PRESENTED BY

MRS.RAJESWARI

PROFESSOR

ICON

UNIT-V NURSING PROCESS

PROCESS: process is a set of actions used to determine, plan, implement and evaluate nursing care.

NURSING PROCESS: nursing process may be defined as a systematic method of assessing the health status, diagnosing health care needs, formulating a plan of care, initiating the plan and evaluating the effectiveness or outcome of the plan.

The term process was introduced by Hall in 1955.

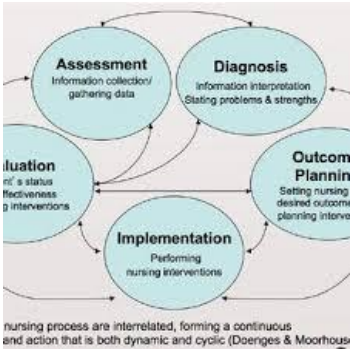
PURPOSES OF NURSING PROCESS:

1. Primary purpose of nursing process is to help the nurse to manage each patient's care intelligently, sufficiently, and judiciously.
2. To help the patient in maintaining health.
3. To protect the client from illness
4. To identify client's health problems
5. To determine priorities.
6. To initiate plan for meeting the identified needs.
7. To deliver the specific nursing interventions
8. To evaluate the effectiveness of nursing care provided.
9. During terminal illness, help the client to have a peaceful death.

CHARACTERISTICS OF NURSING PROCESS:

1. ***Problem oriented***: nursing process is always focusing on client's problem. Problem may be 1. Actual/ current 2. Potential
    - Actual problems mean the problems from which client is already suffering. E.g.) loss of appetite, loss of sleep, vomiting, constipation.
    - Potiential problems means problems which are not presently, client have in future, there are chances. e.g.) in case of bedridden and obese-potential problem will be developing bed sore, muscle wastage, constipation.

2. ***Universally applicable***: it means information collected in one setting will be understood similarly in other setting. In nursing process we are using standardized steps as well as NANDA Diagnosis. Regardless of location worldwide terminology will be applied.
3. ***Dynamic:*** it is a dynamic activity which begins when the nurse collects subjective and objective data. Dynamic means changeable .new data is added if the patient condition changes or pt. reveals more information.
4. ***Cyclic process:*** nursing process involves interrelated steps. Nurse can't process by omit one step. Just like wheel, the nursing process continuously proceeds until the problem is solved or goal is achieved. If the problem is not solved, nurse has to follow the assessment, the planning step or have to change the nursing strategic steps.



5. ***Interpersonal and collaborative approach:*** nursing process involves interpersonal and collaborative approach in the sense; nurse cannot give independent care to client in hospital.
   In the assessment phase, nurse collects, verifies information from laboratory investigation as well as medical records.
6. ***Goal oriented***: nursing process is always goal oriented. While approaching the client, nurse keeps in mend her professional goal i.e. to promote health, to alleviate disease, to protect the client from complications etc..,
7. ***Open and flexible***: open means information is gathered through client's cooperation. It is discussed with patient. It changes as the clients need change or problem is resolved.
8. ***Creativity in designing ways***: in every step of nursing process, nurse follows critical thinking to assess/ identify the client's problem.in the planning phase, she thinks about various ways(keeping in mind the clients educational level, learning needs, economic status, his values and feelings).
9. ***Client oriented***: nursing process involves identifying and solving the client's problems and not the nurses. It doesn't mean that nurse will carry out the care as per her desires. Always keep in mind client's age, education, gender, personal interest, values and feelings.

10. ***Systematic and planned***: Always follow a series of actions/ 5 steps. Nurse can't proceed to 3rd step until she follows first 2 steps in sequence. It is planned activity.
11. ***Feedback***: Nursing process gives much weightage to the feedback. If the feedback is positive, the problem is solved, gives satisfaction to nurse for her activities. If the feedback is negative, she again follows the nursing steps to resolve the problem.
12. ***Nursing process steps are interrelated:***
    Every step in nursing process is closely related. Each step is dependent on other step.

STEPS OF NURSING PROCESS:

Nursing process helps the nurse to organize and deliver effective nursing care. It includes 5 steps, 1. Assessment 2. Nursing diagnosis, 3. Planning 4. Implementation 5. Evaluation.

1. **Nursing assessment:**
   - Nursing assessment is the process of gathering, verifying and communicating the data.
   - It helps in establishing base line data about client level of wellness, health practices, past illness, related experiences and health care goals.
   - This is the initial step in nursing process and continuous throughout nurse patient association
2. **Nursing diagnosis:**
   - Nursing diagnosis is a statement of the potential or actual problem of the client that the nurse is licensed and competent to treat.
   - Based on the nursing assessment, nurse formulates the nursing diagnosis.
   - There is a difference between nursing and medical diagnosis.
3. **Planning:**
   - It is the process of thinking before doing
   - It involves determination of goals as well as nursing activities required to achieve the desired /set goals.
   - Planning involves setting goals, priorities and nursing care to be performed.
4. **Implementation:**
   - Implementation follows the planning phase of nursing process
   - It puts the nursing care into an action.

5. **Evaluation:**
    - Evaluation is the consequence / result/ outcome of the nursing interventions.
    - It may be positive or negative. It determines the effectiveness of the nursing care.

IMPORTANCE OF NURSING PROCESS:

- Helps in ensuring quality care. It helps to evaluate what quality care is provided to the client.
- Nursing activities performed for a client, family, society is available in written form.
- It avoids duplications (unnecessary repetitions) and omissions.
- It enhances communication as well as cooperation among nursing personnel.
- It helps in meeting the client's individualizes preferences and needs.
- Nursing process is legal document.
- It provides organized methods of giving care.
- It helps nurse to gain satisfaction by getting results.
- It promotes flexibility in giving individualized nursing care.
- It helps to improve continuity of care.

NURSINGASSESSMENT: Assessment is the first step in the nursing process. In this step, a nurse systematically collects, verifies, analyses and communicates data about a client health status.

Definition: Assessment refers to the collection and interpretation of clinical information. It focuses on gathering the data about a client's state of wellness functional ability, physical status, strengths, and responses to actual and potential health problems.(Gordon 1987)

Purposes of nursing assessment:

- To gather information regarding client health.
- To determine client's normal function
- To organize collected information
- To enhance investigation of nursing problems.
- To frame nursing diagnosis
- To identify the client's strength
- To identify the need for health teaching.

Types of assessment:

TYPES OF ASSESSMENT

Type	Aim	Time frame
1- Initial assessment	Initial identification of normal function, functional status, and collection of data concerning actual or potential dysfunction. Baseline for reference and future comparison.	Within the specified time frame after admission to a hospital, nursing home, ambulatory healthcare center.
2- Focus assessment	Status determination of a specific problem identified during previous assessment.	Ongoing process, integrated with nursing care, a few minutes to a few hours between assessments.
3- Time – lapsed reassessment	Comparison of client's current status to baseline obtained previously, detection of changes in all functional health patterns after an extended period of time has passed	Several months (3,6,9 months or more) between assessment
4- Emergency assessment	Identification of life – threatening situation	AT anytime

Initial assessment:

- This is the assessment done within specified time after admission
- The assessment is done as soon as the client comes to hospital and is very comprehensive. Thus it is responsibility of the nurse to do assessment completely and accurately.

Focus assessment:

- This daily assessment done by nursing personnel of admitted client.
- In this assessment, nurse may identify new/ overlooked problems or misdiagnosed problems,
- Focus assessment concentrates on collecting data about a problem already identified. Nurse daily evaluates the status of identifying problems whether it is improved or deteriorated.

Emergency assessment:

- Emergency assessment is done, if client has suddenly physiologic or psychological crisis. It helps to identify life threatening problems. The focus is on preserving the life.
- e.g.) unconsciousness, airway obstruction, sudden BP Fall.

Time lapsed assessment:

- This assessment is done several months / weeks after initial assessment. It helps in comparing the client's current health status from the baseline data similar to focus assessment.
- Assessment is done as patient comes for follow up. This is less comprehensive.

COMPONENTS OF ASSESSMENT:

1. .Collecting data 2. Organizing data 3. Validating data 4.Interpreting data 5.Documenting data

COLLECTING DATA: -

- Data collection is the process of gathering information about client's health status.
- It includes the nursing history, physical assessment, physician's assessment, physical examination, laboratory results physician's record, diagnostic tests.
- Data should include the past as well as present complaints. Data collection must be systematic, continuous to prevent the omission of significant data. Data collected should be relevant to the actual or potential health problems.
- Data should be clear, accurate, concise, and complete.

Types of Data:

1. Subjective data 2. Objective data.

S.no	***Subjective data***	***Objective data***
1	These are the symptoms of health problems. E.g.) stomach pain	These are the signs regarding health problems
2	These are covert cues	These are overt cues
3	It includes the client's feeling and statement related to his health problems	It includes observable, perceptible and measurable.
4	It is provided by client himself through interview or in written form	It is obtained by the senses (vision, heat, touch, smell)or measuring devices(thermo meter) laboratory studies(Hemoglobin, blood grouping)

5	It is not always feasible to validate or confirm the data form other sources. e.g.) pain, nauseating	Obtained data can be verified or validated by other. e.g.) body rashes, heart rate, Blood Pressure, Bowel Sounds.

SOURCES OF DATA: it can be of 2 sources 1. Primary source 2. Secondary source.

1. ***Primary source***: client is the best source of information unless he is too ill, confused, he provides subjective data. He provides most accurate information about health care needs, life style patterns, present past illness, perception of symptoms.
2. ***Secondary sources:*** Family members, health care team, records.
    - ***a) Family and significant others:*** who knows the client well can provide information. They are the primary source of information for clients, critically ill and mentally handicapped and unconscious client.
    - ***b) Health care team:*** every member in a health team is a potential source of information. They can identify and communicate data as well as verify information from other sources.
    - ***c) Records:*** Medical records, Therapies record by other health professionals, laboratory records provide and information.
    - ***d) Review of books*** and keeping up to date knowledge is very important for nurses.

<u>METHODS OF DATA COLLECTION:</u>

1. Observation 2. Interviewing 3.Laboratory data 4.Physical examination

1.Observation: Gather the data using senses: e.g.) labored breathing, flushing, pain, paleness.

2.Interview: an interview is a planned communication or a conversation with a purpose. e.g.) collecting history from the client.

There are four phases of nursing interview1. Preparatory phase 2. Introduction phase, 3. Working phase 4. Termination phase

1. *Preparatory phase:*
    - A) Nurse collects background information from previous chart.
    - B) Ensure environment is conducive
    - C) Arrange seating 1. 3-4 ft. apart 2. Interviewer at 45 degree angle.
    - D) Allow adequate time.
2. *Introductory phase:*
    - A) Nurse introduce self
    - B) Identifies purpose of interview
    - C) Ensure confidentiality of information

D) Provide for patient needs before starting interview.

3. *Working phase*:
    A) Nurse gathers information from subjective data.
    B) Excellent communication skills are needed 1. Active listening 2. Eye contact 3. Open ended questions.
4. *Termination phase:*
    A) Inform patient when nearing end of interview.
    B) Ensure patient knows what will happen with information
    C) Offer client chance to add anything

3.Methods of physical examination:

1. Inspection
2. Palpation
3. Percussion
4. Auscultation

Problems related to data collection:

- Inappropriate organization of the data
- Omission of pertinent data
- Inclusion of irrelevant or duplicate data
- Failure to establish rapport and partnership
- Recording interpretation of data rather than observed data
- Failure to update the data base.

ORGANISING DATA

Nurses use a written or computerized format for arranging the data systematically

VALIDATING THE DATA:

Act of double checking Verifies understanding of information, Comparison with another source.

DOCUMENTING DATA

- Record in permanent record
- Use client's own words in subjective data
- Avoid generalization, be specific.
- Don't make summative statements.

NURSING DIAGNOSIS

NURSING DIAGNOSIS INTRODUCTION

Diagnosis is the second phase of nursing process. It is often referred to as analysis as well as problem identification or nursing diagnosis. It provides the basis for the selection of nursing intervention to achieve the outcome for which the nurse is accountable.

DEFINITION

- Diagnosing refers to the reasoning process.
- Diagnosis A statement or conclusion regarding the nature of phenomenon. Nursing diagnosis definition by NANDA (1990):- A nursing diagnosis is a clinical judgment about individual, family or community response to actual and potential health problems/ life process.
- Nursing diagnosis provides the basis for selection of nursing intervention to achieve the outcome for which the nurse is accountable.

PURPOSE

- Identify how an individual, group or Community responds to actual or potential health and life processes.
- Identify factors that contribute to or cause health problems (etiologies).2
- Identify resources or strengths the individual, group or community can draw on to prevent or resolve problems.

Development of nursing diagnosis

- Began in 1973 by faculty members of Saint Louis University, Kristine Gebbie & Mary Ann Lavin.
- IN 1977 International recognition came with the first Canadian Conference in Toronto & the International Nursing Conference in 1987, Canada.
- 1982 The Conference group accepted the Name North American Nursing Diagnosis Association (NANDA), (Nurses in Canada & US.)

PURPOSE OF NANDA

To define, refine and promote a taxonomy of Nursing diagnostic terminology of general use to Professional Nurses.(Taxonomy is a classification system or set of categories arranged on the basis of single principle or set of principles).

Members of Nanda

Staff Nurses, Clinical Specialists, faculty, Directors of Nursing, Deans, Theorists & Researchers.

NURSING DIAGNOSIS VERSES MEDICAL DIAGNOSIS

Medical diagnosis

- Identify disease
- Describe problems for which the physician directs nurses within the scope of the primary treatment
- Remains the same as long as the disease is present
- Example of Medical- Myocardial infarction-(heart attack)

Nursing diagnosis2. 2

- Focuses on unhealthy responses to health and illness
- Describe problems treated by independent Nursing practice. 2
- May change from day to day as the patients' response change2. 2
- Example of nursing diagnosis :for a person with myocardial infarction
- Fear
    - Altered health maintenance
    - Pain
    - impaired tissue perfusion.
    - Knowledge deficit

TYPES OF NURSING DIAGNOSIS

- Actual Nursing Diagnosis

- Risk Nursing Diagnosis
- Possible Nursing Diagnosis.
- Syndrome Wellness Nursing Diagnosis

Actual Nursing Diagnosis:

It is judgment about the client response to a health problem that is present at a time of nursing assessment. E.g.: Ineffective breathing pattern &anxiety

. ***Risk Nursing Diagnosis***

It is a clinical judgment that a client is more vulnerable to develop the problem than others in the same or similar situation.Eg: Risk for impaired skin integrity related to surgery.

Possible Nursing Diagnosis

It describes a suspected problem for which current and available data are insufficient to validate the problem. E.g.: Possible social isolation related to unknown etiology.

Syndrome Nursing Diagnosis

It is clusters of nursing diagnoses that frequently goes together and present a clinical picture.Eg: Rape Trauma Syndrome

Wellness Nursing Diagnosis

It is clinical judgments about an individual, group or community in transition from a specific level of wellness to a higher level of wellness.Eg: Family coping: potential for growth-related to unexpected birth of twins.

. **COMPONENT OF NURSING DIAGNOSIS**

- Problem Statement
- Defining Etiology
- Characteristics

- ***Problem Statement (Diagnostic Label)***: It describe the client health problem or response for which nursing therapy is given clearly and concisely in a few words.Eg: Knowledge deficit (medications) Some Qualifier are also added to give additional meaning to the statement such As Impaired, Decreased, Ineffective, Acute, Chronic.
- ***Etiology (Related Factors & Risk Factors):*** This component identifies one or more probable causes of health problem. It helps the nurse to give individualized patient care.Eg: Anxiety related to hospitalization.
- ***Defining Characteristics***: These are the clusters of signs and symptoms that indicate the presence of a particular diagnostic lebel.Eg: Fluid volume deficit related to decreased oral intake manifested by dry skin and mucus membranes.

FORMULATION OF NURSING DIAGNOSTIC STATEMENT

The basic format for a diagnostic statement is " problem related to etiology" however nurses must be able to write one , two, three and four part diagnostic statement, as well as some variation of each.

. BASIC TWO PART STATEMENT

- The basic two part statement is used for actual, high risk, and possible nursing diagnosis. It includes the following: 1. PROBLEM (P) : statement of client response 2. ETIOLOGY (E) : Factors contributing to or probable causes of responses.
- The two part joined by the words related to, or associated with rather than due to.e.g.1. Noncompliance (diabetic diet) related to denial of having disease. 2. Pain related to surgery

BASIC THREE PART STATEMENT

The basic three part statement is called the PES

1. PROBLEM (P): Statement of client response.

2. ETIOLOGY (E): Factors contributing to or probable causes of responses.

3. SIGN AND SYMPTOMS(S) : defining characteristics manifested by the client.

Using "secondary to" divided the etiology into two parts thereby making the statement more descriptive and useful .e.g. High risk for impaired skin integrity related to decreased peripheral circulation secondary to diabetes.

ADVANTAGES

- COMMUNICATION
- CHARTING QUALITY
- IMPROVEMENT

. LIMITATION

- LIMIT NURSING PRACTICE
- IMPRESICE LANGUAGE
- LIMITED TONURSINGPROFESSIONAL

NURSING PROCESS-PLANNING PHASE

INTRODUCTION

- Planning is the important 3rd step in nursing process
- It is the determination of what is to be done, when is to be done, where is to be done, Who will do and how to evaluate
- Planning involves interaction with the client , familymembers,health team members, review of literature, record relevant information.

DEFINITION

- Acc. To Kozier (1975) - planning is a deliberate systematic phase of nursing process that involves decision making and problem solving.
- Acc.to Potter and Perry(2001)- planning is a category of nursing behavior in which client centered goals are established and interventions are assigned to achieve the goals.

PURPOSES OF PLANNING

- Give direction to client care activities.
- Enhance the continuity of care.
- Permit the delegation of specific activities.

TYPES OF PLANNING

There are 3 types of planning

- Initial planning
- Ongoing planning
- Discharge planning

1. **Initial planning**

The planning done immediately after the initial assessment. Planning must be started early because of trend towards shorter hospital stay.

2. ***Ongoing planning***

   The ongoing planning is done by all nurses who give care to the client. They carry out daily planning by using ongoing assessment.

3. ***Discharge planning***

   Discharge planning is the process of planning about the needs which occur after the discharge of the client.

PHASE OF PLANNING

- Setting priorities
- Establishing goals and outcomes
- Selecting planned nursing interventions
- 4-Developing nursing care plan

Setting priorities

Is a decision making process in which nurse determines the order in which patient's problem is approached.

Setting priorities-classification

- High priority
- Medium priority/ Intermediate priority
- Low priority

High priority

The nursing diagnosis , if not treated may give more harm to the client or others who have high priorities.

Example:

Nsg diagnosis: Ineffective airway clearance after surgery related to abdominal incision pain.

Rationale: Risk of postoperative pulmonary complications , nurse will formulate plan acc.to priority

Intermediate priority

Nursing diagnosis involves non emergent and non threatening needs of the client.

Example: pain related to surgical procedure

Imbalanced nutrition less than body requirement related to chronic Diarrhea .

Rationale: This nursing diagnosis does not affect client's immediate physiological or emotional status.

Low priority

Client needs may not be directly related to client illness.

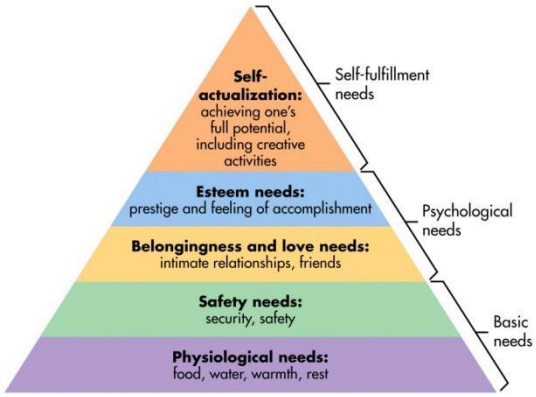
Example: Deficient knowledge related to smoking cessation programme.

Rationale: this nursing diagnosis indicates clients long term needs.

MASLOW'S HIERARCHY OF NEEDS

Planning can be ranked according to the Maslow's hierarchy of needs

While assigning priorities to nursing diagnosis, nurse should take into consideration the need of client, the resources of health care system etc..,



Hierarchy of needs is useful way for nurses to plan for the needs of client.

Maslow's hierarchy

Determining goals or expected outcome

The next step is determining goals or expected outcome.

After assessing, Diagnosing, Establishing priorities, nurse formulate goals and expected outcome for each nursing Diagnosis.

Establishing goal is important because it is necessary to sure that every knows what is to be attained and when it is expected to be accomplished.

What is goal?

Goals are the statement of expected outcome of nursing interventions.

Purpose of goal

To evaluate the client progress towards outcome

To evaluate the effectiveness of nursing interventions.

Types of goals

- Depending on the client needs and the nature of nursing services, the goals are of two types:
    1. Short term goal
    2. Long term goal.

Short term goal

- Short term goal is an objective that is expected to achieve in a shorter period usually less than a week.

Eg) ineffective airway clearance related to the effect of sedation.

Goal: Absence of abnormal lung sounds within 2 days.

- Short term goals are the stepping stone to reach long term goal.

Long term goal

- Long term goal is an objective that is to be achieved over a long period of time usually over weeks or months.
- These can be carried out after discharge also.

E.g.) Ineffective airway clearance related to the effect of sedation.

Long term goal: Remain free of upper respiratory infection for 6 months...

EXPECTED OUTCOME

- Expected outcome describe the behavior the patient is expected to achieve.
- Outcome is the measurable change of the client for the nursing diagnosis.

Difference between the nursing gal and expected outcome

NURSING Goal	***EXPECTED OUTCOME***
Describe what the nurse expects to do for accomplishing client goal. e.g.) to teach the client how to do deep breathing exercise.	Describe what the client is expected to attain as a result of nursing goal.
Gives direction/pathway to select nursing activities	Gives direction to client activities.

.

Rules for formulating the outcome

- out come should be related to the problem statement.
- Outcome should be client centered.
- Outcome should be clear and concise.
- Outcome should be measurable and observable.

  e.g.) fluid volume deficit related to nausea and vomiting.

  Outcome will be: client drinks 1000 ml in 24 hrs.
- Avoid “the client will" at the beginning.
- ❖ Outcome should be time limited.

- ❖ The time for the outcome should be stated.e.g) by the time of discharge, within 24 hrs. By the end of teaching.
- ❖ Outcome should be realistic.
- ❖ The outcome should be determined by the client and nurse together.

Selecting the nursing strategies

Nursing intervention defines how the nurse will assist the client to achieve the purposed outcome.

Types of nursing interventions

- **Nurse initiated / independent intervention**
  These are the activities that may be performed by nurse without a direct physician's order.
- **Physician initiated intervention**
  These are base don the physician's response to a medical diagnosis and the nurse completes the physician written order
- **Collaborative intervention**
  It describes the activities that the nurse carries out in cooperation with the other health team members.

NURSING PROCESS: IMPLEMENTING AND EVALUATING

Introduction•

It is the phase in which the nurse implements the nursing interventions.

Definition:

Implementing consist of doing & documenting the activities that are the specific nursing actions needed to carry out the interventions.

• The degree of participation depends on the client's health status.
• For Eg. An unconscious man, Ambulatory client. •

The first 3 steps of nursing process provide basis for the nursing actions performed during the implementing step.

Implementing skills• Need cognitive, interpersonal & technical skills. –

- Cognitive: - includes problem solving, decision making, critical thinking & creativity.
- Interpersonal: - Verbal & nonverbal. –
- Technical Skills: - "Hands on" skills like manipulating equipments giving Injections & bandaging, moving lifting & repositioning. Other use called "Psychomotor skills"

Process of Implementing

- Reassess the client
- Determining the nurse's need for assistance
- Implementing nursing interventions
- Supervising delegated care
- Documenting nurses activities.

Reassessing the client•

Before implementing the nurse must reassess the need

.• Even order written on the care plan, the client's condition may have changed.

• Eg. Mr. A has nursing diagnoses of disturbed sleep pattern related to anxiety & unfamiliar surroundings.

. • During rounds, the nurse discovers that Mr. A is sleeping & therefore defers the back massage that have been planned as a relaxation strategy

• New data may indicate a need to change the priorities of care of the nursing activities.

Determining the nurses need for assistance

• When implementing some nursing interventions, the nurse may require assistance for one of the following reasons. - The nurse is unable to implement the nursing activity safely alone

(E.g. ambulating on unsteady obese client)

Determining the nurses need for assistance- Assistance would reduce stress on client (E.g. turning a person who experiences acute pain when moved)- The nurse lacks the knowledge or skills to implement a particular nursing activity.

3) **Implementing the Nursing Interventions**

• When implementing nurse should follow these guidelines.–Base nursing interventions on scientific knowledge, nursing research & professional standards of care, whenever possible.–Nurse is must know scientific rationale & Side effects or complications of all interventions. E.g. Drug before meals

- Clearly understand the orders to be in implemented & question any that are not understood.
- Adopt activities to the individual client
- Implement safe care.
- Provide teaching, support & comfort.
- Be holistic
- Respect the dignity of the client & Enhance self esteem
- Encourage client to participate actively in implementation

***Supervising Delegated C*are** If care has been delegated to other health care personnel, the nurse responsible for all the client's care must ensure that the activities have been implemented according to the care plan.

Documenting Nursing Activities•

- The nurse completes the implementing phase by recording the interventions and client responses in the nursing process notes.
- The nurse may record routine or recurring activities such as mouth care in the client record at the end of shift, while some actions recorded in special worksheets according to agency policy.
- •Immediate recording helps safe guard the client to prevent double actions.

EVALUATION

- The last phase of the nursing process, follows implementation of the plan of care
- It's the judgment of the effectiveness of nursing care to meet client goals based on the client's behavioral responses.

Definition•

Evaluating is a planned, ongoing, purposeful activity in which clients and health care professionals determine the client's progress toward achievement of goals/outcomes and the effectiveness of the nursing care plan.

- Evaluation is continuous
- Done immediately after implementation to make on the spot modifications in an intervention.
- Evaluation performed at specified intervals.
- .Evaluation continues until the client achieves the health goals or discharged from nursing care.
- Evaluation includes goal achievement & self-care abilities.\
- Through Evaluation Nurses demonstrates responsibility accountability for their actions, indicate interest in the results of the nursing activities.

Process of Evaluating Client Responses

1. Collecting data related to the desired outcomes
2. Comparing the data with outcomes
3. Relating nursing activities to outcomes
4. Drawing conclusions about problem status
5. Continuing, modifying, or terminating the nursing care plan.

When determining whether a goal has been achieved, the nurse can draw one of the three possible conclusions

- The goal was met, that is the client response is the same as the desired outcomes.

- The goal was partially met, that is either a short term goal was achieved but the long term was not, or the desired outcome was only partially attained.
- The goal was not met.

Relationship of Evaluation to Nursing Process

"When goals have been partially met or when goals have not been met, two conclusions may be drawn:

• The care plan may need to be revised, since the problem is only partially resolved OR

• The care plan does not need revision, because the client merely needs more time to achieve the previously established goals. So the nurse must reassess why the goals are not being partially achieved.

TABLE 7-1 (continued)
NANDA-Approved Nursing Diagnoses: Taxonomy I to Taxonomy II

Taxonomy I Nursing Diagnosis	*Taxonomy II Nursing Diagnosis*
Bowel incontinence	Bowel incontinence
Risk for constipation	Risk for constipation
Altered urinary elimination	Impaired urinary elimination
Stress incontinence	Stress urinary incontinence
Reflex urinary incontinence	Reflex urinary incontinence
Urge incontinence	Urge urinary incontinence
Functional urinary incontinence	Functional urinary incontinence
Total incontinence	Total urinary incontinence
Risk for urinary urge incontinence	Risk for urge urinary incontinence
Urinary retention	Urinary retention
Altered tissue perfusion (specify type: renal, cerebral, cardiopulmonary, gastrointestinal, peripheral)	Ineffective tissue perfusion (specify type: renal, cerebral, cardiopulmonary, gastrointestinal, peripheral)
Risk for fluid volume imbalance	Risk for imbalanced fluid volume
Fluid volume excess	Excess fluid volume
Fluid volume deficit	Deficient fluid volume
Risk for fluid volume deficit	Risk for deficient fluid volume
Decreased cardiac output	Decreased cardiac output
Impaired gas exchange	Impaired gas exchange
Ineffective airway clearance	Ineffective airway clearance
Ineffective breathing pattern	Ineffective breathing pattern
Inability to sustain spontaneous ventilation	Impaired spontaneous ventilation
Dysfunctional ventilatory weaning response	Dysfunctional ventilatory weaning response
Risk for injury	Risk for injury
Risk for suffocation	Risk for suffocation
Risk for poisoning	Risk for poisoning
Risk for trauma	Risk for trauma
Risk for aspiration	Risk for aspiration
Risk for disuse syndrome	Risk for disuse syndrome
Latex allergy response	Latex allergy response
Risk for latex allergy response	Risk for latex allergy response
Altered protection	Ineffective protection
Impaired tissue integrity	Impaired tissue integrity
Altered oral mucous membrane	Impaired oral mucous membrane
Impaired skin integrity	Impaired skin integrity
Risk for impaired skin integrity	Risk for impaired skin integrity
Altered dentition	Impaired dentition
Decreased adaptive capacity: Intracranial	Decreased intracranial adaptive capacity
Energy field disturbance	Disturbed energy field
Communicating	
Impaired verbal communication	Impaired verbal communication
Relating	
Impaired social interaction	Impaired social interaction
Social isolation	Social isolation
Risk for loneliness	Risk for loneliness
Altered role performance	Ineffective role performance
Altered role performance	Ineffective role performance

(continues)

TABLE 7-1 (continued)
NANDA-Approved Nursing Diagnoses: Taxonomy I to Taxonomy II

Taxonomy I Nursing Diagnosis	*Taxonomy II Nursing Diagnosis*
Relating (continued)	
Altered parenting	Impaired parenting
Risk for altered parenting	Risk for impaired parenting
Risk for altered parent/infant/child attachment	Risk for impaired parent/infant/child attachment
Sexual dysfunction	Sexual dysfunction
Altered family processes	Interrupted family processes
Caregiver role strain	Caregiver role strain
Risk for caregiver role strain	Risk for caregiver role strain
Altered family processes: Alcoholism	Dysfunctional family processes: Alcoholism
Parental role conflict	Parental role conflict
Altered sexuality patterns	Ineffective sexuality patterns
Valuing	
Spiritual distress (distress of the human spirit)	Spiritual distress
Risk for spiritual distress	Risk for spiritual distress
Potential for enhanced spiritual well-being	Readiness for enhanced spiritual well-being
Choosing	
Ineffective individual coping	Ineffective coping
Impaired adjustment	Impaired adjustment
Defensive coping	Defensive coping
Ineffective denial	Ineffective denial
Ineffective family coping: Disabling	Disabled family coping
Ineffective family coping: Compromised	Compromised family coping
Family coping: Potential for growth	Readiness for enhanced family coping
Potential for enhanced community coping	Readiness for enhanced community coping
Ineffective community coping	Ineffective community coping
Ineffective management of therapeutic regimen: Individual	Ineffective therapeutic regimen management
Noncompliance (specify)	Noncompliance (specify)
Ineffective management of therapeutic regimen: Families	Ineffective family therapeutic regimen management
Ineffective management of therapeutic regimen: Community	Ineffective community therapeutic regimen management
Effective management of therapeutic regimen: Individual	Effective therapeutic regimen management
Decisional conflict (specify)	Decisional conflict (specify)
Health-seeking behaviors (specify)	Health-seeking behaviors (specify)
Moving	
Impaired physical mobility	Impaired physical mobility
Risk for peripheral neurovascular dysfunction	Risk for peripheral neurovascular dysfunction
Risk for perioperative-positioning injury	Risk for perioperative-positioning injury
Impaired walking	Impaired walking
Impaired wheelchair mobility	Impaired wheelchair mobility
Impaired transfer ability	Impaired transfer ability
Impaired bed mobility	Impaired bed mobility
Activity intolerance	Activity intolerance
Fatigue	Fatigue
Risk for activity intolerance	Risk for activity intolerance
Sleep pattern disturbance	Disturbed sleep pattern
Sleep deprivation	Sleep deprivation

(continues)