Module 5
NURSING PROCESS

INTRODUCTION

This module is a review of the nursing process and its application to nursing practice. Read through the entire module at least once to refresh your memory and then study each unit in depth. Complete the self-tests, which are included for the units. As you finish a self-test, check your answers with the correct responses at the end of the module. Be certain that you understand each unit before proceeding to the next. This is important because the steps in the nursing process are dependent and build on one another.

OBJECTIVES

Upon completion of this module, you should be able to:

- Describe nursing process and its components.
- Identify systematic methods for data collection.
- Describe types of nursing interventions and considerations important to deliver of care.
- Apply the nursing process to a client situation.

THE NURSING PROCESS

Definition of nursing process:
Nursing process is a systematic method of planning, delivering, and evaluating individualized care for clients in any state of health or illness. Based on the scientific problem-solving method, it constitutes the foundation for nursing practice.

Characteristics of the nursing process:
The nursing process is **systematic** and organized with specific components:

- **Assessment**: Assessment of data.

- **Nursing diagnosis**: analysis of assessment data to determine the client’s actual and potential health problems by the RN.

- **Planning**: development of a plan of action to reduce, resolve, or prevent potential problems, establish priorities, formulating goals/expected outcomes by the RN, and planning nursing actions while documenting the nursing care plan.

- **Implementation**: the delivery of nursing care, performing the planned nursing interventions while continuing to collect data about the client.

- **Evaluation**: determining the effectiveness of the plan of care.
The nursing process is **cyclic**, with each phase leading logically to the next. Each phase is dependent on the accuracy of the preceding one. For example, appropriate nursing diagnoses cannot be identified without accurate assessment data. Although the phases of the nursing process are described as separate entities, in actual practice the nurse often moves back and forth among the phases. For example, during the phase of implementation, the nurse continues to collect assessment data. The nurse has to always be thinking and recognizing what step in the nursing process is being utilized.

The nursing process is **purposeful** and **goal-directed**. That goal is to provide quality, individualized, client-centered care.

The nursing process is **dynamic** to meet the everchanging needs of the client. The nursing process is **interactive** because it involves reciprocal interpersonal relationships between the nurse and the client, family, significant others, and other health team members.

The nursing process is **theoretically based** as it is grounded in knowledge of the sciences and the humanities. The nurse must incorporate knowledge from many areas in order to deliver holistic care, that is, to meet the total needs of the client.

The nursing process is **flexible** and can be used effectively in any health care setting. It is appropriate for use with individual clients, families, groups, or communities. It can be used with the acutely or chronically ill as well as in primary care (health maintenance). Nurses can utilize the nursing process with clients of any age and with any developmental level.

**Implications of the nursing process:**

Use of the nursing process has implications for the client, nurse, and the profession of nursing. The client benefits because use of the nursing process ensures quality and individualized care and encourages client participation in all phases of the process. The benefits to the nurse are increased job satisfaction and enhanced professional growth. For the profession of nursing, the use of the nursing process defines the scope of nursing practice and contributes to the autonomy of the profession.
Unit 1
Assessment

The first and most crucial step in the nursing process is assessment. Assessment is the organized and systematic process of collecting information from a variety of sources in order to evaluate the health status of the client. Through assessment the nurse develops a data base regarding the client’s level of wellness, past illnesses and experiences, health practices, and health care goals. Because assessment is the foundation for the remainder of the nursing process, it is critical that it be thorough and objective. Analysis and interpretation of the assessment data by the RN leads to the development of nursing diagnoses, expected outcomes, nursing interventions, and evaluation of nursing actions. Assessment provides the basis for the delivery of quality, individualized care.

The purpose of assessment is to collect adequate data so that analysis will yield information to assist in determining the client’s health care needs. Through assessment, you can help identify current problems, areas of potential problems and the client’s potential for achieving optimal well-being. The RN then uses the data to determine nursing diagnoses, to establish priorities, and to plan appropriate interventions.

Assessment also provides and opportunity for nurse/client interaction and the beginning of a therapeutic relationship. It allows the client to be an active participant in the health care process, and to ask questions of you, the nurse.

The process of assessment begins with the first client contact and must be continuous throughout the nursing process. The initial assessment enables you and the RN to begin planning for the client’s care. Subsequent assessments by you and other health team members are necessary to validate previously identified nursing diagnoses and to document the client’s progress toward expected outcomes. Continuing assessment is necessary to refine and revise a previous care plan and to identify new areas of concern.

**SOURCES OF INFORMATION**

**The Client – Subjective Data**

In most instances, the primary source of information is the client. The client who is oriented and responds appropriately can provide the most information about his past and present illnesses, life-style, and health care needs. He can most accurately describe his personal perceptions and feelings about health and illness and can identify specific problems or goals. He can best validate his responses to diagnostic procedures and treatments. Communication is the basis for all nurse-client interactions. Utilizing therapeutic communication, a nurse can get clients to share their opinions and feelings openly.
Objective Data:

Family or significant others

The second major source of information is the client’s family or significant others. This source becomes primary in situations where the client is unable to participate, such as when the client is an infant or child, critically ill, mentally handicapped, disoriented, or unconscious.

The family/significant others are equally important in supplementing the client’s data in order to clarify or validate information. Their perceptions and observations about the client’s needs can provide additional information, which can impact the delivery and effectiveness of care.

Observation of the interaction between the client and family/significant others can provide you with insight into the effects of the client’s condition on the family unit, which may be pertinent in the planning of care.

Medical records

Current and past medical records contain an abundance of pertinent information with regard to past medical history and current status. The admission sheet contains vital statistics such as name, age, occupation, and religion, information which is basis to beginning the assessment process. History and progress notes written by the physician provide insight into the past medical history, present signs and symptoms, diagnosis, and prognosis. The medical plan of treatment contained in the doctor’s orders and the laboratory reports provide current information about the client’s present health status.

Nursing staff and other health staff members

Communication with other members of the health care team can also be a valuable source of information. Public health nurses, social workers, physical therapists, clergy and others can offer pertinent data and assist in revision of the plan of care. Nursing care conferences, change of shift reports, nursing rounds, Kardex, and nursing notes also provide important assessment information.

Other sources

In addition to the above sources, you should remember that personal experience and knowledge contribute to the care that you give. You also have access to nursing literature that can enhance your understanding of the client’s nursing problems. Conferring with colleagues may also contribute to the database, which will provide the basis for effective care.

Methods of data collection

Assessment data is gathered by interviews, observations, physical examinations, laboratory and diagnostic tests. Various techniques enable you to approach data collection systematically and logically in order to gather the necessary information for creating a nursing care plan.
Interview

Interviewing in the context of the nursing assessment has four primary purposes:

1. To allow the nurse to obtain specific information necessary for diagnosis and planning.
2. To promote the nurse/client relationship by providing an opportunity for dialogue.
3. To allow the client to receive information and to participate in problem identification and goal-setting.
4. To help the nurse in identifying areas for specific investigation during the other parts of the assessment.

The nursing interview is a complex process, which requires that you possess effective communication and interaction skills. It is different from interviews conducted by other health team members in that it focuses on identifying client problems, which may be treated through nursing intervention. The nursing interview allows both you and client to give and receive information.

The nursing interview should ideally be conducted as soon as possible after the initial contact with the client. This will provide necessary data for the development of the nursing care plan.

A structured interview conducted by the nurse is the usual technique utilized in obtaining the health history. Interviews are done in all types of health care settings such as a hospital, physician’s office, health department, or the client’s home. The format and documentation of the health history vary with each setting.

Professional attitude is the most significant factor in determining the success of the interview. When you participate in an interview, introduce yourself and explain the purpose of the interview. Assure the client that all information is confidential and direct all questions to the client. Your approach to the interview should create an atmosphere that will promote the development of a therapeutic nurse-client relationship.

As the interview progresses, begin to focus the dialogue on specific areas in order to obtain the necessary information. First ask about the client’s chief complaint and proceed to such areas as past medical history, family history, and religious and cultural information. This portion of the interview may vary with the specific health history format appropriate to the setting. There are four main types of interview techniques a nurse can utilize: Open-ended questions, back channeling, problem seeking, and closed-ended questions.

As the interview closes, summarize the most significant points, which have been discussed. This allows the client opportunity to verify or negate your perceptions and also provides the foundation for mutual goal-setting. As you end the interview, convey warmth and appreciation: “Thanks for sharing this information about yourself. It will be very helpful to us in planning your care.” This provides the basis for future nurse/client interactions.
As soon as possible after the interview, proceed to document information, which you have obtained. Quality nursing care starts with having a detailed and accurate description of the client’s problems and needs.

**Observation**

A nurse’s skillful observations are a basic element of nursing practice. Observations provide information needed in planning nursing care. Through observation you are also able to determine the client’s response to nursing care.

In making observations, use sight, hearing, smell, and touch. Although the sense of taste is seldom used, knowledge of how something tastes to the client can often be valuable. For example, unpleasant drugs can often be made more palatable by being mixed with food or fluids, or being diluted or cold.

To be most useful, observations must first be scientific; that is, they must be objective and based on knowledge of the biological, physical, and social sciences. Secondly, they must be systematic. Systematic observation involves the use of the senses to obtain information about the client, his environment, significant others, and the interaction of all these factors. Objective data is based on accepted standards (or norms). Record observations objectively and specifically, avoiding interpretation in the documentation.

**Physical assessment**

The final activity of the initial nursing assessment is the physical examination performed in the RN.

The physical assessment will yield necessary objective data (what you observe, measure) as well as subjective data (what the client states regarding his health status).

Physical assessment of the client continues during the delivery of nursing care. You assess the client on a regular basis and document this data appropriately. Changes in the physical assessment data may prompt alterations or additions to the plan of care.

**Documentation of assessment data**

When data collection is completed, you and the RN proceed to document the information. The format for this documentation will vary according the setting. Before the data can be documented effectively, it must first be organized. Record the data objectively, without bias, value judgments, or personal opinions. Indicate subjective information from the client or other persons by quotation marks (e.g., chief complaint: “I have sharp pains in my stomach.”) Describe findings as completely as possible, and include appropriate defining characteristics such as shape and size. Avoid generalizations as well as terms such as “good,” “normal,” and “fair.” Record data as concisely as possible, using correct grammar and spelling. Write or print documentation legibly in nonerasable black ink.
Summary

While assessment is the first and most basic step in the nursing process, it is never completed. Instead, assessment is necessarily a continuous process, which begins with the first client contact and continues with each subsequent contact. While proceeding with the remaining components of the nursing process, you should continue to interview, observe, and physically assess the client in order to ensure the most appropriate, effective nursing care.
1. What is the purpose of assessment?

2. When is assessment done?

3. Name the three methods of assessment.

4. List sources of assessment.
Unit 2
Nursing Diagnosis

In North Carolina, formulation of a nursing diagnosis is a component of practice that is reserved for the RN. LPN’s, therefore, will contribute collected data to the RN that she/he may use in the formulation of nursing diagnoses for the plan of care. LPN’s, cannot by law formulate the nursing diagnoses. After collecting, analyzing, and interpreting assessment data, the next step in the nursing process is to develop nursing diagnoses. A nursing diagnosis is the statement of the client’s current health status and concerns, which can be helped by nursing intervention. These concerns are actual or potential problems, which the client is experiencing or may experience, that may be prevented, resolved, or reduced through nursing intervention. Carpenito (2004) states that a:

“Nursing diagnosis is a clinical judgment about individual, family, or community responses to actual or potential health problems/life processes. Nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.” (p4)

The importance of the nursing diagnosis is reflected in the ANA policy statement (1995), which defines nursing as “the diagnosis and treatment of human response to actual or potential health problems.”

Nursing diagnoses allows a nurse to individualize the care of a client in this step of the nursing process. Writing a nursing diagnosis creates the basis of a care plan. Also, the nursing diagnosis distinguishes the role of the nurse from the physician and the medical diagnosis.

Nursing diagnoses focus on human responses and alterations in the client’s ability to function as an independent human being. Nurses must realize that the human response is significantly influenced by each person’s own unique perspective. Thus, the use of nursing diagnosis requires that you endeavor to view health management through the eyes of the client. For example, at the close of an interview and examination, the physician may give the client a “clean bill of health,” indicating that no problems have been identified. However, when you interview and examine the same client, there may be nursing diagnoses which come into focus as you discover the client perceives he has certain health problems and concerns which were not addressed by the physician. Nursing diagnoses are holistic, encompassing all aspects of the human being: physical, psychological, socio-cultural, developmental, and spiritual. Thus, you must view the client as a total human being as you seek to identify and treat nursing diagnoses.

Medical diagnoses and nursing diagnoses are not synonymous. Physicians use medical diagnoses to describe diseases, syndromes, or conditions which require medical treatment. Physicians are trained and licensed to treat nursing diagnoses, which are not medical problems, but instead are human responses to such things as medical problems, treatments, life changes, environmental factors, etc. The use of nursing diagnosis allows you to move beyond the medical realm to identify problems which may or may not be related to the medical diagnoses.

You as an LPN will not formulate nursing diagnoses, the following information may be useful in helping to understand the nursing diagnoses you see on patient’s charts.
Elements of a nursing diagnosis statement

Nursing diagnosis = problems + its etiology or cause (if known)

The Problem. The first element of the nursing diagnosis is the identified problem that the patient is experiencing or may experience.

There are fine types of problems.

1. **Actual**: a problem that is experienced or perceived by the client, one that is occurring in the “here and now.” This type of problem is validated by the presence of defining characteristics or signs and symptoms.

   Examples: Alteration in nutrition, less than body requirement.
   Ineffective airway clearance related to incisional pain.

2. **Risk/High Risk**: a problem which may develop in the future due to the presence of certain risk factors; and altered state which may occur unless specific nursing actions are ordered and implemented. This type of problem is validated by risk factors.

   Examples: Risk for fluid volume deficit related to prolonged vomiting.
   Risk for impairment of skin integrity related immobility.

3. **Possible**: a problem which may exist, but additional data is needed to confirm its presence; “possible” alerts the nurse the need for further data collection.

   Example: Possible self-care deficit related to IV in right hand.

4. **Wellness**: is a change from a certain level of wellness to a higher level of wellness. To have this type of diagnosis two items should be present: (1) an increased desire for greater wellness, and (2) effective level of function should be present. The diagnostic statement will begin with “Potential for Enhanced” or” Readiness for Enhanced.” These diagnoses focus on a client’s healthy responses or strengths; therefore they do not include “related to” factors.

   Example: Readiness for Enhanced Family Processes.

5. **Syndrome**: this type of diagnosis is a combination or group of actual or high-risk nursing diagnoses that all relate to a certain event or situation. This tells the nurse there is a serious clinical situation present. These diagnoses are usually one-part statements that actually include the etiology and contributing factors in the actual diagnostic statement.

   Example: Rape Trauma Syndrome
   Disuse Syndrome
**Cause of Etiological Factors**

The second element of the nursing diagnosis statement consists of the cause or etiology, contributing factors, or risk factors. In order to prevent, minimize, or resolve a problem, you must have some idea about why it is occurring or may occur in the future. The etiology is that which will be affected by nursing intervention. It is preceded in the nursing diagnosis statement by the phrase “related to.” You must remember that the medical diagnosis is not the etiology of a nursing diagnosis statement. Nursing interventions cannot change the medical diagnosis. However, nursing actions can be directed toward etiological factors, as well as toward the diagnostic label.

Example:
Incorrect: Ineffective airway clearance related thoracotomy.
Correct: Ineffective airway clearance related to incisional pain secondary to thoracotomy.

**Note:** In some references and health care settings, you may see the use of a third element of the nursing diagnosis statement. This element is most often used when stating actual problems as it specifies the signs and symptoms which indicate the presence of the problem. The phrase “as manifested by” or “as evidenced by” is used to connect the third element to the problem and etiological factors.

A medical diagnosis can not be the “related to” in a nursing diagnosis,; however, it can be “secondary to” to clarify the statement.

Example: Ineffective airway clearance related to incisional pain as evidenced by poor cough, patient complains of increased pain when coughing.

**Writing nursing diagnoses**

Stating nursing diagnoses is a skill which RNs refine through practice. In order to make it easier for nurses to identify and correctly state nursing diagnoses, there is a “common language” or list of accepted nursing diagnoses. While this list facilitates identification of pertinent diagnoses, it also fosters communication among health professionals through its use. In 1973 the ANA mandated the use of nursing diagnosis in nursing practice. Soon thereafter, clinicians, educators, researchers, and theorists from all areas of nursing practice conferred to offer labels for conditions they had observed in practice. From this beginning, the North American Nursing Diagnosis Association (NANDA) was established as the formal body for the promotion, review, and endorsement of the current list of nursing diagnoses used by nurses in practice. Every two years NANDA meets to consider revisions and additions.

**Verifying nursing diagnoses**

Prior to documenting the nursing diagnoses in the chart and nursing care plan, the RN verifies his/her perceptions with the client, family/significant other. If the client agrees that the nursing diagnoses are appropriate, the RN will proceed with documentation and on the remaining steps of the nursing process. If the client disagrees with the RNs perceptions, the RN will continue to discuss the issues with the client until a consensus is reached.
Documentation

The nursing diagnoses are the first element in the nursing care plan format. After verifying the nursing diagnoses, the RN will document them in the nursing care plan and in appropriate places in the client’s chart.

Unit 3
Planning

After the data has been collected and organized and nursing diagnoses have been formulated, it is time for the planning phase of the nursing process.

Planning is determining the approach to be used in assisting the client toward optimal wellness. It is deciding which actions will be used to help solve, lessen, or minimize the effects of the identified problems, or to prevent potential problems.

There are four essential steps in the planning process:

1. Prioritizing the identified nursing diagnoses.
2. Developing goals/outcome statements.
3. Planning nursing actions.
4. Documentation—the Nursing Care Plan.

Prioritizing

After nursing diagnoses have been formulated, they must be ranked in order of priority. Ideally, the RN consults with the patient in establishing priorities. However, when the patient’s physical and/or mental status are precarious, the RN must assume primary responsibility. In assigning priorities, the RN must consider the needs of the client, the resources available, and the time constraints. Obviously, a nurse cannot realistically address all the problems and nursing diagnoses involved with a client.

Knowledge of scientific and nursing practice principles is necessary to prioritize correctly. Diagnoses can be classified as priority or important. Priority nursing diagnoses are the most urgent or immediate needs of the patient, and may be considered life-threatening. These priorities can be either physical or psychological in nature.

Examples: Ineffective breathing pattern related to effects of anesthesia. (Physical)
Ineffective coping related to unknown medical diagnosis. (Psychological)

Important diagnoses are the non-emergency, non-life-threatening patient needs. These can be delayed without causing harm to the client.
Example: Potential alteration in nutrition: less than body requirements related to loss of appetite.

**Maslow**

In assigning priorities, it may be helpful to utilize Maslow’s hierarchy of needs theory (1943). According to this theory, certain human needs are more basic than others and need to be met before the individual can direct his/her attention toward meeting others. The hierarchy arranges human needs according to five levels of priority.

![Hierarchy of Needs Diagram]

1. **Physiological**: The most basic human needs have the highest priority and are necessary for survival: oxygen, fluid, nutrition, temperature, elimination, shelter, rest, and sex.

Example: Fluid volume deficit related to prolonged vomiting and diarrhea.

2. **Safety and security needs**: These include the need for both physical and psychological security.

Example: Potential for injury related to disorientation.

3. **Love and belongings**: These are needs for friendship, social relationships, family, love, and sexual love.
Example: Alteration in family processes related to effects of hospitalization of mother.

4. **Self-esteem:** This includes the needs for self-confidence, usefulness, achievement, and self-worth.

Example: Powerlessness related to immobility.

5. **Self-actualization:** This is the state of having fully achieved one’s potential and having the capability to cope with life’s situations and solve problems. Self-actualization needs are self-fulfillment, meeting personal goals; order, harmony, truth, beauty, privacy, spirituality.

Example: Spiritual distress related to discrepancy between spiritual beliefs and Prescribed treatment.

The hierarchy of needs is a theory and is *generally* true for people, but is not necessarily true for all persons. People usually progress up the hierarchy, but may have unmet needs on more that one level at a time. Lower level needs do not have to be *completely* resolved for a person to address higher level needs.

Prioritizing nursing diagnoses and needs is a component of practice reserved for the RN. The LPN, through findings in the nursing assessment, participates in the planning of nursing care activities.

**Developing Goal/Outcome Statements**

The second step in the planning phase is to establish goal/expected outcome statements for nursing diagnoses and collaborative problems. In North Carolina setting goals and outcome criteria is a role reserved for the RN only. The terms “goal,” “expected outcome,” “desired outcome,” “predicted outcome,” and “objective” are used interchangeably to describe a desired change in the client’s health status or functioning. It is the statement of a client behavior that would demonstrate reduction, resolution, or preventions of the problem identified in the nursing diagnosis. Client goals directly measure a client’s progress, and therefore the effectiveness of the nursing care plan.

Goal/expected outcome statements are a necessary part of the nursing care planning process because they 1) delineate for the client and the nurse what is to be accomplished and when it is to be accomplished, and 2) provide the criteria for evaluation of the effectiveness of the plan of care.

It is important to realize that, like all components of the nursing process, expected outcome statements are dynamic. This means they are frequently changing according to the client’s changing status. Some goals/outcomes are easily achieved and can then be deleted, while others may require more time to complete and may need frequent re-evaluation.

In writing goal/expected outcome statements, the RN must be realistic in her/his expectations. In some instances, partial changes in behavior may be the only attainable goal. With the shortened length of stay in hospitals, patient outcomes may be completed after discharge by home health nurses. Upon discharge, expected outcomes should be evaluated with the client/family to identify those still requiring completion which may need referral to appropriate agencies.
Goals may be either short term or long term. Short term goals are those which can be achieved fairly quickly, within hours or days. Long term goals cover a longer period of time and often require weeks or months to be achieved.

It may be helpful to think of the goal as what we hope will be accomplished as a result of nursing intervention.

Example: The patient will be free of pain by the fourth postoperative day.

The measurable behavior is how we can determine whether or not the goal was achieved. Usually these verbs are measured or validated by sight, hearing or direct client statements.

Example: The patient states he has no pain.

or

The patient requests no more pain medication.

The goal and the expected outcome(s) are often connected by the phrase “as evidenced by.”

Example: The patient will be free of pain by the fourth postoperative day as evidenced by the patient states he has no pain.

**Planning Nursing Action**

The LPN participates in the plan of health care by providing resource data to the RN as well as through identification of nursing interventions for review by the RN.

Planning nursing interventions for specific nursing diagnoses means determining the actions or activities which will achieve the expected outcome. The nursing interventions identify what the nurse is to do to reduce, resolve, or prevent each of the problems expressed in the nursing diagnoses.

The first step in planning nursing interventions is to examine the second element of the nursing diagnosis statement. This phrase identifies the etiological factors: cause, contributing factors, or risk factors.

Examples: Potential impairment of skin integrity related to prolonged bedrest.

Once the etiological factors have been identified. You should proceed to how these are recognized by the nurse, by stating the “as evidenced by” part of the statement. This actually identifies the signs and symptoms present, when there is actual client problem.

Example: Impaired skin integrity related to prolonged bedrest as evidenced by red sacral pressure point.

After the etiological factors have been identified, you should proceed to determine nursing interventions or actions which would eliminate the factors or minimize their effects.
Individualize the interventions for each client to assist him/her toward achievement of the stated goal/expected outcome.

**Guidelines**

1. Put safety first! Remember that nursing actions must be safe.

2. Individualize the nursing actions for each client and be sure they are appropriate to the expected outcome for that particular client.

3. Base nursing actions on scientific rationale.

4. State nursing actions clearly and specifically so that they may be interpreted in the same way by all nurses responsible for the client’s care.

5. Make nursing actions realistic for:
   - the client based on his/her limitations, age, developmental level, preferences, etc.
   - the nurse based on his/her knowledge and capabilities.
   - resources available (equipment, personnel)

6. Do not let nursing actions interfere with other therapies the client is receiving.

7. Whenever possible, involve the client in planning the nursing actions. Strive to help the client understand how nursing actions will result in achievement of a goal.

**Nursing orders**

The RN writes Nursing actions or interventions in the nursing care plan as nursing orders. Nursing orders describe the specific actions or activities which are to be done by all nurses caring for that client. Nursing orders should include client assessment and client teaching whenever possible. In writing nursing orders, it may be helpful to think “what to assess,” “what to do,” and “what to teach”; this will assist the RN in writing comprehensive orders that encompass more than just the activity to be performed.
Unit 3 Self-Test

Utilizing Maslow’s hierarchy, identify the type of need being addressed in each nursing diagnosis below.

<table>
<thead>
<tr>
<th>Nursing Diagnosis</th>
<th>Type of Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Sleep pattern disturbance</td>
<td>Physiologic</td>
</tr>
<tr>
<td>related to excessive noise.</td>
<td></td>
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</tbody>
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1. Potential for violence, self injury related to hallucinations.

2. Ineffective breathing pattern related to side effects of anesthesia.

3. Potential alteration in parenting related to separation from children during hospitalization.

4. Potential ineffective coping related to potential role changes as result of surgery.

5. Disturbance in self concept related to prolonged disability
Unit 4
Implementation

After deciding upon a plan of action, the next step in the nursing process is to execute that plan.

During implementation, all the previous phases of the nursing process are integrated. While giving the actual care, you must continue to assess, validate concerns, modify the plan and identify priorities as needed with the RN.

Preparation for implementation

Before the plan can be implemented, certain preparations are necessary.

1. Review the plan and validate with the client and other health team members that the plan is appropriate for the client’s current health status. Then make modifications as needed with the RN.

2. Assess knowledge and skills which are needed to implement the plan. If knowledge or skills are lacking, you may choose to refer the plan to someone else or request assistance from other staff members.

3. Prepare the client. Explain the nursing actions, their purposes, expected sensations, and the client’s role.

4. Prepare the environment in terms of space, lighting, equipment, and resources.

Action

Once the preparations are completed, the plan is put into action through the implementation of nursing activities, consisting of the delivery of nursing care according to a plan of care established by the RN and delegated by the RN. The nursing interventions should be client-centered and goal-oriented, with careful attention to the safety needs of the client. **Client-centered** means that the care is individualized for that particular person according to his or her current health status. **Goal-oriented** means consistent with the expected outcomes which were stated in the planning phase. You should provide care competently and efficiently through effective use of intellectual, interpersonal, and technical skills.

The **physical** and **psychological** safety of the client are of utmost importance throughout the delivery of care. Ensure physical safety through such things as use of aseptic technique, obtaining assistance when needed, or placing the client in a safe environment. Psychological safety measures include careful explanations and offering emotional support throughout the delivery of care.

Competent delivery of care is more likely to assist the client toward achievement of goals/outcomes. Efficiency in implementation of care provides more time for nurse/client interaction and working toward other goals.

As in the previous phases of the nursing process, it is important to assure active involvement by the client while implementing care.
During delivery of care you should continue to collect data and to document the behaviors of the client while giving nursing care. It is important to note the client’s responses to nursing interventions because the next component of the nursing process, evaluation, is dependent upon accurate and objective information about the client’s reactions to the nursing care.

Nursing interventions may include any of the following:

1. Directly performing an activity for a client.
2. Assisting the client as he/she performs an activity.
3. Observing or supervising the client as he/she independently performs an activity.
4. Teaching the client and/or family.
5. Counseling the client (or family).
6. Monitoring or assessing the client for potential complications of illness.

Guidelines

1. Prior to performing any nursing action, always reassess the status of the client and determine whether the interventions are still appropriate.
2. Before performing any nursing action, identify the rationale, expected results, possible side-effects, and possible adverse effects of the activity.
3. When performing nursing activities, include the client and family as much as possible.
4. Provide a safe and therapeutic environment for delivery of nursing care.
5. When implementing nursing interventions, refer to the institutional protocols and procedures to ascertain the appropriateness of the interventions.

Documentation

When interventions are completed, you must document the care appropriately, noting the specific actions along with the client’s response. Documentation is essential in monitoring the client’s progress toward achievement of goals/expected outcomes, and to assure continuity of care. Documentation of nursing care is a legal requirement of all health care systems. (Refer to Modules 3 and 4, Legal Aspects of Nursing I and II.)
1. Prior to implementing nursing actions, what should you do?

2. Nursing actions should be ______________________, ____________________,
    ____________________.
    ____________________.
Evaluation of the nursing process can be defined as the planned, systematic comparison of the client’s health status with the goals/expected outcomes. It is an ongoing activity, done on a day-to-day basis, which involves the client, the RN, and other health team members.

The major purposes of evaluation are to:

- Evaluate the status of the client
- Determine the client’s progress toward achievement of the stated goals/expected outcomes.
- Judge the effectiveness of the nursing orders, strategies, and care plan.

The criteria for evaluation are explicit in correctly stated goals/expected outcomes which are developed in the planning phase of the nursing process. Expected outcomes identify the exact client behaviors to be achieved.

Example
Nursing diagnosis: Fluid volume deficit related to fluid loss associated with vomiting.

Expected outcome: The client will resume and maintain normal fluid balance by discharge as evidenced by:

1. normal skin turgor
2. moist mucous membranes
3. stable weight
4. BP and pulse within normal limits and stable with position change
5. urine specific gravity between 1.010 and 1.025.
6. absence of lethargy, confusion, excessive thirst.

Evaluation: On discharge, patient has normal skin turgor, mucous membranes are pink and moist. The patient’s weight has stabilized at 150# which is 5# less than normal weight. Vital signs are within normal limits. Urine specific gravity is 1.020-1.025. Patient is alert and oriented, with appropriate thirst.

If expected outcomes are not correctly stated, evaluation is difficult, if not impossible.

During implementation of care you should appraise the client’s response to nursing care and then decide with the RN whether or not the interventions are promoting progress toward the desired goals/expected outcomes. In evaluating the progress toward goal achievement, there are three possible conclusions: the goal was met, the goal was partially met, or the goal was not met.
If the goal was achieved, the client’s problem is resolved or a potential problem has been prevented. Document this in the client’s chart and on the nursing care plan according to agency policy. It may happen, however, that the goal was achieved, but the problem still exists. The RN must then reassess the client and revise the plan of care.

When you determine that the goal was partially met or not met at all, you must fully document this and then consider possible explanations for the client’s lack of progress toward the goal. Some reasons for unsuccessful goal achievement might be:

- The nursing diagnosis from which the goal was derived was inaccurate or inappropriate.
- The goal was unrealistic for the client’s capabilities.
- The nursing actions were not appropriate for achieving the desired outcome.
- The client’s condition changed, and new concerns appeared.
- Medical orders changed.

Because the goals were not successfully achieved, you must reassess the client’s status, and with the RN, proceed to revise the existing care plan.

Evaluation is essential to the nursing process. It is a necessary, continuous process that measures the quality, appropriateness, and effectiveness of both the plan of care and the care actually given to the client.

**Quality Assurance**

Evaluation of nursing practice is more global than simply assessing the effectiveness of care to a particular client, although this is a most vital aspect. Wider implications for evaluation are seen in determining the effectiveness of care given to groups of clients. This planned and systematic evaluation process is called quality assurance.

Historically, quality assurance activities have focused on chart audits as the sole measure of quality of care. The scope of quality assurance has now evolved to include more accurate indicators of the quality of care. In addition to chart reviews, there are such measures as direct observations of client care and client interviews.

In the past, quality assurance activities were retrospective; that is, the chart was reviewed after the client was discharged. The current trend is toward concurrent reviews of care, done while the client is within the health care setting.

Most health care institutions now have quality assurance departments or individuals responsible for monitoring the quality of client care. Within institutions, all aspects of client care are monitored for quality: nursing, radiology, physical therapy, occupational therapy, dietary care, and so on are part of quality assurance departments which monitor the quality of care given by physicians as well.

What is your role as a nurse in this broader evaluation of client care? Nurses are active participants in quality assurance activities as they assist in the development of standards of care, and are involved in evaluating the quality of client care using quality assurance tools. Your major role, of course, is to deliver
quality client care to all individuals, to document that care appropriately, utilizing aspects of the nursing process competently and confidently.
Unit 5
Self Test

1. What are the purposes of evaluation?

2. Explain quality assurance.

3. Describe the nurse’s role in relation to quality assurance.
BIBLIOGRAPHY


Module 5
Answers to Self-Tests

Unit 1

1. To collect adequate data that will provide the basis for nursing care planning.

2. It begins with the initial patient contact and is continuous thereafter.

3. Observation, interview, and examination.

4. The patient, family, medical records, nursing staff and other health team members.

Unit 3

1. Safety, security
2. Physiologic
3. Love and belonging
4. Self-actualization
5. Esteem

Unit 4

1. Review and validate the plan with other health team members; assess the knowledge and skills needed to implement the plan; prepare the client; prepare the environment.

2. Client-centered, goal-oriented, safe for the patient.

Unit 5

1. To determine the client’s progress toward achievement of the stated goals/outcomes and to judge the effectiveness of the nursing orders, strategies, and care plan.

2. The planned and systematic evaluation of care given to the patient.

3. To assist in development of standards of care; to deliver safe, effective, quality care; to document care that is given; to evaluate the quality of care using quality assurance tools.
Appendix A
Sample Health History Form

I. Identifying Information

A. Date
F. Health care provider
B. Initials
G. Last visit date
C. Age
H. Reason for last visit
D. Sex
I. Medical/surgical Diagnoses
E. Status
(M-S-D-W)

II. General Survey (include gait and language perception/formation)

III. Chief Complaint

A. Onset
F. Precipitating factors
B. Description
G. Aggravating factors
C. Frequency
H. Alleviating factors
D. Severity
I. Influencing therapies
E. Duration
J. Effect on daily living

IV. Past Medical History

A. Most recent exams:
   1. Physical
   2. Dental
   3. Eye
   4. Other
B. Allergies:
   1. Drugs ______________________________
   2. Food ______________________________
   3. Blood/blood products __________________
   4. Other _______________________________
   5. Type of reaction:
   6. Treatment:

C. Within the last two (2) years:
   1. Illness ______________________________
   2. Hospitalizations ____________________
   3. Surgeries __________________________
   4. Accidents __________________________
   5. Injuries ____________________________
   6. Immunizations _______________________
   7. Tobacco use _________________________
   8. Alcohol use _________________________

V. Medications Being Taken Currently:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
<th>Purpose</th>
</tr>
</thead>
</table>

VI. Personal and Social History

A. Daytime activities:
   1. Occupation/# years retired ________________________________
   2. Account of a typical day’s activities _______________________
   3. Perceived mobility limitations ______________________________
   4. Leisure time activities _____________________________________
   5. Perceived energy level (1-10 scale) _________________________
   6. Perceived energy level is (circle one) same / deceased / increased
   7. Other __________________________________________________

B. Pain/Comfort:
   1. Most bothersome pain location ______________________________
   2. Nature/Character __________________________________________
   3. Onset ____________________________________________________
   4. Frequency _______________________________________________
   5. Severity __________________________________________________
   6. Duration _________________________________________________
7. Precipitating ____________________________________________________
8. Aggravating ___________________________________________________
9. Alleviating _____________________________________________________
10. Prescribed treatment __________________________________________
11. Effect on ADL ________________________________________________
12. Perceived cause ______________________________________________
13. Attitude by culture ____________________________________________

C. Psychosocial:
1. Frequency of visits by family members ___________________________
2. Persons(s) (other than family) he/she talks most with ________________
3. Other significant relationships ____________________________________
4. Compatibility with roommate _____________________________________
5. Level of consciousness __________________________________________
6. Mood changes __________________________________________________

D. Comfort/Sleep
1. Perceived degree/amount of rest felt upon awakening in the morning
   __________________________________________________________________
2. Hour of evening retirement to sleep _________________________________
3. Hour of awakening from sleep in morning ____________________________
4. Number of awakenings during night _________________________________
5. Presence of:
   a. daytime napping ________
   b. night chest pain ________
   c. morning headaches ________
   d. night confusion/disorientation ________
   e. night snoring ________
   f. breathing irregularities ________

E. Nutrition:
1. Perceived appetite ________
2. Number of meals/day ________
3. Meals eaten in last 24 hours:
   a. percentage of food eaten:
      1. breakfast drink ____%
      2. lunch _____________%
      3. dinner ____________%
   b. kinds of food eaten:

4. weight/date ______________
5. height ______________
6. weight changes _________
7. body type ______________
8. prosthesis affecting nutrition __________________________
9. therapies affecting nutrition __________________________
10. Other ___________________________________

F. Elimination
   1. urinary tract prosthesis _____________________
   2. bowel prosthesis __________________________
   3. effect on ADL ______________________________

G. Sexuality
   1. expressions of masculinity/femininity observed _____________________
      ______________________________________________________________
   2. satisfaction with intimate relationships __________________________
      ______________________________________________________________
   3. concerns ____________________________________________________
      ______________________________________________________________

H. Environmental conditions that may pose health risks

VII. Review of Systems
   A. General: fever, chills, fatigue
   B. Skin: bruising, lesions, pruritus, jaundice
   C. Lymph nodes: enlarged, painful
   D. Head: trauma, headache
   E. Eyes: vision disturbances, glasses, contacts, cataracts
   F. Ears: discharge, infections, hearing, tinnitus, equilibrium
   G. Nose and throat: colds, hoarseness, dental care, dentures, nasal obstructions, nosebleed, swallowing difficulties
   H. Breasts: family history of cancer, history of masses, self-breast exam
   I. Respiratory: dyspnea, cough, characteristics of sputum produced, history of pneumonia
   J. Cardiovascular: chest, are or neck discomfort, dizziness, weakness, palpitations
   K. Gastrointestinal: swallowing difficulty, vomiting, appetite, change in bowel patterns
   L. Urinary: infections, frequency, nocturia, dysuria, incontinence, color changes, stream changes, excessive amounts
M. **Genital:** infections, discharge, last PAP, testicular self-exam

N. **Musculoskeletal:** weakness, cramping, joint stiffness

O. **Neurological:** fainting, seizures, paralysis, incoordination, gait problems, numbness or tingling sensations

P. **Endocrine:** changes in hair, nails or skin, heat/cold intolerance, excessive thirst, urine or sweating

Q. **Hematologic:** pallor, bleeding, bruising, blood transfusions

R. **Mental/Emotional:** anxiety, tension, memory loss, depression.

VIII. **Physical Assessment Results**
Date performed _____________________________
Vitals: ____________________________________
Changes: __________________________________
General survey:

HEENT:

Chest/Thorax:

Breasts:

Cardiac:

Abdomen:

Musculoskeletal:

Neurological:

Genital:

Other:

IX. **Laboratory Data Results**
Date performed _____________________________
Urinalysis __________________________________
Hgb _________________________________________
Hct _________________________________________
Serum creatinine ____________________________
Serum BUN _________________________________
Serum glucose ______________________________
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<thead>
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<th>Nursing Diagnosis</th>
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Module 5
Answers to Self-Tests

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