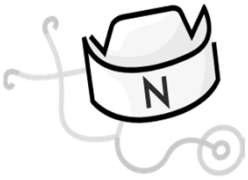

Nursing Process

Leslie Martinez, MSNEd, RN
Los Angeles County
College of Nursing and Allied Health
leslmartinez@dhs.lacounty.gov

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Nursing Process Agenda

- Purpose, definition, & characteristics
- Professional implications
- 5 steps: "ADPIE"
- Prioritization activity
- Nursing Diagnosis activity
- Nursing Care Plan example
- Game on!

2

Goals of Nursing

1. Prevent illness
2. Promote, maintain, or restore health
3. Maximize sense of well-being
4. Maximize client's ability to function in desired role
5. Provide cost-effective, efficient care
6. Improve client satisfaction

Client: an individual, a family, a community or a group

3

Nursing Process Characteristics

1. Data from each phase provides input on the next
2. Achieves patient centered outcomes (QSEN)
3. Forms problem-solving skills
4. Minimizes errors or omissions
5. Strengthens decision making
6. Interpersonal & collaborative
7. Any healthcare settings across lifespan

4

Professional Implications

1. **Identifies consumer of care**
   - Press Ganey survey
   - Internet resources
2. **Incorporated in Standards of Nursing Practice (ANA)**
3. **Board of Registered Nursing (BRN)**
   - Mandates use in Nursing Practice

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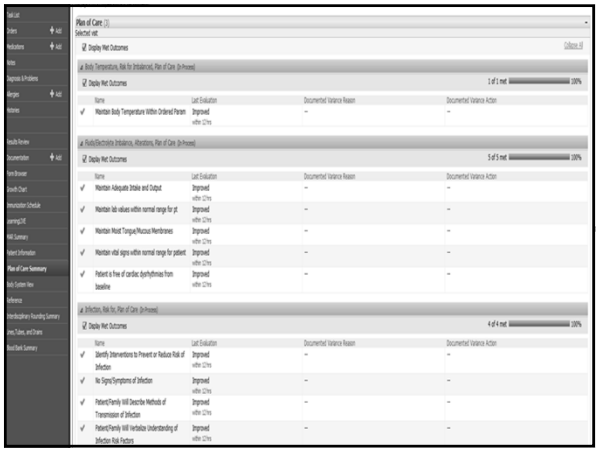

Professional Implications

4. **National Practice Standards**
   - RN accountability
5. Provides the basis for NCLEX exam
6. Tool for critical thinking in clinical
7. Aids Magnet status achievement
   - All nurses must be thoroughly familiar with each phase

7

QSEN Competencies: Knowledge, Skills & Attitude

- Patient-centered care
  - Incorporating patient/family preferences and values for delivery of optimal health care
- Teamwork and collaboration
  - Working with inter- and intraprofessional teams in developing a pt centered plan of care
- Evidence-based practice
  - Integrating best current evidence with clinical expertise and interventions

8

QSEN Competencies: Knowledge, Skills & Attitude

- Quality improvement
  - Interventions must have been researched
    - Evidence must be established to support their effectiveness
- Safety
  - Assessment and evaluation of interventions for level of appropriateness (age/physical capability)
- Informatics
  - Document and plan patient care in the EHR

9

- When you understand the Nursing Process you become thought-oriented rather than task-oriented

10

Nursing Process Steps "ADPIE"

1. **Assessment** (of the client's needs)
2. **Diagnosis** (of human response needs that **nurses** can treat)
   1. Outcome identification
   2. Analysis
3. **Planning** (the client's care)
4. **Implementation** (of the plan)
5. **Evaluation** (of the success of the implemented care)

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Step 1: Assessment

~To establish a database of the client's response to health concerns/illness and their ability to manage health needs

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Assessment Activities

1. Establishing a database
   - Obtain nursing health hx
   - Perform physical assessment
   - Review records & literature
   - Consult support persons & health professionals
2. Update, organize, and validate data
3. Communicate/document data

- Continues through all steps

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Collecting Data

1. Before you see the client
2. When you see the client
3. After you see the client

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Subjective Data (Symptoms)

- Apparent only to the person affected
- Can be described/verified only by the person affected
  - Sensations, feelings, values, beliefs, attitudes & perceptions of personal health status & life situations
- "I feel like my heart is racing"

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Objective Data (Signs)

- Detectable by an observer
- Can be measured or tested against an accepted standard
- Can be seen, heard, felt, or **smelled**
- Obtained through observation or physical examination
- Apical HR 150, regular & strong

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Support Persons

- The **client** is the primary source

- Family
- Support persons
- Health professionals
- Medical records
- Validate information

✓When is it appropriate to use a secondary resource?

= Too ill, unconscious, child, confused...

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3 Methods of Data Collection

1. Observing
2. Interviewing
   1. Setting
   2. Questions
   3. Techniques
3. Assessment

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Observing

- Gathering data using senses
  - Except taste right?
- Used to obtain the following types of data:
  - -Skin color (vision)
  - -Body or breath odors (smell)
  - -Lung or heart sounds (hearing)
  - -Skin temperature (touch)

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Interviewing

- Planned purposeful communication
  - Positive, professional and unbiased
- Purpose
  - Obtain or give information
  - Identify problems
  - Evaluate change
  - Teach
  - Provide support & counseling

20

The Interview Setting

- Preparation
- Time
  - Formal vs. informal
- Place
- Seating arrangements
- Respectful distance
- Language
  - Interpreter, translator, or family?

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Interview Tips

- Terminating interview & assessment
  - Time constraints
  - Summarizing
  - End on positive: Offer availability
- Common communication errors
  - Using first or endearing names
  - Talking down or ignoring cultural considerations

22

Questioning Techniques

- **Closed-ended questions**
  - Do you get along with your husband?
  - Are you allergic to Motrin?
- **Open-ended questions**
  - How is your relationship with your husband?
  - What reaction do you have to Motrin?

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Open-ended Questions

Advantages

- Promotes dialogue
- Reveals what is important to client
- Reveals lack of understanding
- Shows heartfelt interest

Disadvantages

- May allow for avoidance
- Time limits
- Permits for getting off track

Responses difficult to document

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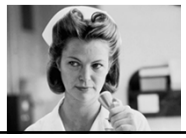
Closed-ended Questions

Advantages

- Clarifies response to open-ended questions
- Saves time
- Focuses the interview
- Assists with sicker clients
- Easily documented

Disadvantages

- May seem threatening
- Limits information offered
- Discourages concerns
- Discourages dialogue
- Interviewer focused



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Physical Assessment

1. Systematic data-collection method
   - Head-to-toe
   - Body system approach
2. Technique
   - Observation, inspection, auscultation & percussion
3. Data obtained
   - BP, HR, heart, lung, & GI sounds, skin temperature & moisture, & muscle strength

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Clustering (Organizing) Data

1. Identifies nursing dx & problems
2. Identifies s/s of possible medical problems
3. Sets priorities
   - Maslow's Hierarchy
4. Promotes critical thinking
5. Identifies client's strengths

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Nursing Assessment Frameworks

- **Nursing Model/Framework**
  - Neuman Model

- **Non-nursing Models**
  - Body systems model
  - Maslow's Hierarchy of Needs
  - Developmental theories

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Maslow's Hierarchy of Needs: Setting Priorities

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Validating Data

1. Compare subjective & objective data
   1. Conflicting information
2. Unreliable source
   1. Altered client
3. Recheck abnormal findings
   1. Compare findings to normal values

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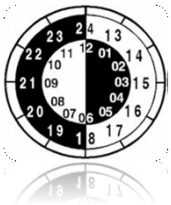
Documentation & Reporting

- Timely reporting promotes:
  - Expedited diagnosis & treatment of urgent problems
  - Continuity of care
  - Factual documentation
    - Use of quotes
    - Measurable terms



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Assessment	Nursing Diagnosis	Planning	Implementation	Evaluation
Subjective: • Fatigue • "lose my breath w/ coughing & deep breathing" **Objective**: • RR: 29 • O2 Sat: 92% on 3L/min via NC • Lung Sounds: Decreased with wheezes • Stabbing R CP • HCT: 30%		Goal:		Goal:

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Step 2: Nursing Diagnosis:

~To identify the client's strengths and health problems that can be prevented or resolved by collaborative & independent nursing interventions

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Nursing Diagnosis Activities

1. Interpret & analyze data
   - Compare data against standards
   - Cluster or group data
   - Identify gaps and inconsistencies
2. Determine client's strengths, risks, & problems
3. Formulate nursing dx & collaborative problem statements
4. Document nursing diagnoses on the care plan

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North American Nursing Diagnosis Association (NANDA)

- **NANDA** ~ Internationally recognized as the leader in development & classification of nursing diagnoses

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Types of Nursing Diagnoses

1. Actual
2. Risk
3. Health Promotion
4. Syndrome
5. Collaborative

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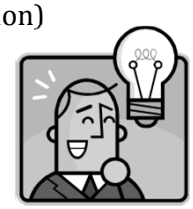
Actual Nursing Diagnosis Components

- **(P)**= Problem (& definition)
- **(E)**= Etiology
  - Pathophysiology
- **(S)** = Signs & Symptoms
  - Assessment



"**(P)** Deficient Fluid Volume r/t **(E)** insufficient intake to replace fluid loss as evidenced by **(S)** tachycardia and poor skin turgor."

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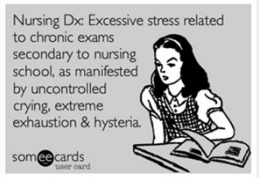
Nursing Diagnoses/Qualifiers

❖Gives additional meaning to Nursing Diagnoses

1. Deficient fluid volume
2. Impaired urinary elimination
3. Decreased cardiac tissue perfusion
4. Ineffective coping

   1. Signs and symptoms should support dx



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Etiology (Cause)

➢Identifies one or more probable causes of the health problem

➢Gives direction to required nursing interventions

➢Aids in individualizing client's care

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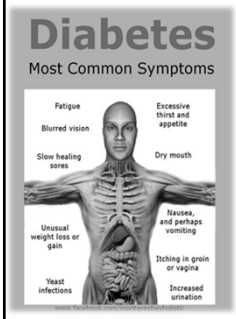
Writing Nursing Diagnoses Correctly

1. Ineffective breathing pattern r/t accumulation of secretions in lungs
   - Nursing terminology
2. Impaired skin integrity r/t immobility
   - Legally acceptable

1. Ineffective breathing pattern r/t emphysema
   - Medical terminology
2. Impaired skin integrity r/t improper positioning
   - Implies legal liability

Defining Characteristics (S/S)



- Cluster of signs and symptoms that demonstrate/support nursing diagnosis problem is present
- Subjective
- Objective

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Actual Nursing Diagnosis

- A problem that is present at the time of **YOUR** nursing assessment.
- (P) Problem
  - "**Ineffective Airway clearance**
- (E) Etiology
  - "related to (r/t) **excessive mucus accumulation**
- (S) Signs/Symptoms
  - …as manifested by the **decreased breath sounds bilaterally, left lobe crackles & ineffective coughing.**"
- Ineffective airway clearance r/t excessive mucous accumulation AMB decreased breath sounds bilaterally, left lobe crackles and ineffective coughing.

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Nursing Diagnosis Statement

1. (P) Low self esteem r/t (E) unrealistic self-expectations AEB (S) receiving a "B" in two nursing courses while working full time.
2. Impaired urinary elimination r/t neurogenic surgical complications AEB no UO for seven hours.
3. Impaired memory r/t fluid and electrolyte imbalance AEB inability to recall recent events.

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Variations of Basic Formats

1. Unknown etiology
   1. *Noncompliance (medication regimen) r/t* ***unknown etiology***
2. Too many etiologic factors
   1. *Chronic Low Self Esteem r/t* ***complex factors***
3. Using the describing word "possible"
   1. ***Possible*** *Low Self Esteem r/t loss of job & rejection of family*
4. Dividing the etiology into two parts
   1. *Impaired Skin Integrity r/t decreased peripheral circulation* ***secondary to*** *diabetes*
5. Adding a second part for precision
   1. *Impaired Skin Integrity* ***(Left Lateral Ankle)*** *r/t decreased peripheral circulation*

44

Physiologic Dx/Psychological Dx

- Formal functions of the body
- Examples
  - Acute pain
  - Ineffective peripheral tissue perfusion
  - Risk for aspiration
- Mental or emotional
- Examples
  - Social isolation
  - Situational low self-esteem disturbance
  - Anxiety
  - Fear

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Risk Nursing Dx

- Health problem **may** develop if the nurse does not intervene
- Identifiable risk factors, **no evidence** of the problem

- Examples: **2 part statement**
  1. (P) Risk for infection r/t (E) **immunosuppression**
  2. (P) Risk for aspiration **r/t** (E) **decreased cough and gag reflex**
  3. (P) Risk for impaired skin integrity **r/t** (E) **excessive diaphoresis & confinement to bed**

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Collaborative Problems: Potential Complications (PC)

- A potential problem nurses manage using both independent & dependent interventions
  - Focus: monitoring condition & prevention of complication developing
  - Requires nursing & medical interventions

- Collaborative problems = present disease or treatment that has specific complications associated with it.

Collaborative Problems

1. **Potential Complication of** Medication: adverse reaction, overdose, toxicity
2. **Potential Complication of** pneumonia: respiratory failure, pleural effusion, atelectasis
3. **Potential Complication of** Preeclampsia: seizures, fetal distress, pulmonary edema, premature labor

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Collaborative vs. Risk Dx?

- Risk: Requires only nursing interventions
- Potential Complication (Collaborative): Requires nursing and physician-prescribed interventions

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Health Promotion Nursing Dx

- A client's preparedness to implement behaviors to improve their health condition.
- Examples: **1 part statement**
  - Readiness for enhanced self-care
  - Readiness for enhanced family coping
    - Wife requests a support group regarding husband having CVA 2 months ago

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Syndrome Nursing Dx

- Associated with a cluster of other nursing diagnoses that happen together
- 1 part statement
  - Chronic Pain Syndrome
    - Disturbed sleep pattern
    - Social Isolation
    - Fatigue
    - Impaired physical mobility

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Medical Diagnosis

- Identifies conditions the doctor is licensed & qualified to treat
- Focuses on the illness, injury, or disease process
- Remains constant until a cure occurs

Nursing Diagnosis

- Identifies situations the nurse is licensed & qualified to treat
- Focuses on the client's responses to actual or potential health problems
- Evolves as the client's response &/or health changes

52

Diagnosis Comparison

- **Medical Diagnosis**

1. Asthma
2. Anemia
3. Arthritis
4. Cerebrovascular Accident (CVA)

- **Nursing Diagnosis**

1. Ineffective Breathing Pattern
2. Activity Intolerance
3. Acute or Chronic Pain
4. Impaired Verbal Communication

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Assessment	Nursing Diagnosis	Planning	Implementation	Evaluation
Subjective: • Fatigue • "lose my breath w/ coughing & deep breathing" Objective: • RR: 29 • O2 Sat: 92% on 3L/min via NC • Lung Sounds: Decreased with wheezes • Stabbing R CP • HCT: 30%	Ineffective breathing pattern **r/t** abnormal breathing pattern **AEB** RR 29, O2 sat 92% on 3L via NC, and c/o "losing my breath".	Goal:		Goal:

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Nursing Diagnosis Worksheet

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Step 3: Planning

~To develop an individualized care plan that specifies client goals/desired outcomes, and related nursing interventions

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Planning Activities

1. Set priorities & goals/outcomes in collaboration with client
2. Write goals/desired outcomes
3. Select nursing strategies/interventions
4. Consult other health care professionals
5. Communicate care plan to relevant health care providers

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Planning

3 types of planning:

1. **Initial planning**: Developing the preliminary plan of care (on admission)
2. **Ongoing planning**: Updates of care based on reassessment
3. **Discharge planning**: Anticipation & preparing for the patient's needs after discharge

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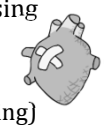
Setting Priorities

- Establishing a sequence for addressing nursing diagnoses & interventions
  1. High priority (life-threatening)
  2. Medium priority (health-threatening)
  3. Low priority (developmental needs)



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Factors to Consider when Setting Priorities

- Client's health values & beliefs
- Client priorities
- Resources available to the nurse & client
- Urgency of the health problem
- Medical treatment plan

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Prioritizing Diagnoses

- Acute Pain
- Ineffective Tissue Integrity
- Ineffective Breathing Pattern
- Social Isolation
- Fear

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Client Goals/ Desired Outcomes

- What the nurse hopes to achieve by implementing nursing interventions
- Purpose:
  1. Provides direction for planning nursing interventions
  2. Serve as criteria for evaluating client progress
  3. Enable the nurse to determine when the problem has been resolved
  4. Help motivate the client and nurse by providing a sense of achievement
  - Each goal is derived from **only** 1 nursing dx

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Short-term Goals

- Describe early, expected benefits of nursing interventions
- "The client will raise right arm to shoulder height by 1200 9/20/15."

Long-term Goals

- Describe benefits expected to be seen at a certain point after the plan has been implemented
- "The client will regain full use of right arm in 6 weeks."

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Components of Goal/ Desired Outcome Statement

1. Subject
2. Verb
3. Conditions or modifiers
4. Desired performance
5. Time bound

"The client will identify two non-pharmacologic modalities to decrease pain to a satisfactory level by 1200 9/30/15."

not

"The nurse will assist with diversion activities to decrease pain by the end of the shift."

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Verbs for Goal Writing

- Measurable Verbs
  - Apply, breathe, choose, define, demonstrate, select, state, turn, verbalize, prepare, identify, inject, describe, name…

- Non-measurable Verbs
  - Know, think, understand, feel…

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Guidelines for Writing Goals/Desired Outcomes

1. Begin with, "The client will"
2. Realistic for client's capabilities
3. Compatible with all health therapies
4. One goal per nursing diagnosis
5. Observable, measurable terms
6. Ensure client values goal

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Case Study

- Assessment
  - 45 y.o. Latino male
  - Self-employed gardener, lives with wife, 4 kids
  - Severe HA, 40 lbs. overweight, BP 180/95
  - Noncompliant: Only takes BP med PRN for HA
- Goal
  - "Client will

Planning Guidelines

1. Include date & time for goal
2. Be specific
   1. (Not "at end of shift")
3. Tailor plan to client's daily routine
4. Include ongoing assessment
5. Include preventative & health maintenance interventions
6. Include plans for discharge/home care needs

Nursing Interventions

- Actions the nurse performs to achieve client goals

1. Actual Nursing Diagnosis interventions:
   - Focus on eliminating or reducing the etiology of the nursing diagnosis
2. Risk Nursing Diagnosis interventions:
   - Focus on reducing risk factors

Nursing Interventions

1. Independent nursing interventions
   - Activities nurses are licensed to initiate on basis of knowledge and skills
2. Dependent nursing interventions
   - Activities carried out under provider licensed to write orders to nurses
3. Collaborative nursing interventions
   - Actions nurses carry out in collaboration with other health care members

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Criteria for Choosing Appropriate Interventions

- Safe & appropriate for the client's age, health & condition
- Congruent with other therapies
- Evidence based practice
  - Must have rationale for every nursing order
- Within established Standards of Care
- Which interventions are appropriate to delegate?

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Nursing Interventions

1. Observations
   - Assessment to determine if complication is developing
2. Prevention
   - Care needed to reduce risk factors
3. Treatments
   - Teaching, referrals, physical care…
4. Enhancement or promotion
   - Care that will lead to higher level of wellness

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- Constipation r/t inadequate diet AMB prolonged and difficult evacuation.
- Nursing Interventions & Rationales
  1. Assess usual bowel pattern
     - *R=To determine if current pattern is abnormal*
  2. Encourage fiber/fluid intake
     - *R=To soften stool and ease evacuation*
  3. Review current medications
     - *R=To assess for contributing factors*
  4. Encourage ambulation/ROM exercises
     - *R=To promote peristalsis*

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Step 4: Implementing

~To assist the client to meet desired goals/outcomes; promote wellness; prevent illness and disease; restore health; and facilitate coping with altered functioning

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Successful Implementation

- Cognitive skills
  - Knowledge
- Interpersonal skills
  - Communication
- Technical skills
  - Psychomotor

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Implementing Activities

1. **Reassess the client** to update database and determine if interventions are safe
   Determine the nurse's need for assistance
2. Implement planned nursing interventions
3. Supervise delegated care
4. Communicate what nursing interventions were implemented:
   1. Document care and client response
   2. Give verbal reports as needed

Key Points to Implementation

- ✓Evidence-based practice
- ✓Clearly understood interventions
- ✓Adapt activities to patient
- ✓Implement safe care
- ✓Be holistic
- ✓Provide teaching, support, & comfort
- ✓Respect the dignity of the patient
- ✓Encourage active patient participation

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4 Parts to Nursing Orders (Nursing Interventions)

1. What to **assess**, observe, or monitor
2. What to **do**
3. What to **teach**
4. What to **document**

- **Scientific rationale**

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Documenting Implementation

- Nursing activities & client responses for nursing actions
- Individualized nursing activities based on assessment data
- Past tense ~ What the nurse did & the client's response to the nursing intervention

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Step 5: Evaluation:

~To determine whether to continue, modify, or terminate the plan of care

~Judgment of client's progress toward goal & effectiveness of the NCP

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Evaluation Activities

1. Collect data related to outcomes
2. Compare data with outcomes
3. Relate nursing actions to client goals/outcomes
4. Draw conclusions about problem status
5. Continue, modify, or terminate the client's care plan
   1. **"Met, partially met, or not met"**

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Evaluation

1. Realistic/Appropriate for client?
2. Consistently implemented?
3. Timely changes made in plan?
4. Patient's opinion of outcome?
5. Impeding factors?
6. What enhanced progress?
7. Need further research → Better results?

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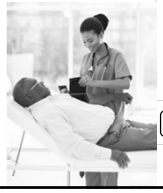
Assessment vs. Evaluation

- Ongoing and continuous at every client interaction
- Data collection is done for the purpose of making a diagnosis
- Data collection is done for the purpose of comparing to goals/outcomes and judging effectiveness of the NCP
  - Differences:
    - When the data are collected
    - How the data are used



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Reporting (Documenting)

- Activities completed & those yet to be completed
- Current problems
- Abnormal findings or changes in the patient assessment
- Treatment results
- Diagnostic tests completed with results (if available) or scheduled

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Nursing Care Plan

- A written guide, organizing patient data into a formal statement of strategies to assist the client to optimal health
- APA source
  - http://owl.english.purdue.edu/owl/resource/747/01/

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Questions?

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