ***detects nonverbal cues*** as presence of pain, anxiety.

2) Interview

It *is a therapeutic interaction used to collect information about client's health history & current client's health needs*. Also **observation of nonverbal** behavior.

Phases of Interview: interview has three phases: ***Introduction, Working and Closure.***

1. Introduction

- Establishes the goals for the interaction
- Collection of data about the client
- Allow adequate time and privacy for the client

- Inform client about approximate interview duration.
- Nurse should sit, establish eye contact with the client, and listen attentively
- Note nonverbal messages that can indicate that the client is uncomfortable, tired, or preoccupied with other matters

2. Working

- Focuses on data collection details
- depends on type of assessment to be conducted
- May be structured and formal or unstructured and informal
- It begins with questions about biographical data; & reason for seeking health care
- Information is gathered from the general to the specific
- Use of Nursing Checklist provides guidelines for interview.
- A comprehensive interview is facilitated by open-ended questions, while focused interview will be facilitated by direct, closed questions.

3. Closure

- The nurse should indicate ***Interview Closure*** by stating that almost all information needed has been obtained or interview time is almost over.
- During closure phase, the nurse summarizes what was covered or accomplished during interview and requests validation of perceptions with the client.

Preparing the Interview Environment

▪ Assure adequate lighting.	▪ Maintain client privacy.
▪ Interview is timed appropriately.	▪ Promote client comfort.
▪ Maintain a comfortable room temperature.	
▪ Select an environment that is as free of noise and distractions as possible.	

3) Health History

1. Demographic information	7. Allergies
2. Reason for seeking health care	8. Current medications
3. Perception of health status	9. Developmental level
4. Previous illnesses	10. Psychosocial history
5. Client/family medical history	11. Socio-cultural history
6. Immunizations/exposure to communicable disease	12. Activities of daily living
	13. Review of systems

4) Physical Examination

The purpose of the physical examination is to **make direct observations of any deviations from normal** and to **validate subjective data** gathered through the interview. **Baseline measurements** are obtained, and **physical examination** techniques are used to gather objective data.

- **Baseline Data**

Is systematic organization of observations obtained during physical examination that forms the basis for comparison and evaluation of a client at a given time.

Measurement of height, weight, & vital signs is important for comparison with future measurements to judge significance of any changes (progress or regression).

Assessment Techniques

Physical examination incorporates the use of ***visual, auditory, tactile, and olfactory senses & systematic assessment techniques.***

The **four assessment techniques** used in physical examination are: ***Inspection***, ***Palpation, Percussion and Auscultation***.

1. Inspection

- **Inspection** involves careful **visual observation**.
- Observe first from a general point of view and then with specific attention to detail.
- Effective inspection requires adequate lighting & exposure of observed body parts.
- Be sensitive to client's feelings of embarrassment with inspection & respond by discussing technique with client & using measures as draping in order to ↑ comfort.

2. Palpation

- **Palpation** uses the **sense of touch** to assess texture, temperature, moisture, organ location & size, vibrations, pulsations, swelling, masses, and tenderness. ***Palpation requires a calm, gentle approach and is used systematically, with light palpation preceding deep palpation & palpation of tender areas performed last.***
- The palpation technique uses ***hands and fingers*** in different ways for assessment of:
  - ***Temperature:*** Best detected using the **dorsal (back) surface of the hand**
  - ***Texture, pulses, and swelling:*** Best detected using **fingertips**
  - ***Vibration:*** Best detected with the **base of the fingers**
  - ***Shape & consistency of organs:*** by **grasping organ or mass between fingertips**

3. Percussion

- **Percussion** uses **short, tapping strokes on the surface of the skin to create vibrations of underlying organs**.
- It is used for assessing structures density or determining location & size of organs.
- Structures with more air (lung) produce louder, deeper, & longer sound than more dense, solid structures (as liver), which produce softer, higher, and shorter sounds.

4. Auscultation

- **It** involves listening to body sounds that are created by air or fluid movement. Areas most often auscultated include lungs, heart, abdomen, and blood vessels. Direct auscultation is sometimes possible and a stethoscope is usually employed.

5) Laboratory and Diagnostic Data

- Useful objective data serve as defining characteristics for various altered health states; helpful in ruling out certain suspected problems. Ex, poor controlled diabetic clients will have elevated blood glucose level. The effectiveness of nursing & medical interventions and progress toward health restoration monitored through lab test.

DATA VERIFICATION

- It is process through which data are validated as being complete and accurate.

- When complete data collection, data are reviewed for inconsistencies or omissions.
- It is done by examining the congruence between subjective & objective data.
- Findings should also be compared with norms.
- Any grossly abnormal findings should be rechecked and confirmed.

DATA ORGANIZATION

- After data collection is completed and information is validated, organizes, or ***clusters, information together*** to identify areas of strengths & weaknesses.

DATA INTERPRETATION

- **Clustering** facilitates recognition of patterns & determines further data needed.
- **Data interpretation** is necessary for identification of nursing diagnoses.

DATA DOCUMENTATION

- Accurate & complete recording are essential for communicating information to other care team members. It determines quality of care & support identified problems.

Types of Assessment Formats

a) Open-Ended Formats

- Allows the nurse to write a narrative description of observations.
- It is more time-consuming for nurse and allows flexibility in recording findings.

b) Checklist Formats

- Facilitate documentation by summarizing findings in an abbreviated form.
- Provide more consistency in information recording & reduce likelihood of omitting relevant information.

c) Combination Formats

- Allow the convenience of a checklist together with space to document a complete narrative description of any significant or abnormal findings.

d) Specialty Formats

- Specialty areas as outpatient surgery, labor & delivery, and psychiatric facilities may use format focused on assessment needs for particular service provided.
- Documentation is essential for health team communication to assure accurate problem identification, determination of appropriate outcomes & care continuity.

2) Nursing diagnosis

Statement that describes the human response (health state or actual/potential altered interaction pattern) of an individual or group which the nurse can order the definitive interventions to maintain the health state or to reduce, eliminate, or prevent alterations".

PURPOSES OF NURSING DIAGNOSIS

Nursing diagnosis allows for:

▪ Empowerment of nursing profession	▪ Facilitates effective communication
▪ Provides a means to individualize nursing care	
▪ Essential to clinical practice & education & pivotal for theory & research	

COMPONENTS OF A NURSING DIAGNOSIS

The Two-Part Statement

- **First component** is a ***problem statement or diagnostic label***.
- **Second component** is the ***etiology*** linked by term *related to* (RT).
  Examples: ***Disturbed Body Image*** RT **loss of left lower extremity**
- ***Activity Intolerance*** RT **decreased oxygen-carrying capacity of cells**.
- **Descriptive words** (**qualifier**s) include: **Acute, Chronic, Decreased, Deficient, Depleted, Disturbed, Dysfunctional, Enhanced, Excessive, Impaired, Increased, Ineffective, Intermittent, Potential for, Ris**k; are (used) before problem statement.

The Three-Part Statement

- **First component** is ***diagnostic label***.
- **Second component** is ***etiology*** linked by *related to*.
- ***Third componen***t is the **defining characteristics** (***signs & symptoms***, ***subjective and objective data, or clinical manifestations).***
- **Third part is joined to the first two components with** phrase "**as evidenced by**"
- Defining characteristics may assist the nurse in identifying client goals, measurable client outcome criteria, and relevant nursing interventions.

Comparison of 1- 2 & 3 Part Nursing Diagnosis Statements

One-Part Statement	Two-Part Statement	Three-Part Statement
Part 1: Wellness condition/state to be enhanced (no Related to, no etiology & no defining characteristics)	Part 1: Problem Related to Part 2: Etiology (no defining characteristics)	1: Problem Related to 2: Etiology 3: Defining characteristics

CATEGORIES OF NURSING DIAGNOSES

Actual diagnoses: are those problems that are already in existence. **Example**:

- ***Excess Fluid Volume*** related to (RT) IV infusion therapy overload
- ***Anxiety*** RT unknown results of breast biopsy.

Risk diagnoses situations in which problems might occur but are **not currently exist.**

Ex: ***Risk for Poisoning*** RT ↑ infant mobility & failure to have house childproofed
Risk for Deficient Fluid Volume RT excessive number of stools.

Wellness diagnoses identify the individual or state that may be enhanced by ***health promoting activities***.

- ***Consist of a one-part statement*** (no "related to") ***that uses label "Potential for Enhanced"*** followed by state nurse desires to enhance.
- **Examples:** ***Readiness for Enhanced Community Coping*** and ***Readiness for Enhanced Spiritual Well-Being***.

TAXONOMY OF NURSING DIAGNOSIS

- It is the ***type of classification under which diagnostic label is grouped*** based on which ***human response client is demonstrating*** to actual or perceived stressor.

- ***NANDA taxonomy is composed of 9 patterns of human response:***

1. Exchanging	2. Valuing	3. Perceiving
4. Communicating	5. Choosing	6. Knowing
7. Relating	8. Moving	9. Feeling

DEVELOPING A NURSING DIAGNOSIS

Assessing Database

- C***ollects data cues from the client***. **Examples** of cues: **poor skin turgor, parched lips, dry skin, decreased urine output, and complaint of thirst**.
- ***Processes these cues*** & **determines a nursing diagnosis, plans client outcomes, and implements therapeutic nursing interventions.**

Validating Cues

- After reviewing data cues, validates that information and examines it carefully.
- Example: determines if information is accurate and complete.

Interpreting Cues

- Through interpretation of data cues and use of critical-thinking strategies, the nurse **assigns a meaning to the data cues.**

Clustering Cues

- Once the cues have been **collected, validated, and interpreted**, the data are then **grouped into clusters**.
- **Related pieces of information about client are grouped together**.
- **Conclusions** are drawn from the data cues.
  Example: data cues that can be clustered include:
  Subjective*: "I eat 5 or 6 times a day" & "I've gained 12 pounds in past year."*
  Objective: weight 204 pounds, protruding abdomen, double chin, pulse 80b/m

STEPS IN DEVELOPING A NURSING DIAGNOSIS

1. Data cues are collected from the assessment phase.	
2. Data cues are validated and examined.	
3. Data cues are interpreted & assigned a meaning through use of critical thinking.	
4. Data are grouped into clusters.	5. The NANDA list is consulted.
6. The first part of nursing diagnosis statement is written.	
7. Related to (RT) factors are identified.	
8. Phrases from steps 6 and 7 are combined to form a two-part nursing diagnosis.	

Writing the Nursing Diagnosis Statement

- ND **from NANDA list** becomes diagnostic label, ***first part of diagnosis statement***.
- Etiologies are also identified from NANDA list.
- ***Appropriate etiology is selected & joined to first part*** with "related to" phrase.

- **<u>In a two-part statement</u>**, would be ***Imbalanced Nutrition: More Than Body Requirements*** RT excessive food intake.
- **<u>The three part statement</u>** would be ***Imbalanced Nutrition: More Than Body Requirements*** AEB weight gain, ↑ appetite, and increased abdominal girth.
- EX Mr. **Lowder** is 62-year-old male admitted last night through emergency room because of difficulty breathing. He was experiencing some difficulty voiding. His lower extremities are very swollen. History reveals he smokes one cigarettes pack a day and has done this for the past 45 years. His vital signs are P 112; R 30; BP 172/96; T 101.1°F. He has an eighth-grade education, attends church every week, is estranged from his daughter, & says, "I hate hospitals my mother died in one."

1. From the data cues in this case study, group data into clusters.

2. Look at NANDA list of diagnoses & see which diagnoses "fit" best with data clusters.

3. Write the first part of the NANDA diagnosis for each cluster.

4. Attempt to identify etiological (related to) factors for the list you started in step 3.

5. Write two-part nursing diagnosis statements by combining steps 3 and 4.

6. Identify whether the nursing diagnoses on your list are actual, possible, risk, or wellness oriented nursing diagnosis statements.

7. Prioritize the nursing diagnoses.

3) Outcome Identification & Planning

The four critical elements of planning include:

- ❑ Establishing priorities
- ❑ Setting goals and developing expected outcomes
- ❑ Planning nursing interventions (with collaboration and consultation)
- ❑ Documenting

Purposes of Outcome Identification and Planning

- ❑ *Maintain or improve health at an optimal level*
- ❑ *Framework on which to base scientific nursing practice.*
- ❑ *Provide adequate direction to ensure quality nursing care for individual clients*
- ❑ *Present a vehicle to improve staff communication, and to provide continuity in the delivery of individualized**, quality nursing care to all clients.***

Process of Outcome Identification And Planning

- Establishing Priorities
- Establishing Goals and Expected Outcomes
- Writing Goals

1- Establishing Priorities

- ***Examines client's nursing diagnoses and ranks them*** in order of **<u>physiological or psychological importance</u>**.
- Nursing diagnoses is ranked by nurse, client or family.
- Priorities of physiological needs (respiration, nutrition, hydration)
- The next (safe environment, stable living condition)

- ***Determine its level of need***, and ***rank the need in order of priority***.
- Consider the ***client preferences***. Involve client in establishing priorities
- **Anticipation of future diagnose**s.

Prioritizing Nursing Diagnoses with Accompanying Nursing Implications

Priority	Diagnosis	Nursing Implications
High	*Ineffective Breathing Pattern*	• Assess breath sounds. • Auscultate lungs. • Monitor vital signs. • Reposition client.
Moderate	*Risk for Impaired Skin Integrity*	• Perform comprehensive skin assessment. • Keep skin clean and dry. • Provide turning schedule.
Low	*Ineffective Coping*	• Assist to identify problem. • Encourage keeping daily journal. •Teach expressing feelings strategies.

Establishing Goals and Expected Outcomes

- After ***assessing client***, ***formulate nursing diagnoses***, & ***establishing priorities***, nurse **sets goals** & establishes **expected outcomes** for each nursing diagnosis.
- Purposes: ***provide guidelines*** for interventions & ***establish evaluation criteria***.

A **goal:** broad statement describing desired change in behavior, response, or outcome.

Expected outcome: detailed, specific statement describes goal achievement methods

Writing Goals

- Goals establish appropriate evaluation criteria to measure the effectiveness of planned nursing interventions
- Goals must meet immediate, long-term prevention & rehabilitation needs of client.
- **A short-term goal:** expectation to achieve nursing diagnosis in **few hours - days**.
- **A long-term goal:** expectation to achieve nursing diagnosis **over weeks - months**.
- Long-term goals is important in **discharge planning**, **assists in coordinating all health care team** to accomplish the same purpose, **promotes continuity of care**
- ***Used in the evaluation process by providing a standard for comparison.***

Expected outcomes are constructed to be:

- **Realistic**
- **Mutually desired by the client and nurse**
- **Attainable within a defined time period**
- They are ***measurable steps toward achieving previously established goals.***
- May be written in spiritual, emotional, physiological & social dimensions.
- Each ND has **one global goal** & **several expected outcomes.**

Components of goals & expected outcome include

1. Subject 2. Task Statement 3. Criteria 4. Time Frame.

1) ***Subject:*** identifies person (**client**) who will perform desired behavior or meet goal
2) ***Task Statement:*** is (***action verb***). It enables to determine the achievement of observable behavior. Only **one task statement** should be used **for each goal**.
3) ***Criteria***: are standards used to evaluate whether the behavior indicates goal accomplishment. **Criteria may include:**

▪ A time limit	▪ Amount of activity
▪ Accurate performance	▪ Description of the performance to be followed

Conditions: under which client should perform/ demonstrate mastery of task.

4) Time Frame: in which client should perform or demonstrate mastery of the task.

APPLICATION: RESTORATIVE CARE SETTING

- Fatima is recovering from orthopedic back surgery. A nursing diagnosis: ***Risk for Disuse Syndrome*** **related to immobilization due to skeletal traction**.

The factors need to be considered in writing goals for this client:

- **Immediate needs:** Maintenance of elimination pattern, skin integrity promotion, effective breathing patterns preservation, & minimization of long-term immobility
- **Rehabilitative needs:** Resumption of normal musculoskeletal function, ability to use assistive devices correctly, ↑ activity tolerance, & enhancement of well-being
- **Short-term goals** should focus on maintenance of physiological patterns involving elimination, skin integrity, respiration, and mobility.
- **Long-term goal** concentrate on return to maximal function & independence

4) Planning Nursing Interventions

- It ***is an action performed by a nurse to help client achieves results specified by goals & expected outcome.***
- ***Several nursing interventions*** are developed for each goals
- Interventions are ***prioritized according to order*** in which will be implemented.
- Delivery of ***quality, individualized care*** is enhanced.
- Interventions can be ***developed from ND etiology.***
- **Example**, for a client with angina with nursing diagnosis of *Pain* related to MI, an appropriate nursing intervention would be to help client conserve energy (rest).

TAXONOMY OF NURSING DIAGNOSIS

- Nurse may use various guidelines in selecting appropriate nursing interventions. These include individual nurse practice acts, state boards of nursing standards, & Joint Commission on Accreditation of Healthcare Organizations standards.
- In determining which nursing interventions to use, the nurse should critically *consider the consequences and the risks of each intervention*.
- Select those interventions that are most effective with the minimum of risk.

- After setting goals and planning appropriate nursing interventions, nurse writes *nursing orders to communicate exact nursing interventions* to be implemented.
- Nursing order: statement written by nurse i.e. is within realm of nursing practice.
- For example, a health care practitioner's order to force fluids must be specified in the nursing order as the *number of milliliters per hour or per shift* (e.g., 100 ml/h or Day shift = 800 ml; Evening shift = 800 ml; Night shift = 400 ml).
- *Well written nursing orders require several essential elements* include: nursing order date, action verb, detailed description, time frame & signature.

Categories of Nursing Interventions

1. **Independent nursing interventions:** nursing actions **initiated by the nurse** that does not require direction or an order from another health care professional.
   It include: ***daily living activities, health education, health promotion & counseling***
   Example: elevate a client's edematous extremity.
2. **Interdependent nursing interventions: actions** implemented in a **collaboration** by nurse with **other health care professionals**. **Example**, client care conference.
3. **Dependent nursing interventions: actions that require an order from another health care professional.**
   Example: administration of a medication.

ND: Acute Pain related to myocardial ischemia ***Goal:*** Client will resume normal activities of daily living. ***Expected Outcome:*** Client will verbalize relief of pain.	***Etiology:*** **Myocardial ischemia** **Nursing Interventions:** ▪ Assess pain (location, quality, severity, duration, onset, relief. ▪ At first signs of pain, instruct to relax and rest. ▪ Instruct client to take sublingual nitroglycerin. ▪ If pain continues after repeating doses/5 minutes for 3 pills, notify practitioner. ▪ Administer oxygen as prescribed. ▪ Note time interval between episodes of pain. ▪ Maintain bed rest and quiet environment. ▪ Give analgesic medications as prescribed. ▪ Offer assurance and emotional support ***Expected Outcome:*** pt will verbalize relief of pain.

Evaluating Care

Involves determining client's progress toward achievement of expected outcome. Effective planning is essential if evaluation is to be effective. Planned outcomes are the yardsticks by which effectiveness of therapies are evaluated. If there is no stated expectation of care (i.e., client outcome), how can progress be measured?

PLAN OF CARE

- It is ***written guide organizes data about client's care into a formal statement of strategies that will be implemented to help client achieve optimal health.***
- Nursing care plans usually ***include the five components of nursing process***.

- It begins on admission & continually updates & individualizes care to discharge
- Plan of care directs efforts of the entire health care team regarding each client.

STRATEGIES FOR EFFECTIVE CARE PLANNING

- Assumes responsibility for the coordination of total nursing care.
- Use critical thinking in establishing collaborative relationships with health team.
- Clear communication of the client's plan of care to other health care personnel.
- Communicate plan of care in clear, precise terms. Avoid using vague terminology
- Realistic care plan avoid setting goal that is difficult or impossible to achieve.

TAXONOMY OF NURSING DIAGNOSIS

P**lanning** includes: ***formulation of guidelines*** that ***establish proposed course of nursing action*** in resolution of nursing diagnoses & development of client's care plan.

Implementation: involves execution of the nursing plan of care derived during the planning phase of the nursing process.

It involves ***completion of nursing activities to accomplish predetermined goals & to make progress toward specific outcomes achievement***. ***Implementation phase begins with assessment*** & continually ***interacts*** with other steps in nursing process

PURPOSES OF IMPLEMENTATION

- Implementation is ***fulfillment of client needs that results in health promotion, prevention of illness, illness management, or health restoration***.
- ***It involves delegation of tasks to staff & assistive personnel & documentation of specific activities executed by nurse & client's response to these activities.***

REQUIREMENTS FOR EFFECTIVE IMPLEMENTATION

- **Cognitive skills:** enable nurses to make appropriate observations, understand rationale for activities performed, and appreciate differences among individuals and how they influence nursing care.
- **Psychomotor skills:** necessary to safely & effectively perform nursing activities
- **Interpersonal skills:** involves communication with clients and families as well as with other health care professionals.

IMPLEMENTATION ACTIVITIES

• Establishment of priorities	• Ongoing assessment
• Allocation of resources	• Initiation nursing interventions
• Documentation of interventions and client response	

Ongoing Assessment

- **Continuous observation** allow for adaptations to made better individualize care
- **Ongoing assessment *demands attention to verbal and nonverbal cues* from client and *requires knowledge of expected responses to specific interventions.***
- **If nurses observe that responses are different from those expected, this can lead to a change in expected outcomes and accompanying interventions.**

Establishment of Priorities

Priorities are determined following ongoing assessment & review of problem list

Priorities are based on:

- ***Most important problems by nurse, client***, family or significant others
- ***Activities previously scheduled by other departments*** (surgery, testing)
- ***Available resources***

Allocation of Resources

Before implementing the nursing plan, nurse ***reviews proposed interventions to determine level of knowledge and types of skills required for safe and effective implementation***. ***Assessment*** provides data for determining if an activity can be ***performed independently*** by client, completed ***with assistance*** from family, or ***requires assistance of health care personnel.***

Delegation of Tasks

- **It is** process of ***transferring selected nursing task*** **to competent individual**
- ***Some interventions are complex and require the knowledge & skills of RN***, **other interventions are simple & can be delegated to assistive personnel**.
- RN **authorized by law to provide care to clients and supervise & instruct others to deliver this care**.
- RN is ***empowered to delegate tasks to others.***

Sample Worksheet of Nursing Activities

Time	Activity
6:45 am	Listen to change-of-shift report.
7:00	Perform head-to-toe assessment, including vital signs.
7:10	Check routine medication times.
7:30	Chart assessment findings.
8:00	Serve breakfast. While client eats breakfast, review chart for new lab test data,
8:30	Record I & O after breakfast; remove breakfast tray.
8:40	Gather supplies for hygiene. Assist with AM care.
9:15	Assist up to chair. Show films about diabetic skin care.
10:00	Document interventions and observations on chart.
10:15	Review care plan for any needed revisions.
10:30	Report status of client to charge nurse.
11:45	Take and record vital signs.

Nursing Interventions

- ❑ It is an action performed by nurse that help client to achieve expected outcomes.
- ❑ All interventions must conform to standards of care.
- ❑ Nurses should understand reason for intervention, expected effect, and potential problems may result.
- ❑ Nursing interventions are a blend of science (rational) & art (intuitive actions).

Types of Nursing Interventions

Nursing Interventions Classification

The format of each intervention include: label, name, definition, a list of activities that a nurse performs to carry out intervention & a list of background readings

Nursing interventions include:

- Delivering skilled therapeutic interventions
- Assisting with ADL
- Monitoring and surveillance of response to care
- Teaching
- Supervising and coordinating nursing personnel
- Discharge planning

Evaluating

- ❑ Determine interventions efficacy by evaluating clients' expected outcomes achievement.
- ❑ Nursing Intervention Classification (NIC), previously described in this chapter, provides a systematic method for linking nursing activities to client outcomes.

Documentation of Interventions

- ❑ Communication of implementation of interventions must be provided through written documentation
- ❑ Nurse is legally required to record all interventions &observations related to client's response to treatment.
- ❑ Documentation provides legal record & allows communication with health team for continuity of care & evaluating progress toward expected outcomes.
- ❑ Documentation is indicators for quality improvement.
- ❑ Form of documentation (checklists, flow sheets, or narrative summaries).
- ❑ A complete description must be provided if there are any deviations from the norm or if any changes have occurred.

5) Evaluation

- ➢ E**valuation** is the fifth step in the nursing process and involves determining whether client goals have been met, partially met, or have not been met.
- ➢ Evaluation is not only a part of the nursing process, but it is also an integral process in determining the quality of health care delivered.

EVALUATION OF CLIENT CARE

- ❑ Evaluation is the measurement of the degree to which objectives are achieved. Evaluating care provided to clients is an essential part of professional nursing.
- ❑ "Evaluation is a planned, systematic process . . . [that] compares the client's health status with the desired expected outcomes"

The purposes of evaluation include:

- ❑ Determine client's progress or lack of progress toward expected achievement
- ❑ Determine nursing care effectiveness in achieving clients expected outcomes
- ❑ Determine overall quality of care provided
- ❑ Determine nursing accountability

COMPONENTS OF EVALUATION

- Evaluation is a fluid process that is dependent on all the other components of the nursing process.
- Evaluation affects, and is affected by, assessment, diagnosis, outcome identification and planning, and implementation of nursing care.

Techniques

- Effective evaluation results from nurse's use of communication & observation skills
- Verbal & nonverbal nurse and client communication can yield important information about accuracy of goals and expected planned outcomes and nursing interventions.
- Nurse needs to be sensitive to clients' willingness or hesitation to discuss their responses to nursing actions & must use therapeutic communication to collect necessary data.

Nursing Audit

A **nursing audit** is the process of collecting and analyzing data to evaluate the effectiveness of nursing interventions.

Nursing audits examine data related to:

▪ Safety measures	▪ Discharge planning
▪ Adequacy of staffing patterns	▪ Client teaching
▪ Treatment interventions & responses to interventions	
▪ Pre-established outcomes used as basis for interventions	

The aspects that need to be evaluated to determine the quality of health care are:

▪ Appropriateness (care provided adhered to standards & achieve goals)	
▪ Clinical outcomes	▪ Cost-effectiveness
▪ Client satisfaction	▪ Access to care
▪ Availability of resources	

Peer Evaluation

P**eer evaluation** (also referred to as *peer review*), is a process by which professionals provide to their peers critical performance appraisal and feedback that are geared toward corrective action. According to the ANA (1988): Peer review in nursing is the process by which practicing Registered Nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers, as measured against professional standards of practice.

MULTIDISCIPLINARY COLLABORATION IN EVALUATION

Evaluating the quality of care is a responsibility shared among members of the health care team. In addition to (health care providers, clients, and families), others interested in the outcomes of evaluation include community and third-party payers (both public and private organizations).