UNIT 3 DEVELOPMENT OF NURSING CARE PLAN USING NURSING PROCESS

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3.0 OBJECTIVES

At the end of this unit, you should be able to:

- obtain assessment data from client and document the data collected.;
- analyze the data;
- formulate appropriate nursing diagnosis;
- formulate nursing outcomes/goals for the selected nursing diagnosis based on priority;
- implement nursing activities to achieve the goals;
- evaluate the care to measure the effectiveness of nursing actions; and
- develop nursing care plan using nursing process format for documentation.

3.1 INTRODUCTION

All health care professionals are striving to upgrade client care. Nurses are concerned to provide health care to both well and ill clients in different settings. In 1950s the term ‘‘Nursing Process’’ was first used and ‘‘nursing diagnosis’’ was considered as ‘‘the weak link’’. In 1972 both the terms emerged as having ‘‘the strong link’’ in nursing practice. Today in the era of cost containment the value of one’s contribution to the health care delivery system must be measurable and demonstrable. The combinations of nursing care plan based on nursing diagnosis gives nurse a concrete instrument to quantify nursing. Nursing care plans are the keys to professional nursing care and must be written for specific nursing diagnosis to document the care needed the care given and the clients responses.

3.2 REVIEW OF STEPS OF NURSING PROCESS

3.2.1 Definition

Nursing process is a framework that enables the nurse and the client together to resolve health related problems of the client in a systematic, organized and logical way.

3.2.2 Purposes

1) It provides a framework within which nurses can identify client's health status and provide quality care and checks its outcomes through evaluation.

2) It helps in rendering individualized care.

3) It avoids unnecessary (duplication of) nursing actions thus saves time.

4) It helps in providing organized priority based care.

5) It encourages clients and family participation in care.

3.2.3 Steps

Nursing process consists of the following steps:

1) Assessment

2) Nursing Diagnosis

3) Planning

4) Implementation

5) Evaluation

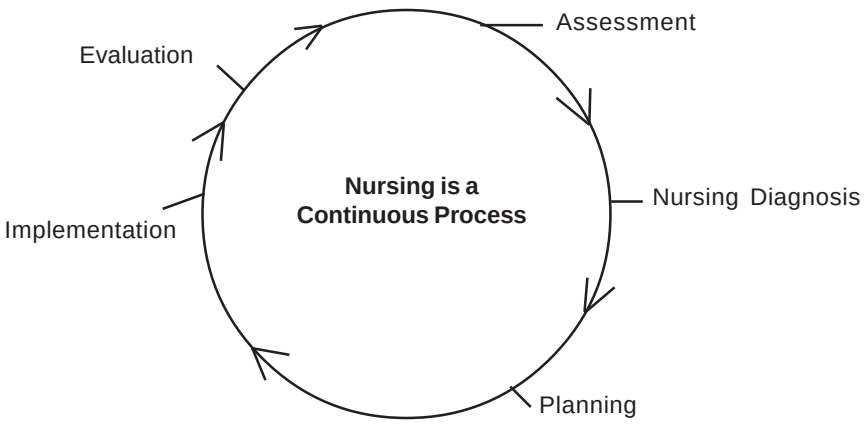

Fig. 3.1: Steps of nursing process

Assessment

Assessment is the foundation step of nursing process. It consists of systematic and orderly collection of information pertaining to and about the health status of the client. The information obtained helps to make nursing diagnosis and to develop a plan of care. Informations are obtained by data collection.

Data Collection

Data collection includes accumulation of comprehensive information about the client on initial assessment. The initial assessment provides baseline data. The data involves information about clients health problem, specific factors that contribute to the problem. The client has health problem (s) with which hes/he gets admitted and may also develop additional problem during his stay in the hospital, because of this course of illness, and the treatment modalities.

As you have already read in unit 5 of this block under section 1.3.6 that data collected by the nurse during assessment are:

- Subjective Data
- Objective Data

Subjective Data

Subjective data includes client's description of his personal health status, problem e.g. feeling, description pain, weakness, nausea. This data also include information supplied by client's family members. The data are not observable and are difficult to measure objectively.

Objective Data

Objective data are usually the one that is obtained through senses –sight, smell, hearing, touch and during physical examination of the client. Objective data are observable and measurable. For example: rate of pulse, weight, presence of oedema. **The data collected by the nurse can be historical data and current data.**

Historical data has information related to the events that have occurred prior to the present. The event might be previous hospitalization, presence of chronic disease, pattern of bowel movement in the past, childhood illness in an adult patient.

Current data refer to the events that are occurring at present e.g. pain, vomiting, inability to pass urine and present illness.

It is always necessary to validate subjective with objective data, historical with current data. For example, subjective data of feeling of pain is validated by objective findings of pallor, increased sweating and hypotension. Similarly, historical data e.g. passing stool once every day and bowels not moved for two days (current) may initiate a strategy to help patient move his bowels. But when substantiated with historical data the client may inform that movement of bowel on every alternate day is his routine at home. Thus the information obtained earlier becomes valid. Therefore, validation of the data is necessary before planning care.

Nursing Diagnosis

The diagnostic process involves processing the data by classification interpretation and validation. Writing nursing diagnostic statement is the basis of identifying client's problems and strengths. The health problem and the etiological factor are reflected in the formulation of diagnostic statement. The diagnosis is verified with the client and documented.

Planning

Planning includes setting priorities and writing outcomes. The different problems of the client identified in the nursing diagnosis needs to be prioritized. The nurse can determine priority problems related to needs of client.

Outcomes/goals are written from the diagnostic statement in terms of client's behaviour that are desired to be achieved by the nurse in the limited time. The characteristic features of outcomes are:

- client centered
- observable and measurable
- time limited and realistic.

The areas in which outcomes are written include:

- appearance and functioning of the body,
- specific symptoms,
- knowledge,
- psychomotor skills and emotional status.

Implementation

Implementation involves preparation for executing the plan and carrying the interventions to resolve client's problem. The interventions include all those independent, dependent and interdependent nursing actions carried out by the nurse to restore health, prevent illness, promote wellness and facilitate copying with altered functioning. The implementation of nursing action is followed by complete and accurate documentation of events.

Evaluation

Evaluation is used to judge each component of nursing process. It measures the effectiveness of nursing interventions. It consists of comparing and judging the data about client's progress. The client's response to the nursing interventions will guide the nurse to continue with the plan care, modify it or terminate. In case the plan of care needs modification the nurse will reassess and carryout the remaining steps of nursing process. When the care is continued the ongoing process of assessment and evaluation is continued.

Check Your Progress 1

Match each phase/step of the nursing process with the examples of activities that occur in that phase. Select the term given in column I and place it on column II.

a)	Assessment	1)	Writing nursing orders on the care plan.
b)	Diagnosis	2)	Using data base to decide if goals have been met
c)	Planning	3)	Mrs. R.S. has blood pressure 120/70, her pulse is 84, she is 10kg overweight
d)	Implementation	4)	Nurse analyzes the data, diagnose that no problem exists, and concludes no interventions are needed.
e)	Evaluation	5)	Becomes aware of ways in which her lifestyle can either increase or decrease risk of disease.
		6)	Giving client pamphlet on "stop smoking"
		7)	Charting the care given to the client
		8)	Change dressing using betadine at Coccyx at 9 A.M.
		9)	Nurse prepares the client to be taken out on a wheel chair and observes that the client has become pale and c/o dizziness
		10)	Nurse classifies, searches for a clearer understanding of the cues

3.3 DEVELOPMENT OF NURSING CARE PLAN

You have learnt about the phases of the nursing process in theory course (BNS-101) Block 2, Unit 1. Documentation of planned care is involved in nursing process. It becomes clear then that in order to develop nursing care plan the nurse must accomplish the steps of the nursing process i.e. assessment, nursing diagnosis and planning. In this section you will learn the performance phases through examples.

3.3.1 Assessment – Data Collection

1) **Subjective Data**

a) ***Identification Data***

Name : .....

Age : .....

Sex : .....

Marital Status : .....

Religion : .....

Ward : .....

Bed No. : .....
Reg. No. : .....
Diagnosis : .....
Education : .....
Occupation : .....
Income : .....
Address : .....
.....
Date of Admission : .....
Date of Discharge : .....
Date of Physical Examination : .....

b) ***History***

i) Family history:

- nuclear/joint
- number of members
- health status of members
- specific disease in the family
- IPM

ii) Personal history:

- life style
- health habits
- exercise
- use of alcohol
- smoking/tobacco
- elimination pattern
- sleep pattern

iii) Health history

- past h/o illness : medical
  : surgical
  : psychiatric
- present h/o illness
- present complaint

2) **Objective Data**

i) ***Observation***

- general appearance/built
- mental alertness
- evidence of pain
- position of patient

ii) ***Physical Examination***

a) Vital signs

b) Height and Weight

c) ***Head to foot Examination***

- ***Skin:*** Colour, pigmentation, scars, edema, moisture, nails, allergy, turgor etc.
- ***Head:*** Symmetry of skull, face, hair colour, distribution, lesions, hair texture etc.
- ***Eyes and Vision:*** h/o burning, pain, vision problems etc. observe external eye structure for any abnormality. Pupils size, reaction to light etc. movement of eye visual field, findings of fundoscopic examination.
- ***Ears and Hearing:*** Auricles, Tympansic membrane, presence of discharge growth etc, otoscopic findings.
- **Nose:** Any deformity, discharge, polyp sinus for tenderness.
- **Mouth and Throat:** Lips colour, ulcers we light and tongue-depressor observes teeth gum, tongue tonsils, phanyx etc. for any abnormality observes voice for hoarseness.
- **Neck:** Range of motion, thyroid gland, jugular, vein, lymph nodes.
- **Breast:** (Female) areola and nipple size, symmetry, palpation for any lumps, nodes etc. any discharge.
- **Throat and Lungs:** Symmetry of chest, any structure deformity, movement of chest wall. Auscultate the chest for breath sounds.
- **Heart:** All pulses, (radial, brachial and femoral) auscultate heart sound
- **Abdomen:** Contour, symmetry, visible peristatis , scars, rashes, shape of umbilicus, auscultate for bowel sounds. Palpate for mass, tenderness etc.
- **Genitalia:** Hygiene, discharge, tumors, lesions etc.
- **Extremities:** Range of motions, muscle strength, symmetry, mass, deformity etc.
- **Neurological:** Mental status, alertness, orientation to time, place and person, function of cranial nerves, reflexes etc.

iii) ***Laboratory Data/Investigations***

- Laboratory values of various investigations done in the patient -X-rays
- Special investigations if any.

Based on the above-mentioned objective and subjective data you can formulate nursing diagnosis according to priority.

3.3.2 Nursing Diagnosis

It is a statement of a patient's problem that is arrived at by making inferences from the collected data. Examples of nursing diagnosis are as follows:

Table 3.1: Nursing Diagnosis

Subjective Data	Objective Data	Nursing Diagnosis
– Anorexia, nausea, weakness, abdominal cramps	– Diarrhoea, vomiting, vomiting, dry skin	– Fluid volume deficit related to disease condition
– Scared to go for surgery patient feels he may not survive after surgery	– Tearful, facial, muscles tense, nube l00/ml, teandstrembling	– Anxiety related to surgery – Formulation of nursing diagnosis

3.3.3 Planning

It is the third phase of nursing process begins after formulation of nursing diagnosis. Planning includes goals and outcomes for nursing actions, which are based on priorities.

Planning involve the following:

- Setting priorities
- Establishing goals/expected outcomes
- Planning nursing actions/interventions
- Documenting the plan of nursing care.

Setting Priorities

Today's nurse must learn how to set priorities. The first step in setting priorities is that of making a list of the problems that you have identified during the assessment phase. You must then study the list and decide which are the most Important problems.

Next you will have to decide the order of nursing care (i.e. what problems you will look after first)

Here are some suggestions of the questions, you ask yourself when setting priorities.

- Which are the problems that must be taken care of immediately?
- Which are the problems that you will work to prevent, reduce or resolve today?
- Of the problems you with work on today, which will you work on first, second, third?
- Are there any problems that can be worked on at same time (for example you may choose to work on promoting communication about fears and concerns about illness while assisting the client wit morning care).

Establishing Goals/Expected Outcomes

Nursing care planned according to priority setting will reflect the goals of care established by the client and nurse. Setting goals is an activity that includes the family and significant others as well as the client.

Goals should not only meet the immediate needs of the client, but should also include prevention and rehabilitation. Goal setting establishes the framework for the nursing care plan. Ultimately, goal results in development of expected outcome of the nursing intervention.

The expected outcome is the specific, desired change in the client's condition in the psychological, social, emotional spiritual dimensions. The nurse also uses the outcomes as criteria to evaluate the effectiveness of nursing activities.

Example:

Table 3.2: Establishing Goals/Expecteed Outcome

Problem	Goal	Expected Outcome
Potential ineffective airways clearance postoperatively related to abdominal incisional pain.	Lungs remain clear immediately after surgery	Clien able to clear airway with deep breathing and coughing. Lungs clear on auscultation

Check Your Progress 2

List the four activities involved in the planning process.

a) .....

b) .....

c) .....

d) .....

3. 3.4 Implementation

It is the execution nursing actions to achieve the goals/expected outcomes. Thus meeting the needs of the client and relieving the problems.

Example:

Table 3.3: Implementing Nursing Actions

Nursing Diagnosis	Planning (goal/outcome)	Implementation
Fluid deficit related to disease condition	– Maintenance of normal fluid volume – Maintenance of proper tissue perfusion – Prevention of complications	– Encourage oral fluids – I/v as ordered – I/o chart – Assess hydration – Check vital signs, BP

In order to plan nursing interventions, the expected outcomes of the plan of care should be considered as well as the cause of the problem. This will help you to determine exactly what nursing actions will help this particular patient achieve the expected outcomes.

Guidelines: Planning Nursing Interventions/Actions

– Always check or reassess the status of the problem before determining appropriate nursing interventions.

– Look for intervention that will reduce or eliminate the cause of the problem.

– Consider the expected outcome to be sure that your interventions are specific for that particular patient.

– Identify the strengths of the client and family that can be encouraged so that they can participate in correcting the problem.

– Individualize nursing actions. What may work for one person may not for another?

– Utilize scientific rationale as a basis for your actions (i.e. know why you are performing a nursing intervention).

– Create opportunities for teaching and learning wherever possible (e.g. teach the patient the reasons for the nursing actions that you have chosen).

– Consult other professionals whenever necessary (e.g. doctors dietitian, physiotherapist etc).

3.3.5 Evaluation

It is used to judge each component of the nursing process and is done by comparison of clrent's health status with the outcome. Evaluation reflects whether the patient's problems are resolved or not. If the expected outcomes are achieved, then further assessment planning and intervention are to be reinforced. Since evaluation is an ongoing and continuous process. Example of evaluation is as follows:

Table 3.4: Evaluation of Nursing Actions

Nursing Diagnosis	Planning	Implementation	Evaluation
Fluid volume related to disease condition	• Maintenance of normal fluid volume • Maintenance of proper tissue perfusion • Prevention of of complications	• Encourage oral fluids • I/V as prescribed • I/O chart • Assess hydration • Check vital signs, BP	Skin turgor normal: – Lips and mucous membrane of mouth moist – Fluid intake 3500 output 1800ml

3.4 DOCUMENTATION OF NURSING CARE PLAN

Documenting the plan of nursing care or writing the nursing care plan, is the final product planning process. If you fail to document your plan of nursing care, you waste all the effort that you have done in determining an individualized care plan for your patient. No one will know the work that has been done. Nursing care plan serves five purposes:

1) To validate that there has been a thorough plan of care formulated for each patient.

2) To serve as a record that can later be studied to evaluate patient care.

3) To communicate to other nurses the specific problems, goals and interventions that have been identified for the patient.

4) To same; time and avoid duplication of work.

5) To help in legal purposes.

Check Your Progress 3

Write whether the following informations are subjective or objective data.

a) Temperature of 39°C: .....

b) Heart rate 96/mt: .....

c) Pain in the leg .....

d) Feeling fatigue .....

3.5 FORMAT OF NURSING CARE PLAN BASED ON NURSING PROCESS

i) **Identification data**

Name : .....

Age : .....

Sex : .....

Religion : .....

Marital Status : .....

Educational Background : .....

Occupation : .....

Date of Admission : .....

M.R.D. No. : .....

Diagnosis : .....

Ward : .....

Bed No. : .....

Address : .....

.....

Date of Discharge : .....

Date of Planning : .....

ii) **Brief Socio-Eeconomic History**

1) Family history

a) Type of family—Nuclear/joint

b) Numbers of family members

c) Any specific disease in members

d) Health status of family members

e) Total Income

f) Dietary habits

g) Housing condition — Own/Rental/Water/Electricity Supply etc.

h) I.P.R. Among Family Members

2) Personal history
- Hygine and grooming
- Any H/O Allergy
- H/O smoking, alcohol, tobacco, drinking etc.
- Life style flabits–exercises-drugs etc.

3) Hisotry of fast illness

4) History of present illness — Present complaints

5) Examination by doctor (from casesheet)

6) Investigations:

Date	Name of Investigation	Findings in patient	Normal Value

7) Doctors Ordes:

Sl. No.	Dr's Prescription	Purposes

8) Assessment:

a) Subjective Assessment:

b) Objective Assessment : vital signs
Head to foot examination

9) Nursing Care Plan

Nursing Dignosis	Planning Goals/	Implementation Expected outcome	Evaluation

10) Health Teachings

11) Progress Notes— (Day wise)

12) Activity

a) Write three nursing care plans using nursing process.
Select patient from anyone of the following setting

- OPD
- Medical/surgical ward
- ICU, CCU, RR, Neuro ICU

b) Discuss nursing process with your supervisor?

c) Write five objective and subjective data?

3.6 LET US SUM UP

In this practical you learnt about writing a nursing care plan by using nursing process. In assessment you learnt regarding data collection to identify actual or potential health problems. Systematic physical examination helps in retaining objective data. Planning and nursing diagnosis are based on assessment. Other than the medical diagnosis which physician makes you will be able to make nursing diagnosis which helps you to write nursing care plan. Thus provides comprehensive nursing care to client in all the shifts of duty. It is an important steps towards professional writing nursing care plan is an excellent documentation for continuity of care, as well as for further reference and self improvement.

3.7 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

a) 9

b) 1

c) 8

d) 7

e) 4

Check Your Progress 2

a) Objective

b) Objective

c) Subjective

d) Subjective

Check Your Progress 3

a) Setting Priorities

b) Establish goal/outcome

c) Plan nursing action

d) Documenting the actions

3.8 ACTIVITIES

Activity 1

Select a patient from your clinical setting take a case history of the patient:

i) Write five objective and five subjective data

ii) Make nursing diagnosis and list down the desired outcome as expected.

iii) Write a nursing care plan using nursing process. You may follow format given in unit 3, Section 3.5.

iv) Discus nursing process with your supervisor.