

THE NURSING PROCESS

By valan

- The **nursing process is the framework for providing professional**, quality nursing care. It directs nursing activities for health promotion, health protection, and disease prevention and is used by nurses in every practice setting and specialty.

HISTORICAL PERSPECTIVE

- Lydia Hall first referred to nursing as a “process” in a 1955 journal article, yet the term was not widely used until the late 1960s.

At this time, the nursing process involved only three steps:

- Assessment
- Planning
- Evaluation.

In their 1967 book *The Nursing Process*, Yura and Walsh identified four steps in the nursing process:

- Assessing
- Planning
- Implementing
- Evaluating

Currently, the steps in the nursing process are:

- Assessment
- Diagnosis
- Outcome identification and planning
- Implementation
- Evaluation

North American Nursing Diagnosis Association (NANDA), formulate, design, modify and publish Nursing diagnosis every year

PROCESS

A process is a series of steps or acts that lead to accomplishment of some goal or purpose.

Components of the Nursing Process

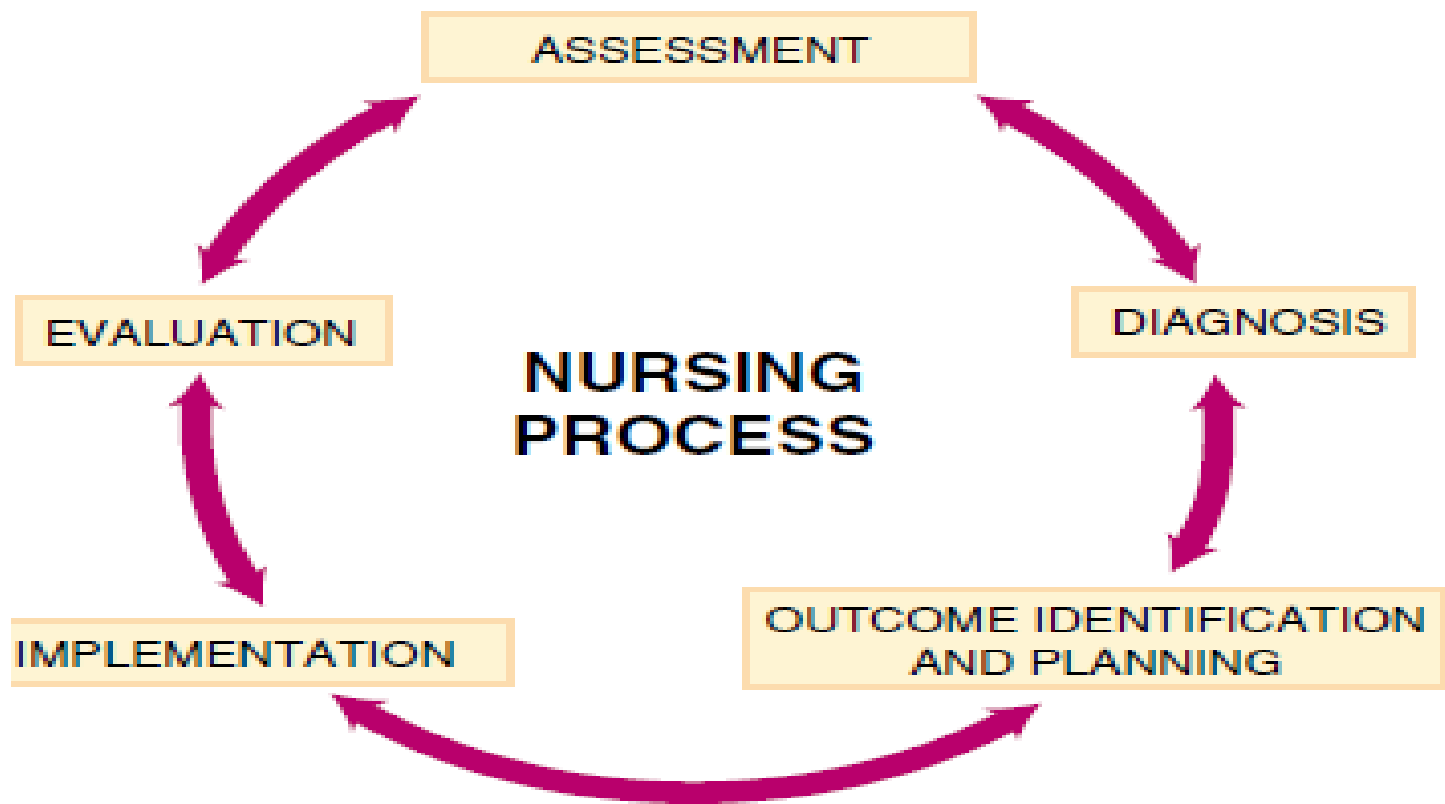


Figure 5-1 Components of the Nursing Process

Assessment

Assessment is the first step in the nursing process and includes systematic collection, verification, organization, interpretation, and documentation of data for use by health care professionals.

ELEMENTS OF THE ASSESSMENT PROCESS

- Data collection
- Data verification
- Data organization

- Data interpretation
- 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.
- Through assessment, the nurse determines the client's functional abilities and the **absence or presence of dysfunction.**

- The assessment phase also offers an opportunity for the nurse to form a **therapeutic interpersonal relationship** with the client.
- During assessment, the client is provided an opportunity to **discuss** health care concerns and goals with the nurse.

ASSESSMENT AS A STANDARD

Data must be:

- Relevant to client needs
- Collected from a variety of sources
- Collected using appropriate techniques

- Collected in a systematic manner
- Documented in a usable format

TYPES OF ASSESSMENT

Three types of assessment

Comprehensive Assessment

- A comprehensive assessment is usually completed upon admission to a health care agency and includes a complete health history to determine current needs of the client.

- This database provides a baseline against which changes in the client's health status can be measured.

Focused Assessment

- A focused assessment is an assessment that is limited in scope in order to focus on a particular need or health care problem or potential health care risks. (e.g., outpatient surgery centers and emergency departments)

Ongoing Assessment

- An ongoing assessment is an assessment that includes

systematic monitoring and observation related to specific problems.

- Ongoing assessment is particularly important when problems have been identified and a plan of care has been implemented to address these problems.
- Systematic monitoring and observations allow the nurse to determine the response to nursing interventions and to identify any emerging problems.

DATA COLLECTION

- The nurse must possess strong cognitive, interpersonal, and technical skills in order to elicit appropriate information and make relevant observations during the data collection process.
- This process often begins prior to initial contact between the nurse and the client , primarily through the nurse's review of biographical data and medical records.

TYPES OF DATA

These two types of information are referred to as subjective and objective data.

Subjective data

- These are data from the client's point of view and include feelings, perceptions, and concerns.
- They are called subjective because they rely on the feelings or opinions of the person experiencing them and cannot be readily observed by another.

Objective data

- These are observable and measurable (quantitative) data that are obtained through observation, standard assessment techniques performed during the physical examination, and laboratory and diagnostic testing.

SOURCES OF DATA

- **Primary source of data**

The information collected from the patient, using both interview techniques and physical examination skills.

- **Secondary sources**

The information collected from, include family members, other health care providers, and medical records.

Two types of information are collected through the assessment component: subjective and objective.

METHODS OF DATA COLLECTION

The nurse collects information through the following methods:

- Observation
- Interview
- Health history
- Symptom analysis
- Physical examination
- Laboratory and diagnostic data.

OBSERVATION

The nurse uses the skill of observation to carefully and attentively note the general appearance and behavior of the client.

- Factors such as client mood, interactions with others, physical and emotional responses, and any safety considerations.
- Nonverbal cues that indicate a variety of feelings, including presence of pain, anxiety, and anger.
- Warning signs of physical changes (e.g., pallor and sweating).

INTERVIEW

- An interview is a therapeutic interaction that has a specific purpose.

INTERVIEW PREPARATION

- The interview is more productive if the nurse has an opportunity to prepare for the interaction.
- Such preparation includes review of the client's medical records, conversations with other health care team members (e.g., personnel in emergency departments or long-term care facilities), and research of the presenting medical diagnosis.

- **Closed questions** are questions that can be answered briefly or with one-word responses. For example, the question “Have you been in the hospital before?”
- **Open-ended questions** are questions that encourage the client to elaborate about a particular concern or problem. For example, the question “What led to your coming here today?”

HEALTH HISTORY

DEMOGRAPHIC INFORMATION

- Personal data including name, address, date of birth, gender, religion, race/ethnic origin, occupation, and type of health plan/insurance should be included.

REASON FOR SEEKING HEALTH CARE

The client's reason for seeking health care should be described in the client's own words.

PERCEPTION OF HEALTH STATUS

- Perception of health status refers to the client's opinion of his or her general health.

- **PREVIOUS ILLNESSES, HOSPITALIZATIONS, AND SURGERIES**

- **CLIENT/FAMILY MEDICAL HISTORY**

The nurse needs to determine any family history of acute and chronic illnesses that tend to be familial.

IMMUNIZATIONS/EXPOSURE TO COMMUNICABLE DISEASE

Any history of childhood or other communicable diseases should also be noted. In addition, a record of current immunizations should be obtained.

- Exposure to communicable diseases, such as tuberculosis, or to human immunodeficiency virus (HIV).

ALLERGIES

Any drug, food, or environmental allergies should be noted in the health history. In addition to the name of the allergen, the type of reaction to the substance should also be noted.

CURRENT MEDICATIONS

All medications currently taken, both prescription and over-the-counter, are to be recorded by name, frequency and dosage.

PSYCHOSOCIAL HISTORY

- Psychosocial history refers to assessment of dimensions such as self-concept and self-esteem as well as usual sources of stress and the client's ability to cope.
- Sources of support for clients in crisis, such as family, significant others, religion, or support groups, should be explored.

SOCIOCULTURAL HISTORY

- In exploring the client's sociocultural history, it is important to inquire about the home environment, family situation, and client's role in the family.

- For example, the client could be the parent of three children and the sole provider in a single-parent family.

ACTIVITIES OF DAILY LIVING

The activities of daily living is a description of the client's lifestyle and capacity for self-care and is useful both as baseline information and as a source of insight into usual health behaviors.

Nutrition:

Includes type of diet and foods eaten and fluids consumed regularly, food preparation, the size of portions, and the number of meals per day.

Elimination:

Includes both urinary and bowel elimination frequency and patterns. Any recent changes or problems in these patterns should be noted.

Rest/sleep:

Includes the usual number of hours of sleep, number of hours of sleep needed to feel rested, sleep aids used, and the time within the day or night when sleep usually occurs.

Activity/exercise

Includes types of exercise and patterns in a typical day or week.

- If assistance is needed with activities such as walking, standing, or meeting hygienic needs, this information should be noted.

REVIEW OF SYSTEMS

The review of systems (ROS) is a brief account from the client of any recent signs or symptoms associated with any of the body systems.

Location: The area of the body in which the symptom (such as pain) can either be pointed to or described in detail.

Character: The quality of the feeling or sensation (e.g., sharp, dull, stabbing).

- ***Intensity:*** The severity or quantity of the feeling or sensation and its interference with functional abilities. The sensation can be rated on a scale of 1 (very little) to 10 (very intense).
- ***Timing:*** The onset, duration, frequency, and precipitating factors of the symptom.
- ***Aggravating/alleviating factors:*** The activities or actions that make the symptom worse or better.

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

- Baseline data collection is the systematic organization of observations obtained during the physical examination that forms the basis for comparison and evaluation to establish the status of a client at a given point in time.
- Measurement of height, weight, and vital signs (temperature, pulse, respirations, and blood pressure) is important for comparison with future measurements in order to judge the significance of any changes (progress or regression) over time.

TECHNIQUES

- The physical examination incorporates the use of visual, auditory, tactile, and olfactory senses and the use of systematic assessment techniques.
- The four assessment techniques used in physical examination are **inspection, palpation, percussion, and auscultation.**

INSPECTION

Inspection involves careful visual observation. The client is observed first from a general point of view and then with specific attention to detail.

- For example, the nurse first observes for patterns of skin lesions and then focuses on the specific characteristics of individual lesions.

PALPATION

Palpation uses the sense of touch to assess texture, temperature, moisture, organ location and size, vibrations and pulsations, swelling, masses, and tenderness.

Palpation requires a calm, gentle approach and is used systematically, with light palpation preceding deep palpation and palpation of tender areas performed last.

The technique of palpation uses the 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 and consistency of organs or masses:** Best detected by grasping organ or mass between fingertips

PERCUSSION

- Percussion uses short, tapping strokes on the surface of the skin to create vibrations of underlying organs.
- It is used for assessing the density of structures or determining the location and the size of organs in the body.
- Structures with relatively more air (such as the lungs) produce louder, deeper, and longer sounds.
- Solid structures (such as the liver), which produce softer, higher, and shorter sounds.

AUSCULTATION

Auscultation involves listening to sounds in the body that are created by movement of air or fluid.

- Areas most often auscultated include the lungs, heart, abdomen, and blood vessels.

LABORATORY AND DIAGNOSTIC DATA

Results of laboratory and diagnostic tests can be useful objective data as these values often serve as defining characteristics for various altered health states; these can also be helpful in ruling out certain suspected problems.

- For example, diabetic clients who are poorly controlled on diet and/or medication will usually have an elevated blood glucose level.

DATA VERIFICATION

Data verification is the process through which data are validated as being complete and accurate.

DATA ORGANIZATION

After data collection is completed and information is validated, the nurse organizes, or clusters, the information together in order to identify areas of strengths and weaknesses.

DATA INTERPRETATION

Data clustering facilitates recognition of patterns, and determination of further data that are needed. Data interpretation is necessary for identification of nursing diagnoses.

DATA DOCUMENTATION

Accurate and complete recording of assessment data are essential for communicating information to other health care team members. In addition, documentation is the basis for determining quality of care and should include appropriate data to support identified problems.

NORTH OAKS MEDICAL CENTER

Initial Nursing Patient Assessment

Admission Date	Room	Time
		__ AM __ PM

How admitted: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance ☐ Other:

Accompanied by: ☐ Family ☐ Friend ☐ Other:

VITAL SIGNS

ORIENTATION

Temperature	Height	Call Light/Bed Control ☐	Visitation Rules ☐	Bed locked ☐
Pulse	Weight (Actual) lbs.	Television ☐	Phone ☐	
Respiration		Educational Channels ☐	Bathroom/Emergency Light ☐	
B/P		Lights ☐	ID Band On ☐	

PERSONAL ESSENTIALS LIST / TRANSFER INFORMATION

Valuables to Safe ☐ No ☐ Yes (list on valuables envelope only) ☐ Sent Home	Date/Room	Date/Room	Date/Room	Date/Room
Essentials at bedside: (check only those that apply)				
Rings: ☐ Plain yellow metal ☐ Yellow metal with stone ☐ Plain white metal ☐ White metal with stone				
Watch – Describe				
Hearing Aid ☐ Left ☐ Right				
☐ Eyeglasses ☐ Contacts ☐ Right ☐ Left				
Dentures Full: ☐ Upper ☐ Lower Partial: ☐ Upper ☐ Lower				
Other (wheelchair, prosthesis, cane, etc.)				
	Admission	Sending RN	Sending RN	Sending RN
		Receiving RN	Receiving RN	Receiving RN

ALLERGIES

☐ No Known Allergies

☐ Yes

Allergy:

Type of Reaction:

HEALTH PERCEPTION/HEALTH MANAGEMENT PATTERN

(May be completed by RN or LPN)

Nursing Diagnosis (Must be completed by RN)

1. Informant: ☐ Patient ☐ Family Member ☐ Friend ☐ Unable to Obtain

2. Present Illness/Current Complaint/Reason for Hospitalization:

3. Date last admitted to North Oaks Medical Center

☐ Never admitted

4. Previous Hospitalization/Surgical Procedures:

5. Medical History:

☐ Diabetes	☐ Respiratory Disease	☐ Cancer	☐ Kidney Disease	☐ Mental Illness
☐ Hypertension	☐ Hepatitis	☐ GI Disease	☐ Thyroid Disease	☐ Arthritis
☐ Heart Disease	☐ Vision Disorder	☐ Sickle Cell	☐ Neuro-Muscular Disorders	☐ Sexually Transmitted Disease
☐ Tuberculosis	☐ Seizure Disorder	☐ Blood Disorder	☐ Problems with Anesthesia	☐ Other:

☐ Health Maintenance. Altered

☐ Noncompliance (Specify)

☐ Infection, Potential for

☐ Injury, Potential for

☐ Other (Specify)

NURSING DIAGNOSIS

Diagnosis is the science and art of identifying problems or conditions.

- **Medical diagnosis** is the terminology used for a clinical judgment by the physician that identifies or determines a specific disease, condition, or pathologic state.
- **Nursing diagnosis** is the terminology used for a clinical judgment by the professional nurse that identifies the client's or aggregate's actual, risk, wellness, or syndrome responses to a health state, problem, or condition.

- **COMPARISON OF SELECTED NURSING AND MEDICAL DIAGNOSES**

Sl.no	<i>Nursing</i>	<i>Medicine</i>
1.	<i>Ineffective Breathing Pattern</i>	Chronic Obstructive Pulmonary Disease
2.	<i>Activity Intolerance</i>	Cerebrovascular Accident
3.	<i>Acute Pain</i>	Appendectomy

Types of Nursing Diagnoses

- Actual problems
- Potential problems (including those where risk factors exist and there are possible problems)

Actual nursing diagnosis

It indicates that a problem exists, and is composed of the diagnostic label, related factors, and signs and symptoms.

Eg. *Impaired Skin Integrity* related to prolonged pressure on bony prominence as manifested by redness of the skin.

Risk nursing diagnosis (potential problem)

It indicates that a problem does not yet exist, but special risk factors are present.

A risk diagnosis is composed of the diagnostic label preceded by the phrase “risk for,” with the specific risk factors listed.

An example of a risk diagnosis is: *Risk for Impaired Skin Integrity* related to inability to turn self from side to side in bed.

PURPOSES OF NURSING DIAGNOSIS

- Nursing diagnosis is unique in that it focuses on a client's *response to a health problem, rather than on the problem itself*.
- Nursing diagnosis also provides a means for effective communication.
- Holistic client, family, and community-focused care are facilitated with the use of nursing diagnosis.
- Nursing diagnoses also have the potential of providing an avenue for theory development and nursing research.

COMPONENTS OF A NURSING DIAGNOSIS

- There are several formats that have been used to structure nursing diagnosis statements. Two formats that are frequently seen in the nursing literature are the two- and three-part statements.

The Two-Part Statement

- The components of a nursing diagnosis typically consist of two parts.

- The first component is a problem statement or diagnostic label that describes the client's response to an actual, possible, and risk health problem or a wellness condition.
- The second component of a two-part nursing diagnosis is the etiology.
- The etiology is the related cause or contributor to the problem.
- The diagnostic label and etiology are linked by the term *related to (RT)*.

Examples of nursing diagnoses are

- *Disturbed Body Image related to loss of left lower extremity.*
- *Activity Intolerance RT decreased oxygen-carrying capacity of cells.*

The Three-Part Statement

- The nursing diagnosis can also be expressed as a three part statement.
- As in the two-part statement, the first two components are the diagnostic label and the etiology.

- The third component consists of **defining characteristics** (collected data that are also known as signs and symptoms, subjective and objective data, or clinical manifestations).
- In the three-part nursing diagnosis format, the third part is joined to the first two components with the connecting phrase “as evidenced by” (AEB).

Example

- *Feeding Self-Care Deficit related to decreased* strength and endurance as evidenced by inability to maintain fork in hand from plate to mouth
- **TAXONOMY OF NURSING DIAGNOSIS**

Hypothermia - Decreased temperature

Hyperthermia- Increased temperature

Bowel incontinence- unable to control the bowel movements.

- Fluid volume excess – more fluid in the body
- Fluid volume deficit- Dehydration(decreased amount of fluid in the body)
- Risk for injury- in sedative, difficulty in walking
- Impaired gas exchange-
- Ineffective airway clearance
- Ineffective breathing pattern
- Risk for poisoning
- Risk for trauma
- Risk for aspiration

- Impaired skin integrity
- Impaired verbal communication
- Sexual dysfunction

LIMITATIONS OF NURSING DIAGNOSIS

- The primary concern is directed toward the lack of consensus among nurses regarding the NANDA-approved nursing diagnosis list.
- Many nurses are not familiar with the NANDA list and do not know how to use it or feel “it doesn’t have the diagnosis” they need.
- Nurses are more overworked than ever and have less time to spend with clients.
- The nursing diagnosis list does not always fit the client situation.

OVERCOMING BARRIERS TO NURSING DIAGNOSIS

- Agree on a common language.
- Support colleagues when they use nursing diagnosis language.
- Adopt a positive attitude toward the principles and taxonomy of nursing diagnosis.
- Participate in conferences, workshops, and other educational activities that advance and promote nursing diagnosis.
- Continue communicating with other nurses about nursing diagnosis.

Planning,

- The third step of the nursing process, includes the formulation of guidelines that establish the proposed course of nursing action in the resolution of nursing diagnoses and the development of the client's plan of care.
- A plan of action is developed with specific goals to resolve the nursing diagnoses or health problems of the client.

The four critical elements of planning include

- Establishing priorities
- Setting goals and developing expected outcomes
(outcome identification)
- Planning nursing interventions (with collaboration
and consultation as needed)
- Documenting

PROCESS OF OUTCOME IDENTIFICATION AND PLANNING

Critical Thinking

The planning of nursing care occurs in three phases

Initial planning

- Initial planning involves development of beginning of care by the nurse who performs the admission assessment and gathers the comprehensive admission assessment data.

Ongoing planning

Ongoing planning entails continuous updating of the client's plan of care. Every nurse who cares for the client is involved in ongoing planning.

Discharge planning

It involves critical anticipation and planning for the client's needs after discharge.

Establishing Priorities

The establishment of priorities is the first element of planning.

In establishing priorities, the nurse examines the client's nursing diagnoses and ranks them in order of physiological or psychological importance.

- **Prioritizing Nursing Diagnoses with Accompanying Nursing Implications**

Sl.no	Priority	Diagnosis	Nursing Implications
1.	High	<i>Ineffective Breathing Pattern</i>	Assess breath sounds. Auscultate lungs. Monitor vital signs. Reposition client.
2.	Moderate	<i>Risk for Impaired Skin Integrity</i>	

Writing Goals

- Written goals need to be constructed clearly. Clear, precise terminology improves the chances that goals will be achieved.
- The client has a clear idea of the direction to be taken for achieving resolution of each nursing diagnosis.
- Goals should be established to meet the immediate,
as well as long-term prevention and rehabilitation, needs of the client.

- **A short-term goal is a statement written** in objective format demonstrating an expectation to be achieved in resolution of the nursing diagnosis in a short period of time, usually in a few hours or days.
- **A long-term goal is a statement written in objective format** demonstrating an expectation to be achieved in resolution of the nursing diagnosis over a longer period of time, usually over weeks or months.

Planning Nursing Interventions

- Once the goals have been mutually agreed on by the nurse and client, the nurse should use a decision-making process to select appropriate nursing interventions.
- A nursing intervention is an action performed by a nurse that helps the client to achieve the results specified by the goals and expected outcome.
- Usually, several nursing interventions are developed for each of the goals identified for the client.

- The interventions are prioritized according to the order in which they will

SI		
	<i>Nursing Diagnosis:</i> <i>Acute Pain</i> related to myocardial Ischemia. <i>Goal:</i> <i>Client will resume normal activities of daily living.</i> <i>Expected Outcome:</i> <i>Client will verbalize relief of pain.</i> <i>Etiology:</i> <i>Myocardial ischemia</i>	<i>Expected Outcome:</i> <i>Client will verbalize relief of pain.</i> Nursing Interventions Assess pain characteristics such as location, quality,

- At first signs of pain, instruct client to relax and discontinue activity.
- Instruct client to take sublingual nitroglycerin.
- If pain continues after repeating doses every 5 minutes
for a total of three pills, notify the health care practitioner or nurse practitioner.
- Administer oxygen as prescribed.
- Note time interval between episodes of pain.
- Maintain bed rest and quiet environment to decrease oxygen demands.

A nursing order

- A **nursing order is** a statement written by the nurse that is within the realm of nursing practice to plan and initiate.
- These statements specify direction and individualize the client's plan of care.
- **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**).

ELEMENTS OF NURSING ORDERS

- Date-The date on which the order is written. This information is updated to reflect review and revision.
- Action-Directs the nurse's action. Examples of action verbs are *explain*, *demonstrate*, and *auscultate*.
- Detailed description - Precisely clarifies what the nurse's action will be. This phrase explains what, when, where, and how
- Time frame: Describes when, how often, and how long the nursing order is to be performed.

- Signature: Indicates the nurse who writes the order. This element implies legal and ethical accountability.

Categories of Nursing Interventions

- Nursing interventions are classified according to three categories: independent, interdependent, and dependent.

Independent nursing interventions

- These are nursing actions initiated by the nurse that do not require direction or an order from another health care professional.

In many states, the nurse practice acts allow independent nursing interventions regarding activities of daily living, health education, health promotion, and counseling.

Interdependent nursing interventions

- These are those actions that are implemented in a collaborative manner by the nurse with other health care professionals.
- Collaboration is a partnership in which all parties are valued for their contribution.
- For example, a client care conference or a discharge planning committee uses an interdisciplinary approach that includes health care members such as a nursing supervisor, a home health care nurse, a dietitian, a social worker, a physical therapist, and occasionally a physician.

- **Dependent nursing interventions**

These are those actions that require an order from another health care professional.

- **An example** of a dependent intervention is administration of a medication.

Implementation

- Implementation, the fourth step in the nursing process, involves the 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 and to make progress toward achievement of specific outcomes.

- **IMPLEMENTATION ACTIVITIES**
- Ongoing assessment
- Establishment of priorities
- Allocation of resources
- Initiation of nursing interventions
- Documentation of interventions and client response

Ongoing Assessment

- The nursing plan of care is based on the initial assessment data collected by the nurse and the nursing diagnoses derived from those data.
- Because a client's condition can change rapidly, or new data may become available through interaction with the client, ongoing assessment is necessary to validate the relevance of proposed interventions.

Establishment of Priorities

- Which problems are deemed most important by the nurse, the client, and family or significant others.

Allocation of Resources

- Before implementing the nursing plan of care, the nurse reviews proposed interventions to determine the level of knowledge and the types of skills required for safe and effective implementation.

Delegation of Tasks

- **Delegation** is the process of transferring a selected nursing task in a situation to an individual who is competent to perform that specific task.
- It must be remembered that, although some activities can be assigned to other health care personnel, the registered nurse remains accountable for appropriate delegation and supervision of care provided by these individuals.

Nursing Intervention Activities

Activities of Daily Living

- Clients frequently need assistance with ADL such as bathing, grooming, ambulating, eating, and eliminating.
- The nurse's role is to determine the extent of assistance needed and to provide support for ADL while at the same time fostering independence.
- The nurse must always provide privacy when assisting clients with personal hygiene.

Therapeutic Interventions

- Therapeutic nursing interventions are those measures directed toward resolution of a current problem and include activities such as administration of medications and treatments, performing skilled procedures, and providing physical and psychological comfort.
- Written orders must be verified before implementing interventions requiring prescriptive authority.
- In addition, a nurse must also understand the rationale, expected effects, and possible complications that could result from any intervention.

Monitoring and Surveillance

- Observation of the client's response to treatment is an integral part of implementation of any intervention.
- Specific interventions require specific monitoring activities; however, typical monitoring activities include observations such as vital signs measurement, cardiac monitoring, and recording of intake and output.

Teaching

- Numerous opportunities arise every day for informal teaching related to client care. For example, teaching clients about the medications they are taking and possible side effects should occur routinely as medications are administered.

Discharge Planning

- Teaching related to any changes in diet, medications, or lifestyle must be implemented; any barriers or problems in the home environment must be resolved before discharge.

Supervision and Coordination of Personnel

- The management style and type of facility, as well as the needs of the client, determine the scope of interventions associated with supervision and coordination of client care.
- The nurse needs to coordinate client activities around the schedule of diagnostic tests or physical therapy.

Evaluating Interventions

- An important step to assure the delivery of quality care is evaluation of nursing interventions.

Documentation of Interventions

- The nurse is legally required to record all interventions and observations related to the client's response to treatment.
- This not only provides a legal record but also allows valuable communication with other health care team members for continuity of care and for evaluating progress toward expected outcomes.

Evaluation

- **Evaluation is the fifth step in the nursing process**

and involves determining whether the client goals have been met, have been partially met, or have not been met.

- Evaluation is the measurement of the degree to which objectives are achieved.
- “Evaluation is a planned, systematic process . . . [that] compares the client’s health status with the desired expected outcomes”.

The purposes of evaluation include:

- To determine the client's progress or lack of progress toward achievement of expected outcomes.
- To determine the effectiveness of nursing care in helping clients achieve the expected outcomes.
- To determine the overall quality of care provided.
- To promote nursing accountability (discussed later in this chapter)

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.

Nursing Process Phase	Evaluation Focus
Assessment	Data collection was thorough and complete. Data were collected from multiple, varied sources. Data were relevant to client needs. Appropriate methods were used to obtain data. A systematic, organized method was used in collecting data.
Diagnosis	Nursing diagnoses were client-centered, accurate, and relevant. Each nursing diagnosis was complete. Nursing diagnoses were comprehensive. Diagnoses were based on the collected data. Nursing diagnoses guided planning and implementation of care.
Outcome identification and planning	Expected outcomes were relevant to nursing diagnoses. Objectives were prioritized. Outcomes were realistic and achievable. Resources (including team members) were used efficiently. Nursing plans were documented.
Implementation	Team members followed the plan of care. Necessary resources were available. Nursing actions assisted client in meeting expected outcomes. Client achieved expected outcomes.

Techniques of evaluation

- Effective evaluation results primarily from the nurse's accurate use of communication and observation skills.
- Both verbal and nonverbal communication between the nurse and the client can yield important information.
- Observation occurs through use of the senses. In other words, what the nurse sees, hears, smells, and feels when touching the client all provide clues to the client's current health status.

Sources of Data

- Evaluation is a mutual process occurring among the nurse, client, family, and other health care providers.

EVALUATION AND QUALITY OF CARE

Evaluation is performed at the individual and institutional levels.

- Appropriateness
- Clinical outcomes
- Client satisfaction
- Cost-effectiveness
- Access to care
- Availability of resources

Elements in Evaluating the Quality of Care

- Organizational evaluation examines the agency's overall ability to deliver quality care.

Structure Evaluation

- Structure evaluation is a determination of the health care agency's ability to provide the services offered to its client population.
- Structure evaluation examines the physical facilities, resources, equipment, staffing patterns, organizational patterns, and the agency's qualifications for staff.

Process Evaluation

- Process evaluation is the measurement of nursing actions by examination of each phase of the nursing process.
- This type of evaluation is done to determine whether nursing care was adequate, appropriate, effective, and efficient.

Outcome Evaluation

- Outcome evaluation is the process of comparing the client's current status with the expected outcomes.
- This type of evaluation examines all direct care activities that affect the client's health status.