chapter 5

Assessment, Nursing Diagnosis, and Planning

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Objectives

Upon completing this chapter, you should be able to:

Theory

1. Identify the purpose of assessment (data collection).
2. Discuss the three basic methods used to gather a patient database.
3. Differentiate objective data from subjective data.
4. Use sources of data for the formulation of a patient database.
5. Correlate patient problems with nursing diagnoses from the accepted North American Nursing Diagnosis Association–International (NANDA-I) list.
6. Select appropriate outcome criteria for selected nursing diagnoses.
7. Plan goals for each patient and write outcome criteria for the chosen nursing diagnoses.

Clinical Practice

1. Collect assessment data for a patient and document it.
2. Analyze the data collected to determine patient needs.
3. Identify appropriate nursing diagnoses from the NANDA-I list for each assigned patient.
4. Prioritize the nursing diagnoses.
5. Write specific goal/outcome statements.
6. Plan appropriate nursing interventions to assist the patient in attaining the goals/expected outcomes.

Key Terms

cues (KĒWS, p. 61)
data (p. 54)
database (p. 54)
defining characteristics (p. 62)
etiologic factors (ē-tē-ō-LŌ-jĭk, p. 62)
expected outcome (p. 63)
goal (p. 63)
inferences (ĬN-fĕr-ĕn-sĕs, p. 61)
interview (p. 55)
nursing diagnosis (p. 61)
objective data (p. 55)
signs (p. 62)
subjective data (p. 55)
symptoms (p. 62)

ASSESSMENT (DATA COLLECTION)

The first three steps in the nursing process—assessment and data collection, nursing diagnosis, and planning—are discussed in this chapter. **Assessment** consists of gathering information about patients and their needs using a variety of methods. During the assessment phase of the nursing process, **data** (pieces of information on a specific topic) are systematically obtained, organized into a logical **database** (all the information gathered about a patient), and documented. Data collection is a large part of assessment. Assessment for the LPN/LVN is guided by the National Federation of Licensed Practical Nurses (NFLPN) Standard 4 under the *Planning* area of the nursing process: "The planning of nursing includes assessment/data collection of health status of the individual patient, the family and community groups" (see Appendix C).

A registered nurse (RN) is designated as the staff member who must perform the initial admission assessment of each patient. However, the **LPN/LVN is often asked to assist with this task and participates in carrying out the plan by continuing to collect data.**

Assignment Considerations

Assigning Admission Tasks

If assistive personnel are available to help, you may assign the tasks of weighing, measuring, and obtaining a urine specimen for the newly admitted patient. The assistant could open the admission supplies and set up the patient's room. Be certain to alert the assistant of any safety measures needed for the patient.

There are various approaches to data collection. One is a structured format to obtain a comprehensive database based on the 11 functional health patterns,

Review Questions for the NCLEX® Examination

*Choose the **best** answer for each question.*

1. Input from the _____ during the planning stage of the nursing process results in greater success. *(Fill in the blank.)*

2. The planning phase of the nursing process correlates with which step of the scientific method?
   1. Brainstorming
   2. Data analysis
   3. Developing solutions
   4. Implementing the decision

3. Priorities of care change constantly because: *(Select all that apply.)*
   1. the nurse's workload may change as patients are admitted.
   2. physicians' orders may change throughout the shift.
   3. a patient's condition may deteriorate.
   4. tests or therapies may not be done on time.
   5. many visitors are in the rooms.

4. Clinical reasoning is necessary to:
   1. plan nursing care.
   2. organize care for several patients.
   3. collaborate with others.
   4. draw sound conclusions from assessment data.

5. Attributes of critical thinkers include: *(Select all that apply.)*
   1. setting priorities.
   2. consulting physicians.
   3. verifying accuracy and reliability of data.
   4. reasoning logically.
   5. accepting others' decisions.
   6. being flexible.
   7. recognizing inconsistencies in data gathered.

6. Critical thinking:
   1. is optional for the LPN/LVN.
   2. only occurs in the clinical setting.
   3. is incorporated throughout the nursing process.
   4. is independent of data collection.

7. Critical thinking will help you in the clinical setting to:
   1. delegate work efficiently.
   2. make good decisions most of the time.
   3. identify nursing diagnoses.
   4. write care plans more effectively.

8. How do concept maps assist critical thinking?
   1. They help point out relationships among the data.
   2. They stimulate left brain activity.
   3. By using color, they stimulate right brain activity.
   4. They provide a roadmap for critical thinking.

9. Which is the best way to demonstrate critical thinking to your clinical instructor who has just asked you about your patient?
   1. Pausing and thinking before answering the question
   2. Answering her as quickly as possible, ideally before she finishes the question
   3. Stating the first thought that "pops" into your head
   4. Avoiding the question, since she will probably ask someone else

10. Which is an example of clinical judgment?
    1. Weighing the pros and cons of which school to send your children to
    2. Deciding which nursing midterm examination to study for first
    3. Prioritizing which call light to answer first
    4. Answering the physician's question in a diplomatic manner

Critical Thinking Activities

Read each clinical scenario and discuss the questions with your classmates.

Scenario A

As a student, you have several tasks to complete. There is an Anatomy and Physiology test 4 days away. A comprehensive paper is due in 1 week, and you just collected the library materials you need for it. A 50-page reading assignment needs to be completed for a lecture the day after tomorrow.

1. How would you organize to accomplish these tasks?
2. In what order of priority would you place each of these tasks? Explain why you placed each task in the order chosen.

Scenario B

Your clinical area does not have sphygmomanometers (blood pressure cuffs) on the wall by each patient; portable ones are used. You need to take 8 A.M. vital signs (temperature, pulse, respiration rate, and blood pressure) quickly, and there is no portable unit available right now. How would you solve this problem?

Scenario C

Your clinical assignment is for:
M.H., age 72; diagnosis: pneumonia
F.S., age 52; diagnosis: leg ulcer
J.P., age 78; diagnosis: abdominal hernia repair

1. It is 9:45 A.M. If J.P. needs to be ambulated three times a day, M.H. needs his antibiotic given at 10 A.M., and F.S. needs her dressing changed this morning, in what order would you do these tasks?
2. How did you make this decision?

Box 5-1 Gordon's 11 Health Patterns

- Health perception–health management pattern
- Nutritional-metabolic pattern
- Elimination pattern
- Activity-exercise pattern
- Cognitive-perceptual pattern
- Sleep-rest pattern
- Self-perception–self-concept pattern
- Role-relationship pattern
- Sexuality-reproductive pattern
- Coping-stress-tolerance pattern
- Value-belief pattern

For each pattern, the following are assessed:

FUNCTIONAL
- Present function
- Personal habits
- Lifestyle and cultural factors
- Age-related factors

DYSFUNCTIONAL
- History of dysfunction
- Diagnostic test abnormalities
- Risk factors related to medical treatment plan

All problems identified within a pattern are considered according to their relationship to the other functional patterns. Nursing focus is aimed at improving the patient's functional status in each pattern area.

From Gordon, M. (1994). *Nursing Diagnosis: Process and Application* (3rd ed.). St. Louis: C. V. Mosby. Adapted from Harkreader, H., Hogan, M. A., & Thobaben, M. (2007). *Fundamentals of Nursing: Caring and Clinical Judgment* (2nd ed., p. 107). Philadelphia: Elsevier Saunders.

as formulated by Mary Gordon (Box 5-1). After data in all 11 areas are collected, a review is performed to see if there are patterns indicating problems. The assessment data are then compared with the patient's baselines, such as usual blood pressure, heart rate, weight, and so forth. The functional patterns represent the interaction between the patient and the environment. The 11 patterns are each part of a whole, and any one pattern is understood only in conjunction with the other 10 patterns. The analysis and comparisons help identify patient strengths and patient weaknesses. Many nursing schools teach this approach.

A second method of data collection is to begin with areas in which problems are evident, such as pain. Factors causing or affecting the pain are explored. This is a **focused assessment** because it is concerned with one very specific problem. The assessment and data collection then progress to how the problem affects other areas of the patient's life. If the patient is in acute distress, a focused assessment may be performed before a total assessment and data collection are completed.

A third method is to assess every area in Maslow's hierarchy of basic needs (see Figure 2-3). Whatever method is used, assessment and data collection must

Table 5-1 Examples of Subjective and Objective Data

SUBJECTIVE DATA EXAMPLES	OBJECTIVE DATA EXAMPLES
"I have a headache."	Temperature 101.4° F (38.6° C)
"I am nauseated."	135 mL emesis at 08:20
"The sharp pain is in my hip."	Bruise on right hip
"I've been feeling really blue lately."	Eyes downcast, flat affect
"I've been lonely since my husband died."	Only one visitor seen in room all day
"I'm tired all the time."	Hgb 10.5 mg/dL, HCT 31%
"I'm afraid I have cancer."	Pathology report states tissue is adenosarcoma

Key: *Hgb*, Hemoglobin; *HCT*, hematocrit.

be comprehensive, covering all aspects of the patient: physical, psychosocial, and spiritual.

An admission assessment and data collection **interview** (conversation in which facts are obtained) is usually performed when patients are assigned to the nursing unit, enter the care of a home health agency, or become residents in a long-term care facility. The nurse interviews the patient to find out his major complaints, performs a physical examination, and determines the patient's overall health status. Information is also gathered by observing the patient; reading the chart or other sources of written information; and consulting with the family, significant others, and other health professionals.

Data obtained from the patient verbally are called **subjective data.** A headache, tingling in the feet, or pain in the shoulder is only apparent to the patient, and only the patient can describe or verify such symptoms. These are examples of subjective data. Information obtained through the senses and hands-on physical examination is **objective data.** The observed inabilities of a patient to grasp a glass in his left hand or to support his body when standing are examples of objective data. Vital signs, physical examination findings, and results of diagnostic tests are also objective data (Table 5-1).

Other sources of data are the physician's history and physical, ancillary staff notes, and the admission note. The data collection is guided by a printed form that is filled out and placed in each patient's chart. The nursing student may be assigned to interview patients using a more comprehensive form as part of a learning experience (Figure 5-1). Examples of a portion of a typical electronic nursing admission assessment and data collection form are on the Evolve website. Other sections of the form include skin, nutrition, personal habits, pain, education, and psychological/spiritual assessments.

ADMISSION DATE & TIME	PRIMARY LANGUAGE IF NOT ENGLISH	ADMITTED FROM: ☐ ED ☐ ECF ☐ HOME ☐ DIRECT ☐ OTHER MODE OF TRANSFER: ☐ W/C ☐ BED ☐ GURNEY ☐ AMBULATED	HT. IN. ☐ STATED ☐ MEASURED	WT. ☐ STANDING ☐ BED SCALE ☐ CHAIR SCALE	VITAL SIGNS T R /min.
ROOM NUMBER:	☐ SIGN LANGUAGE				

Patient Statement / Complaint:

R L

P BP

Instruction of Routine and Services to Patient /Family

- ☐ Nurse Call System/Intercom
- ☐ Bed Controls
- ☐ Fall Prevention Program
- ☐ Patient Identification (Name & Date of Birth)
- ☐ Bedside Shift Report/Hourly Rounding
- ☐ Patient Care Handbook
  - Visitor Guidelines (Pg.5)
  - Patient Safety/How to Report Concerns (Pg.8)
  - Infection Prevention (Pg.9)
  - Pain Management (Pg.22)
  - Condition HELP

SIGNATURE & TITLE

The valuables/personal effects policy has been explained, and, I understand that Marian Medical Center does not assume responsibility for valuables (money, jewelry, or other personal effects) not secured in the Marian Medical Center safe.

_____ Signature
Patient or Responsible Person

La poliza tocante objectos de valor ha sido explicada, y yo entiendo que Marian Medical Center no asume responsibilidad por estos objectos (alhajas, dinero, etc.) o cualquier otra prenda personal que no sea asegurada en la caja fuerte de Marian Medical Center.

_____ Firma
Paciente o persona responsible por el paciente

DISCHARGE PLANNING

Environmental Concerns at home (i.e., stairs, lack of running water) _____

☐ Case Management notified (Discharge Planner)

Living situation: (home, B&C, SNF, living alone) _____

Anticipated Post Hospital Care Issues: _____

Care Partner: Name: _____

Relationship: _____ Phone: _____

Other contact: _____

Relationship: _____ Phone: _____

Anticipated Ride Home _____ Phone: _____

MEDICAL HISTORY

	YES	NO
Diabetes	☐	☐
Asthma	☐	☐
Epilepsy / Seizure Disorder	☐	☐
Family Bleeding Tend.	☐	☐
Glaucoma	☐	☐
Cardiac	☐	☐
CHF	☐	☐
Pneumonia	☐	☐
AMI	☐	☐

Any other Medical/Surgical Conditions:

Marian Regional Medical Center.
A Dignity Health Member

PATIENT ADMISSION ASSESSMENT

PAGE 1

6010-08(10/11)

ACCESS

PATIENT ID

FIGURE 5-1 Example of a patient admission assessment form. This is the first page of a four-page form; the entire form is included on the Evolve website.

NEUROLOGICAL STATUS

PUPIL SIZE CHART

R Reactive S Sluggish NR Non-Reactive

LEVEL OF CONSCIOUSNESS: ❑ ALERT ❑ ORIENTED
❑ Confused ❑ Slow to respond/Comprehend
❑ Disoriented ❑ Lethargic ❑ Vertigo
❑ Pupils: Size & reaction: Right _____ Left: _____

SENSORY LIMITATIONS:				If Pt. Uses	If with Patient
❑ Taste	❑ Speech	❑ WNL	Glasses	❑	❑
❑ Touch	❑ Smell	❑ Sight	Contact Lenses ❑ R ❑ L	❑	❑
		❑ Hearing	Hearing Aid ❑ R ❑ L	❑	❑

FUNCTIONAL STATUS (LEVEL OF SELF CARE)

MOBILITY: ❑ WNL ❑ Decreased mobility over last month

Limitations:
❑ Walking ❑ Stairs
❑ Transfer ❑ Standing
❑ Turning in bed ❑ Generalized Weakness

ASSISTANCE REQUIRED:
❑ Hygiene/Grooming ❑ Dressing ❑ Meals ❑ Other

	If PT Uses	If with Patient
Cane/Crutches/Walker	❑	❑
Artifical Limbs ❑ R ❑ L	❑	❑
Brace	❑	❑

WEAKNESS PARALYSIS/TRAUMA/SURGERY: _____

MOTOR FUNCTION
RUE _____
LUE _____
RLE _____
LLE _____

CODE: 5 (Normal Strength)
4 (Mild Weakness)
3 (Moves Against Gravity)
2 (Moves Not Against Gravity)
1 (Some Movement)

❑ Request Rehab. Services consult
❑ Acute onset
❑ Changes in mobility in the last month
❑ _____

SAFETY RISK

		Score
1. History of falling	No	0
	Yes	25 _____
2. Secondary diagnosis	No	0
More than 1 medical dx	Yes	15 _____
3. Ambulatory Aid:		
None/Bedrest/Nurse assist	No	0
Crutches/Cane/Walker	Yes	15 _____
Furniture	Yes	30 _____
4. IV therapy/Saline lock	No	0
	Yes	20 _____

	Score
5. Gait	
Normal/bedrest/wheelchair	0 _____
Weak	10 _____
Impaired	20 _____
6. Mental Status:	
Oriented to own ability	0 _____
Overestimates/forgets limitations	15 _____

Total Score _____

❑ > 51 Initiate Safety Risk Protocol Care Plan Identified at High Risk for Fall

❑ Request PT evaluation

RESPIRATORY

❑ WNL BREATH SOUNDS RATE
❑ Accessory Muscles ❑ Secretions ❑ Nasal Flaring
❑ Dyspnea ❑ Tracheostomy ❑ Orthopnea
❑ Abnormal Breath Sounds ❑ Tachypnea ❑ Cough
❑ Oxygen ❑ Type _____

CARDIO VASCULAR

❑ WNL REGULAR RHYTHM, RATE
❑ Abnormal Pulses Apical/Radial/Pedal ❑ Abnormal Heart Sounds ❑ Jugular Vein Distension ❑ Pedal Edema ❑ Pacemaker

GASTRO INTESTINAL

❑ WNL
❑ NAUSEA-VOMITING
❑ TUBES ❑ N/G ❑ GT ❑ J/T
❑ OTHER _____
❑ BLOODY STOOL
❑ LAST BOWEL MOVEMENT: _____
❑ OSTOMY/ELIMINATION AIDS

❑ INCONTINENT OF BOWEL
❑ OCCASIONAL ❑ FREQUENT
❑ BOWEL SOUNDS
❑ NORMAL ❑ HYPO ❑ HYPER ❑ ABSENT
❑ CONSTIPATION ❑ DIARRHEA
❑ ABDOMINAL DISTENSION
❑ ABDOMINAL TENDERNESS/PAIN LOCATION _____
❑ OTHER _____

GENITOURINARY / GYN

❑ Anuric
❑ Nocturia
❑ Burning
❑ Urgency
❑ Urinary Incontinence
❑ Urinary Frequency
❑ Stress Incontinence
❑ WNL
❑ Other: _____
❑ Catheter
Date Placed _____

GYN

❑ Not Applicable
❑ Vaginal Discharge
_____
❑ Unusual Bleeding
Pad Count _____
❑ Pregnant
❑ LMP _____

❑ If pregnant and over 20 weeks, complete OB Assessment.

Obtain prenatal record from L&D or Obstetrician

ACCESS

FIGURE 5-1, cont'd Example of a patient admission assessment form. This is the second page of a four-page form; the entire form is included on the Evolve website.

Think Critically

Can you think of two other pieces of information that might be obtained during an assessment that would be subjective data?

THE INTERVIEW

The interview is focused on gathering data and is not a social interaction. Good communication is vital to adequate assessment. Communication may be verbal—talking and listening—or nonverbal, which involves noting facial expressions, body posture, movement, and gestures.

Cultural Considerations

Be Attentive to Cultural Needs

If your patient is of a different culture, recall the specifics of cultural differences in communication, personal space, and expected courtesies. Obtain an interpreter if there is a language barrier to good communication.

The course of the interaction is directed to elicit specific information concerning the patient's health status or feelings about her health. The interview contains three basic stages: (1) the opening, when rapport is established with the patient; (2) the body of the interview, when the necessary questions are presented; and (3) the closing segment of the interview. After establishing rapport, discuss the purpose of the interview. While asking the necessary questions, examine the patient. Indicate the closing of the interview by stating, "Do you have any questions?" or, "I would be glad to answer any questions you have." Another way of closing the interview is to say something like, "Well, I guess that's all I need for now." Thank patients for their time, express some concern for their welfare, and tell them what will happen next. Summarize their problems and tell them when you will be back (see Chapter 8).

After the initial assessment, continue to gather data about the patient each time there is an encounter. **Assessment is an ongoing process.** If you are assigned to a patient in the days after the admission, a quick chart review can provide data needed to provide adequate care.

Elder Care Points

When interviewing an elderly person, allow more time because the person will probably have a more extensive history and may take a little longer to recall the needed information.

CHART REVIEW

A chart review is a data collection tool that assists in obtaining the information needed to intelligently interview the patient or to prepare adequately for the day's patient assignment. To perform a chart review, methodically look through the chart, checking the sections listed in Box 5-2. Of course, if the patient has just been admitted, you can seek information only from the face sheet and the physician's orders. If it is an electronic chart, you will need to go to the various sections of the chart on the computer.

To do a review in preparation for your clinical assignment, look first at the face sheet and then at the most current physician's orders, as well as those of the previous 2 days. Check the medication profile (medication administration record, or MAR) to find out what medications the patient is receiving and whether the MAR contains current orders. This will provide information

Box 5-2 Quick Chart Review

Look for the following information:

Face sheet: Age, sex, marital status/significant other, religion, occupation, residence, next of kin and address, allergies, insurance status

Physician's orders: Admitting diagnosis, date of admission; current orders regarding diet, activity, frequency of vital signs measurement, daily weight, treatments, medications, diagnostic tests ordered, IV fluids, therapies ordered

Nurse's notes: Status during the last 24 hours

Physician's progress notes: Findings from last 2 days; status of problems

Medication administration record (MAR): Medications received, frequency of PRN medications, allergies

Physician's patient history and physical: Current complaint, chronic problems, physical finding abnormalities, allergies, impressions

Surgery operative report: Procedure done, organs removed, type of incision, drains or equipment in place, blood loss, problems during surgery

Pathology report: Presence of malignancy or infection

Current diagnostic tests: Check for any abnormal findings: CBC, UA, blood chemistries, x-ray films, culture and sensitivity, other tests

Nursing admission history and assessment: Reason for hospitalization, average number of cigarettes smoked per day, average amount of alcohol consumed per day, last bowel movement, special diet requirements, use of aids or prostheses (e.g., hearing aid or eyeglasses), medications taken regularly, identification of significant other, previous hospitalizations or surgeries, baseline vital signs, physical abnormalities

Fall risk assessment: Risk factors to consider, safety measures to provide

Skin assessment: Risk factors to consider, areas needing inspection and care

Nursing care plan or problem list

Key: *CBC,* Complete blood count; *IV,* intravenous; *PRN,* as necessary; *UA,* urinalysis.

about concurrent chronic conditions that may not be initially evident. Read the physician's admitting history and physical assessment if they are included in the chart. Scan any surgical procedure reports and accompanying pathology reports, paying particular attention to the conclusions. Note the psychosocial data on the face sheet. Does the patient live with family or a significant other? This information gives some idea of available support systems. Next, check the nurse's notes from the previous 24 to 48 hours, and then scan the current diagnostic test results. Read the nursing care plan or care map. Finally, read the nurse's admission assessment for data concerning events leading up to this hospitalization, previous hospital and illness experiences, other chronic health problems, and a history of allergies.

To visualize the nursing process in action, consider the following scenario:

> Victoria Torres, age 76, room 728, bed A, suffered a stroke 3 days ago and has left-sided weakness (hemiparesis). She has difficulty with bladder control and urinary incontinence. She is left-handed, cannot firmly grasp objects, and therefore needs assistance with all personal care. She is receiving physical therapy to strengthen the muscles in her left arm and leg and is learning to walk with a walker, but she tires very easily.

This information alone can help you begin to plan care for the patient. Concept Map 5-1 shows the relationships between Mrs. Torres' identified health problems and Maslow's areas of basic need for which nursing assistance is indicated. However, you need to systematically gather data to obtain a full picture of the patient's problems and needs.

PHYSICAL EXAMINATION

The RN conducts a physical examination. However, parts of this examination may be delegated to the LPN/LVN. To conduct the examination, use techniques of inspection (looking), auscultation (listening), palpation (touching), and percussion (thumping).

CONCEPT MAP 5-1 Health problems and needs of patient Victoria Torres from data given.

(These techniques are discussed in Chapter 22.) The examination is carried out in a systematic manner and begins with measuring height, weight, and vital signs. Record a history of what drugs the patient is taking and any drug allergies. The list should include any over-the-counter medications the patient uses, including herbal preparations, and prescription drugs. Take a brief medical history. Ask about special assistive devices needed, such as a hearing aid, glasses, cane, prosthesis, or dentures. Then perform a review of systems. Usually the assessment and data collection form contains a section for a psychosocial history and often one regarding needed assistance for self-care. Gather a nutrition and skin assessment and note the findings. A risk screening for falls may be required, and a determination of educational or discharge planning needs is appropriate so planning can begin.

Listen to the patient's heart and lungs and perform a physical examination, paying particular attention to any system in which the patient is expressing a problem. If he has abdominal pain, auscultate and palpate the abdomen. If he complains of a joint hurting, examine the joint and check the range of motion of the extremity. If a urinalysis has been ordered, obtain a urine specimen before leaving the patient.

After the admission assessment, each patient should be visited and assessed during the first hour of each shift. Perform a head-to-toe examination, which should take approximately 10 minutes. Box 5-3 presents areas to cover for this assessment and data collection procedure. Later in the shift, explore particular problem areas for each patient in greater depth. Listen to the heart and lungs of patients with respiratory or heart problems; examine the abdomen of the patient with gastrointestinal tract problems or abdominal pain; and perform a neurologic examination on the patient with a neurologic disorder. At the time of the initial data collection and assessment, determine what supplies and equipment will be needed for the patient for the shift. Ongoing nursing data collection and examination focus on the body systems in which there is a problem or potential problem. Concept Map 5-2 shows how data should be gathered for every basic need and then analyzed to define Mrs. Torres' problems and attach the appropriate nursing diagnosis label. This map includes the next nursing process step, planning.

? Think Critically

From the information about Victoria Torres that has been given, which areas do you think would need in-depth assessment?

ASSESSMENT IN LONG-TERM CARE

An extensive initial assessment is performed when a patient enters a long-term care facility. Reassessment is done at fixed intervals and as the patient's condition changes. For Medicare patients, a reassessment by an

Box 5-3 Quick Head-to-Toe Assessment

INITIAL OBSERVATION
Breathing
How patient is feeling
Appearance
Affect
Skin color

HEAD
Level of consciousness
Ability to communicate
Mentation status
Appearance of eyes

VITAL SIGNS
Temperature
Pulse: rate, rhythm
Respirations: rate, pattern and depth; oxygen saturation
Blood pressure: compare with previous readings

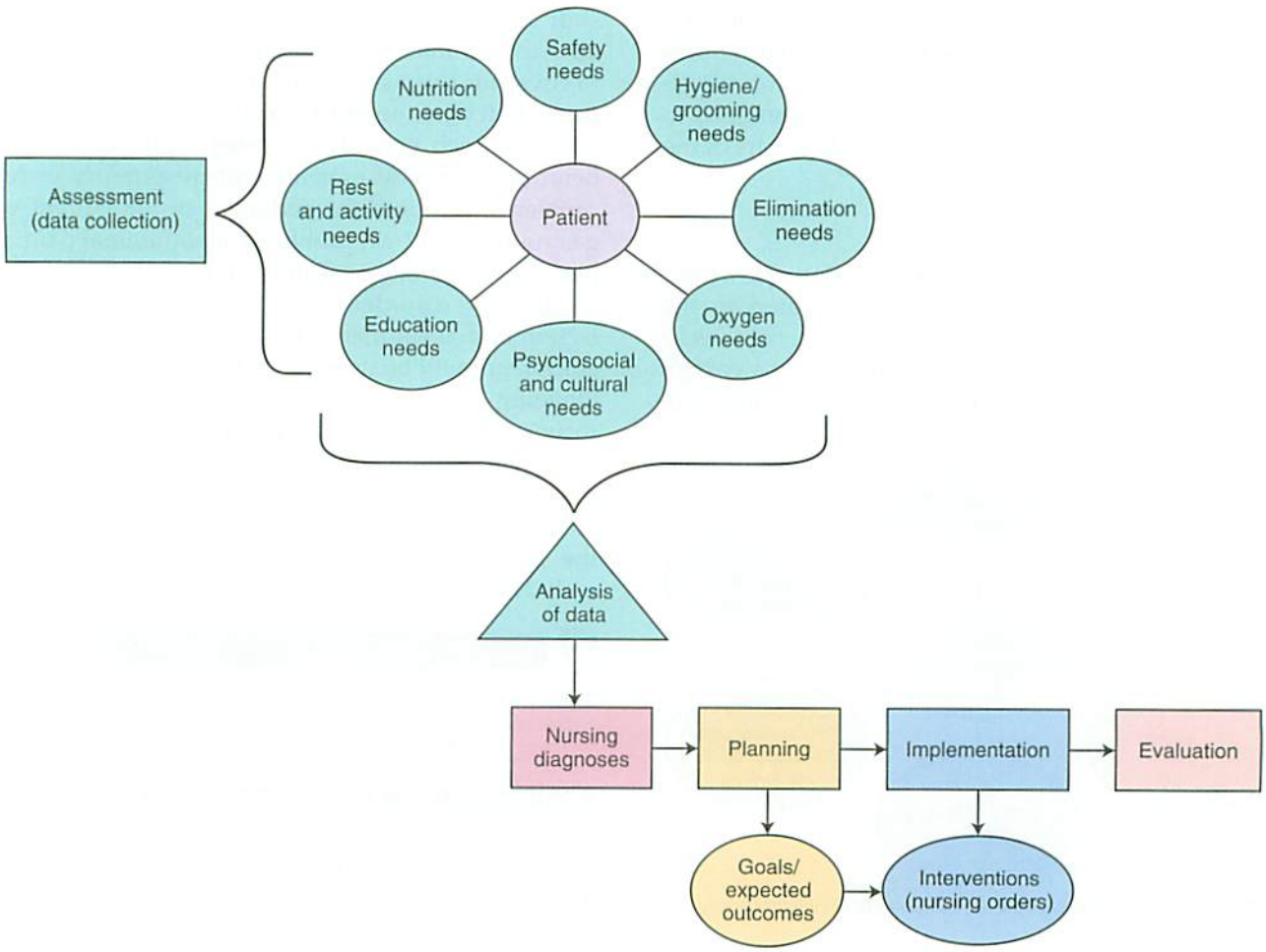
HEART AND LUNG ASSESSMENT, NEUROLOGIC CHECK
Auscultation of heart and lungs done to determine a baseline
Neurologic check done now if ordered or indicated

ABDOMEN
Shape
Soft or hard
Bowel sounds
Appetite
Last bowel movement
Voiding status

EXTREMITIES
Normal movement
Skin turgor and temperature
Peripheral pulses
Edema

TUBES AND EQUIPMENT PRESENT
Oxygen cannula: liter flow rate; chest tube functioning correctly
Nasogastric tube: suction setting, amount and character of drainage; percutaneous endoscopic gastrostomy (PEG) tube; jejunostomy tube
Urinary catheter: character and quantity of drainage
Intravenous catheters: type; condition of site(s), fluid in progress, rate
PEG: intact, skin condition
Dressings: location, character and amount of drainage, wound suction device, drains
Pulse oximeter: intact probe; readings
Traction: correct weight, body alignment, weights hanging free
Sequential compression device: correct application, turned on
Continuous passive motion: machine set and applied correctly, turned on
Cardiac monitor: leads placed correctly, alarm parameters set

PAIN STATUS
Use a pain scale (e.g., 1 to 10)



CONCEPT MAP 5-2 Basic needs and the nursing process.

RN is necessary every 90 days, and the care plan is reviewed and revised at that time. In addition to the physical assessment, health history, and medication history, a functional assessment is performed. The functional assessment supplies a picture of the activities of daily living (ADLs) with which the patient will need assistance. An assessment of personal preferences regarding routines for bathing, sleeping, daytime activities, food likes and dislikes, hobbies, and so forth is also completed. A fall risk assessment (see Figure 20-3) and a comprehensive skin assessment (see Figure 19-2) are part of the admission procedure. A mental status assessment completes the admission process. **Usually the LPN/LVN collects data for the RN, who finalizes the assessment.**

ASSESSMENT IN HOME HEALTH CARE

The initial patient assessment in the home is performed by the RN. The family is assessed regarding attitude and ability to help with care of the patient, their ability to provide emotional support for the patient, their ability to cope with the situation, and teaching that will need to be provided for them. The nurse must work within the patient and family's territory, and that requires a shift in attitude and perspective as compared with working in a health care facility. The LPN/LVN, when doing private duty in a home, performs daily assessments and maintains the necessary documentation. Changes found on assessment are reported to the RN supervisor.

ANALYSIS

Once the information has been gathered, the database is analyzed for cues that indicate deviations from the norm. **Cues are pieces of data or information that influence decisions.** Problems are identified so that nursing diagnoses can be written by the RN as required by ANA Standard II: **Diagnosis** (see Box E1-2 on the Evolve website for the ANA Standards). The LPN/LVN may assist in this process.

The database is analyzed, pieces of data are sorted, related data are grouped (clustered), and missing data are identified. An example of a cluster of data would be a need to void frequently, occasional incontinence of urine, and some burning on urination. These data are all related to a urinary system problem. Diagnosis depends on the nurse's knowledge base and previous experience. The student uses texts to read about the underlying condition, signs and symptoms, and causes. The database is reviewed for signs and symptoms of abnormalities. Once cues are identified, they are grouped, and inferences can be made regarding the patient's problems. While clustering the data, interpret the possible meaning of the cues.

From Mrs. Torres' situation, cues that suggest a problem exists include the following: she cannot firmly grasp objects with her left hand, she will need to use a walker to support herself when ambulating, and she is incontinent of urine. Factors contributing to the problem are also important. In Mrs. Torres' case, the fact that she has suffered a stroke (cerebrovascular accident) and has some neurologic impairment is pertinent. Nursing diagnosis statements are used to state the specific problems.

Inferences (conclusions made based on observed data) made from the data include that Mrs. Torres' mobility is decreased, she cannot perform self-care unassisted, she has left-sided weakness and is at risk of injury from a fall, and she is incontinent of urine. She will need encouragement and reinforcement for her physical therapy program. Concept Map 5-2 shows how the assessment data collected by all techniques are analyzed. The map indicates the next steps to be completed in the nursing process: nursing diagnosis, planning with goals and expected outcomes, implementation with the selection of interventions to help the patient meet the expected outcomes, and evaluation to see if the outcomes have been met.

NURSING DIAGNOSIS

The second step of the nursing process results in the development of a diagnostic statement or **a nursing diagnosis. A nursing diagnosis statement indicates the patient's actual health status or the risk of a problem developing, the causative or related factors, and specific defining characteristics (signs and symptoms).** The medical diagnosis (e.g., stroke, or cerebrovascular accident) is never included in the construction of the nursing diagnosis. Although RNs formulate nursing diagnoses, LPN/LVNs are expected to be able to complete a care plan after the nursing diagnoses have been designated. Nursing diagnoses fall into four categories (see the Evolve website).

The diagnostic labels are formulated by the North American Nursing Diagnosis Association–International (NANDA-I) and are revised every 2 years. Research is ongoing to validate the current diagnostic labels and to support new nursing diagnoses, which are then added to the official NANDA-I list (NANDA International, 2010). Language changes to simplify the diagnoses are considered every 2 years. Diagnoses may be actual or related to a risk, syndrome, or to promote wellness.

Once the nursing diagnoses are identified, the planning phase occurs. The NANDA-I list of diagnostic labels is used to form the first part (stem) of the nursing diagnoses used in nursing care plans. The nursing diagnosis describes a health problem amenable to nursing intervention. The current list of approved NANDA-I nursing diagnoses is inside the back cover of this book. The stem label (the problem) is combined with the cause or causative factors. An example of a nursing diagnosis for Mrs. Torres might be "Reflex

urinary incontinence related to neurologic impairment, as evidenced by the inability to retain urine." "Reflex urinary incontinence" is the stem. Another nursing diagnosis appropriate for Victoria Torres is "Impaired physical mobility related to decreased motor function and left-sided muscular weakness, as evidenced by the inability to bear weight on the left leg." Because of her left-sided weakness, Mrs. Torres is at high risk for falling. This potential problem should be included on the care plan. The appropriate nursing diagnosis is "Risk for injury related to neurologic impairment" and "Muscular weakness as evidenced by inability to support body weight." Handbooks are available that present each of the approved nursing diagnosis labels, their possible etiologic factors, defining characteristics, and possible nursing interventions.

? Think Critically

Do the above nursing diagnoses with the problem related to a basic need apply to Concept Map 5-1?

ETIOLOGIC FACTORS

Etiologic factors are the causes of the problem. In Mrs. Torres' case, the etiologic factor for her decreased mobility is neurologic impairment

DEFINING CHARACTERISTICS

Defining characteristics are those characteristics (signs and symptoms) that must be present for a particular nursing diagnosis to be appropriate for that patient. These supply the evidence that the nursing diagnosis is valid. **Signs** are abnormalities that can be verified by repeat examination and are objective data. A bruise on the arm would be a sign. **Symptoms** are factors the patient has said are occurring that cannot be verified by examination; symptoms are subjective data. A headache would be a symptom. You cannot see or verify that the patient actually has a headache; you must trust what the patient tells you.

Nursing diagnoses differ from medical diagnoses in that the nursing diagnosis **defines the patient's response to illness,** whereas the medical diagnosis **labels the illness.** Table 5-2 shows how a nursing diagnosis is constructed.

PRIORITIZATION OF PROBLEMS

Priorities of care are set so that the most important interventions for the high-priority problems for each patient are attended to first. Then, as time permits, the lower-priority problems are considered.

Once the nursing diagnoses have been formulated, they are ranked according to their importance. This order can be guided by the hierarchy of needs adapted from Maslow (see Figure 2-3), by the patient's beliefs regarding the importance of each problem, and by what is most life threatening or problematic for the patient. **Physiologic needs for basic survival take precedence.** One of the first rules concerning priorities of care is that the **airway always comes first.** Without an adequate airway, the patient will die very quickly. Circulation usually is the next priority: Failure of the heart and loss of too much blood will also quickly cause death. Thereafter the nurse consults with and involves the patient in determining the priority of needs. A patient in considerable pain will usually give pain relief a higher priority than the need for food, at least on a short-term basis.

Table 5-2 Construction of a Nursing Diagnosis

Nursing diagnosis	= Problem +	Etiology (cause)	+ Signs and symptoms
Problem		Nursing diagnosis label (stem)	
Etiology		Related to (etiologic or causative factors)	
Signs and symptoms		As evidenced by (defining characteristics)	

After physiologic needs are met, safety problems take priority. For a patient at risk for injury related to increased intracranial pressure as evidenced by decreased level of consciousness, safety is the priority need. Increasing intracranial pressure can be lethal. Nursing judgment is crucial in setting priorities. Nurses draw on their knowledge of the disease or disorder in question, the database, and their experience with similar patients. Critical thinking is used to make astute judgments regarding priorities.

After physiologic and safety needs have been met, the psychosocial needs of love and belonging, self-esteem, and self-actualization are given attention. **Every nurse must attempt to look at each patient holistically, keeping psychosocial needs in mind while working on physical problems.** Calling patients by their correct names, giving them opportunities to make some decisions about their care, protecting their privacy, and showing respect help meet psychosocial needs.

NURSING DIAGNOSIS IN LONG-TERM CARE

In a long-term care facility, the care planning process begins when a patient is admitted, often by the LPN/LVN. The supervising RN reviews the care plan, modifies it as needed, and finalizes it for the chart. The same process is used to analyze data, identify problems and safety concerns, and choose nursing diagnoses appropriate for the new resident. Box 5-4 shows some of the more common nursing diagnoses found for residents in long-term care facilities. Once the nursing diagnoses are chosen, the plan is individualized for the resident.

Box 5-4 Selected Nursing Diagnoses Commonly Found for Long-Term Care Residents

- Impaired swallowing r/t weakness or paralysis of the swallowing muscles
- Risk for aspiration r/t impaired swallowing, depressed gag reflex, or decreased level of consciousness
- Impaired verbal communication r/t changes in the cerebral hemispheres
- Self-care deficit r/t impaired mobility, disturbed thought processes, or sensory impairment
- Disturbed thought processes r/t damage to cerebral tissue
- Impaired urinary elimination: incontinence r/t decreased ability to control elimination
- Risk for injury r/t falls, weakness, or altered thought processes
- Self-esteem, situational low r/t change in appearance, loss of self-control, role changes, or dependence on others to meet basic needs
- Imbalanced nutrition: less than body requirements r/t decreased oral intake
- Risk for imbalanced fluid volume r/t inadequate fluid intake or excessive fluid loss
- Chronic pain r/t chronic disease process
- Impaired skin integrity r/t damage to skin associated with friction, pressure, or shearing
- Impaired physical mobility r/t loss of muscle mass, tone, or strength, or paralysis
- Risk for constipation r/t medication side effects, decreased GI motility, loss of nervous control over defecation reflex, or decreased activity
- Impaired social interaction r/t depressed mood, withdrawal, or impaired communication
- Disturbed thought processes r/t inaccurate interpretation of environment
- Ineffective coping r/t inability to function at previous level, poor problem solving, or poor cognitive function
- Wandering r/t decreased cognition, anxiety, and agitation

Key: *GI*, Gastrointestinal; *r/t*, related to.

NURSING DIAGNOSIS IN HOME HEALTH CARE

In addition to the patient's problems, nursing diagnosis in this setting must include any problems identified in the family's ability to cope with the illness or situation and any teaching needs for care of the patient. The care plan encompasses the whole family rather than just the patient.

PLANNING

The third step of the nursing process is planning, and it correlates with the fourth NFLPN Standard, part 3, "the identification of health goals" (see Appendix C).

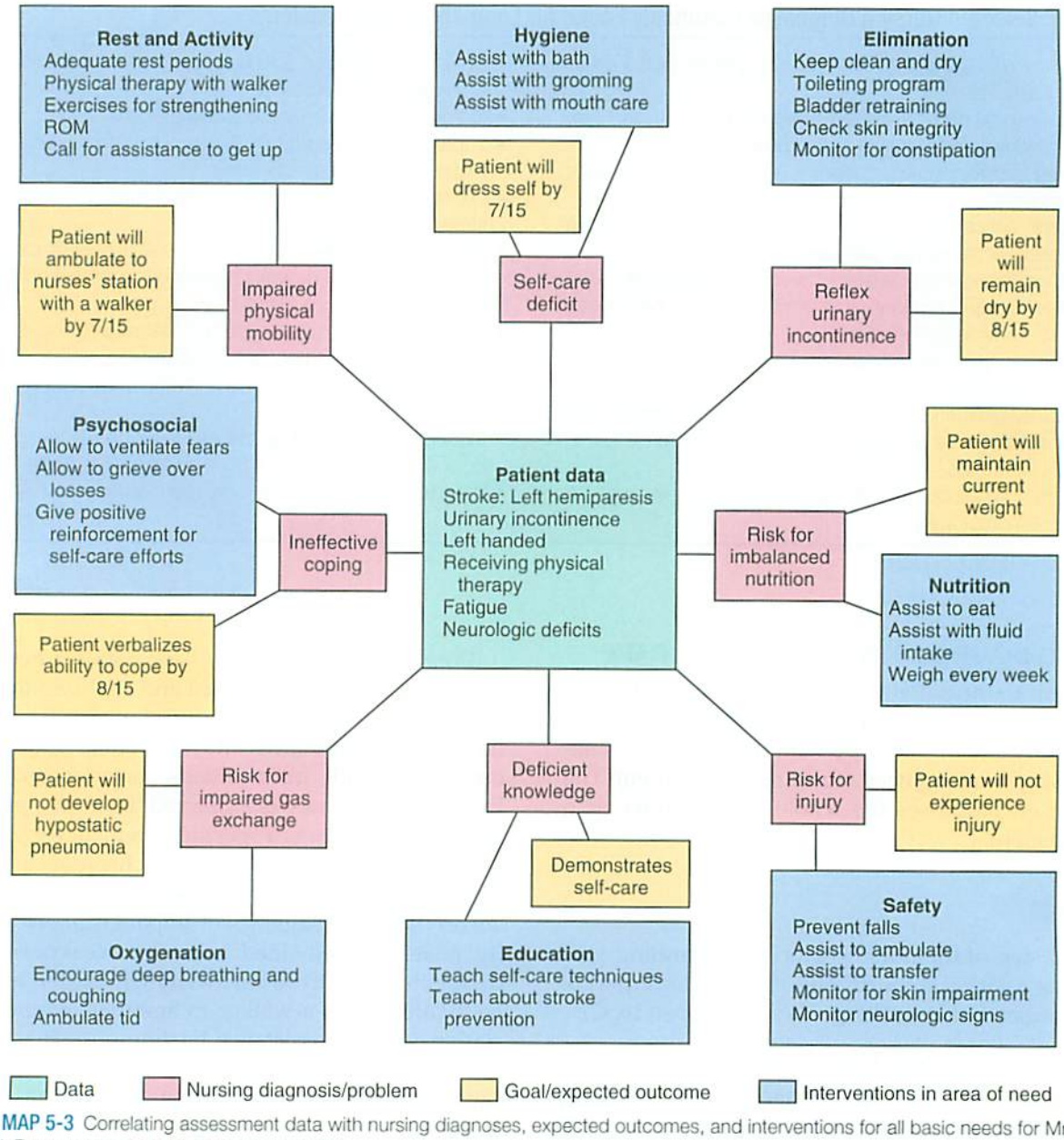
EXPECTED OUTCOMES (GOALS)

A **goal** is a broad idea of what is to be achieved through nursing intervention. **Short-term goals** are those that are achievable within 7 to 10 days or before discharge, whereas long-term goals take many weeks or months to achieve. **Long-term goals** often relate to rehabilitation. When goals are written as expected outcomes, it is easier to evaluate whether interventions have helped the patient meet them. Questions that the nurse considers in this part of the planning process are as follows:

- What are the goals for this patient? How can they be expressed as expected outcomes so that the success of nursing care can be easily evaluated?
- Should the goals for this patient be both short term and long term?
- What are the priorities of care?

A short-term goal regarding Mrs. Torres' incontinence might be that she stays dry for 2 hours at a time between toiletings. A long-term goal for this problem would be that she achieves total urinary continence.

Concept Map 5-3 shows how data for every basic need area have been collected and analyzed to identify problems and nursing diagnoses for Mrs. Torres. Goals have been formulated and converted into expected outcomes, and interventions have been chosen. Expected outcomes are derived from the goals. An **expected outcome** is a specific statement regarding the goal the patient is expected to achieve as a result of nursing intervention. An expected outcome for Mrs. Torres' nursing diagnosis of Impaired physical mobility related to left-sided muscular weakness, as evidenced by inability to bear weight on the left leg, might be "Patient uses a walker to ambulate to the nurses' station without assistance by July 10." The expected outcome should also contain measurable criteria that can be evaluated to see whether the outcome has been achieved. For example, for Mrs. Torres' nursing diagnosis of Reflex urinary incontinence related to neurologic impairment as evidenced by inability to retain urine, an appropriate expected outcome might be "Patient voids in bedpan every 2 hours while awake without intervening episodes of incontinence by July 10." If the nurse assists Mrs. Torres with the bedpan every 2 hours and she voids each time, the expected outcome would be met. If Mrs. Torres is wet between voidings, the goal of remaining dry during waking hours would not have been met. **An expected outcome should be realistic and attainable and should have a defined time line.** Collaboration with the patient regarding the expected outcomes is important. The patient and other health professionals involved in the patient's care must agree on the importance of the expected outcome. Some health facilities use the term *discharge criteria* in place of *expected outcome*. *Desired outcome* is another term often used for expected outcome.



CONCEPT MAP 5-3 Correlating assessment data with nursing diagnoses, expected outcomes, and interventions for all basic needs for Mrs. Torres. Key: *ROM*, Range of motion; *tid*, three times a day.

It is acceptable to use standard abbreviations in the nursing diagnosis—for example, "Pain r/t injury to right ankle AEB discomfort and swelling" instead of "Pain *related to* injury to the right ankle *as evidenced by* discomfort and swelling." Sometimes nursing diagnoses are shortened on the hospital care plan by leaving off the defining characteristics (the "as evidenced by" part). Some nursing diagnoses only have one part. Examples include "Rape-trauma syndrome" and "Readiness for enhanced organized infant behavior."

The Nursing Outcomes Classification (NOC) provides language labels for desired outcomes. The purposes are to (1) identify, label, validate, and classify patient outcomes and indicators; (2) field test the classifications for validation; and (3) define and test the measurement procedures to determine whether the outcomes are met by the interventions that have been implemented (Moorhead et al., 2008). This project is run by the Center for Nursing Classification and Clinical Effectiveness at the University of Iowa, in conjunction with the ongoing work of NANDA-I.

Think Critically

Can you give an example of a short-term and a long-term goal for the patient who has a nursing diagnosis of Pain r/t skin interruption as evidenced by surgical incision?

PLANNING IN LONG-TERM FACILITIES

The planning process in long-term care facilities is the same as for any other facility. Expected outcomes are written for each nursing diagnosis. Maslow's hierarchy

is used to determine priorities of care. Emotional and psychosocial needs must be addressed. Safety of the resident is a high priority. Family members are usually invited to the care planning session so that they have input into the care of their loved one. They are also invited to periodic reviews of the care plan.

PLANNING IN HOME HEALTH CARE

Nurses collaborate with family members concerned with care of the patient when choosing the expected outcomes. This helps the family feel involved and gives a feeling of some control over what will be occurring in their home and for their loved one. Needs of the family are considered throughout the care planning process.

INTERVENTIONS (NURSING ORDERS)

The nurse selects appropriate nursing interventions to alleviate the problems and assist the patient in achieving the expected outcomes. Consider all possible interventions for relief of the problems, then select those most likely to be effective. Write them on the nursing care plan as nursing orders. Interventions for long-term care residents and home health care patients are modified according to the environment in which the patient is living. Specific interventions may be included for the family members in home health care. Questions to consider when choosing nursing interventions include:

- What nursing actions are necessary to monitor the status of a high-risk problem?
- Which nursing interventions can best help the patient reach the expected outcomes?
- What nursing interventions could possibly prevent a potential problem from becoming an actual problem?
- Which interventions require a physician's order (dependent actions)?
- Which interventions fall within the nurse's license to practice?
- What is the scientific rationale for using each intervention?

For Mrs. Torres' nursing diagnosis of Impaired physical mobility related to neurologic impairment and muscular weakness, interventions would include the following:

- Assist with range-of-motion exercises for her left arm and hand during the daily bath, in the afternoon, and in the evening.
- Instruct her to call for assistance before getting out of bed.
- Reinforce the teaching of exercises that will strengthen her muscles while lying in bed.

Interventions listed should include giving medications and performing ordered treatments. Concept Map 5-3 lists interventions that will be implemented for Mrs. Torres.

The Iowa Intervention Project is linking nursing interventions to nursing diagnoses. The project has developed a Nursing Interventions Classification (NIC) taxonomy. The nurse must still individualize the interventions to the patient's needs. The nurse uses critical thinking to link the correct interventions to the nursing diagnosis for a specific patient. There are seven domains in the NIC taxonomy: Physiological: Basic; Physiological: Complex; Behavioral; Safety; Family; Health System; and Community (Moorhead et al., 2008).

Concept Map 5-3 shows the nursing diagnoses, goals, and interventions appropriate for Mrs. Torres. The nursing care plan in Figure 5-2 shows further development of the concepts for four nursing diagnoses to meet Mrs. Torres' individual needs based on the assessment data.

Think Critically

Can you support each nursing diagnosis in Concept Map 5-3 with the corresponding assessment data?

DOCUMENTATION OF THE PLAN

The nursing care plan is supposed to be initiated by an RN. In reality, LPN/LVNs often construct a plan for the approval of the RN. The planning process is not finished until the nursing care plan is in the patient's chart or electronic record. If the LPN/LVN has constructed the care plan, the RN reviews it before it is placed into the record. Many health care facilities now use computerized programs to assist in constructing the nursing care plan. The nurse chooses the appropriate nursing diagnoses and then is presented with computer screens from which to choose the expected outcomes and the nursing interventions. The nurse can change or modify outcomes and interventions to individualize the plan. Some facilities use a standardized care plan, and the nurse adds and deletes items to individualize the plan. Once the entire plan is constructed, it is reviewed and placed in the chart or electronic record.

The nursing care plan should be constructed right after the admission database is collected. It must be readily available to each nurse who is assigned to the patient. **Once every 24 hours, the care plan is reviewed and updated.** Necessary changes can be made to it at any time. The new plan must be placed in the patient's record. Implementation and evaluation of the care plan are discussed in Chapter 6. Many hospitals are using a collaborative "care map" or "clinical pathway" type of plan that incorporates all interventions by the various members of the health care team (see Chapter 6). In such cases the nursing care plan is incorporated into the total collaborative plan.

Interventions for the long-term care resident are chosen in the same manner and individualized. There are generally more long-term goals and expected outcomes than short-term ones on the care plan, since the resident will most likely be in the facility for an extended time.

Nursing Care Plan Sample Nursing Care Plan

SCENARIO Victoria Torres suffered a stroke (CVA) and has left-sided paresis (muscle weakness). She is unable to bear weight on her left leg and cannot grasp items with her left hand. She is incontinent of urine. The following is the nursing care plan written for her. Date of initiation: 6/16.

PROBLEM/NURSING DIAGNOSIS Impaired physical mobility related to decreased motor function and muscular weakness, as evidenced by inability to bear weight on left leg.

Goals/Expected Outcomes	Nursing Interventions	Selected Rationale	Evaluation
Patient will ambulate to the nurse's station using walker, unassisted, by 7/1.	Encourage active ROM to right leg and arm q 4 hr while awake.	Active ROM works muscles and prevents atrophy as well as helping them maintain strength.	*Is patient ambulating unassisted?* Yes, but only for a short distance.
	Assist patient in walking with walker in room tid.	Using the walker promotes confidence and helps build stamina for walking.	Continue plan.
	Encourage patient to walk with walker in hall at least once daily; assist as needed.	Positive reinforcement encourages the desired behavior.	
	Reinforce instructions from physical therapist for exercises and walker use.	Reinforcing instructions helps patient remember them and to perform exercises and use walker correctly.	

PROBLEM/NURSING DIAGNOSIS Reflex incontinence related to neurologic impairment, as evidenced by inability to retain urine.

Goals/Expected Outcomes	Nursing Interventions	Selected Rationale	Evaluation
Voids in bedpan q 2 hr while awake without intervening episodes of urinary incontinence by 6/30.	Collaborate on voiding schedule times. Keep schedule at bedside.	Patient knows her usual pattern for voiding.	*Have there been episodes of incontinence?* No.
	Assist patient to use bedpan.	Conserves energy and prevents spilling.	Expected outcome met 6/18.
	Praise patient for each 2-hr period of continence.	Positive reinforcement encourages the desired behavior.	
	Discuss patient's feelings about bladder problem and progress with retraining.	Allows patient to ventilate feelings; reduces anxiety.	

FIGURE 5-2 Example of a hospital-style nursing care plan. Key: *ROM*, Range of motion; *tid*, three times a day.

Nursing Care Plan Sample Nursing Care Plan—cont'd

PROBLEM/NURSING DIAGNOSIS Risk for injury related to neurologic impairment and muscular weakness, as evidenced by inability to bear weight on left leg.

Goals/Expected Outcomes	Nursing Interventions	Selected Rationale	Evaluation
Will not suffer injury from fall at any time. Will compensate for neurologic impairment with use of aids for ambulation by 7/1.	Keep walker positioned by bed for ease of use. Encourage to use walker whenever out of bed.	Object close at hand encourages use. Encouragement prompts desired action.	*Has patient suffered any injury?* No. *Is patient using a walker?* Yes.
	Ask to use call bell for assistance whenever she needs to get up.	Assistance helps prevent falls.	Continue plan.
	Assess muscular strength, balance, and ability to walk safely with walker daily.	Patient must have sufficient muscle strength to safely use walker.	

PROBLEM/NURSING DIAGNOSIS Self-care deficit, hygiene and grooming, related to muscular impairment, as evidenced by inability to grasp items with dominant left hand and inability to walk without assistance.

Goals/Expected Outcomes	Nursing Interventions	Selected Rationale	Evaluation
Will assist with bath by bathing left extremities by 6/26.	Assist with hygiene and grooming activities; encourage patient to participate.	Encouragement prompts desired action.	*Is patient performing some part of ADLs using the right extremities?* Not yet.
Will attempt to brush hair with right hand by 6/26.	Collaborate with patient regarding daily goals; praise all accomplishments and attempts at self-care.	Goals are more likely to be achieved if the patient helps set the goals.	*Is patient attempting to wash left arm?* Not yet.
Will brush teeth with right hand by 6/30.	Assist patient in attempts at brushing teeth and combing hair using right hand.	Undue fatigue prevents successful achievement of the activity.	Continue plan.
Will learn to put clothes on right extremities before discharge.	Reinforce occupational therapist's instructions for dressing self; supervise practice and give encouragement.	Positive reinforcement encourages the desired behavior.	
	Prevent patient from becoming overtired when attempting own hygiene activities; space activities.		

FIGURE 5-2, cont'd Example of a hospital-style nursing care plan. Key: *ROM*, Range of motion; *tid*, three times a day.

Get Ready for the NCLEX® Examination!

Key Points

- Assessment, the first step of the nursing process, begins at admission with the admission interview, history, and physical assessment.
- Subjective data are pieces of information that are apparent only to the patient and can be described or verified only by the patient.
- Objective data are facts that are obtained through using the senses and hands-on physical assessment.
- A database is compiled through the interview, physical assessment, conversation with family and significant others, communication with other health professionals, and a chart review that includes surveying results of diagnostic tests. The database is all the information obtained.
- Assessment is a continual, ongoing process.
- A chart review is useful for gathering information for the nursing database and for obtaining information for a student assignment.

- A nursing history and assessment are performed at admission.
- The nurse should perform a quick head-to-toe assessment of each assigned patient at the beginning of each shift (see Box 5-3).
- A functional assessment is performed on patients being admitted to a long-term care facility.
- Emotional and psychosocial concerns are always considered when formulating a care plan for the long-term care resident.
- Analysis is used to sort and group assessment data so that nursing diagnoses can be chosen and priorities can be set.
- A nursing diagnosis statement indicates the patient's actual health status or a potential problem, the causative or related factors, and specific defining characteristics (signs and symptoms).
- Nursing diagnoses should be chosen from the NANDA-I approved list (see inside back cover).
- Expected outcomes are written based on the nursing diagnoses and problems.
- An expected outcome should be realistic, attainable, and measurable; have a defined time line; and be easily evaluated.
- Planning is the third step of the nursing process and involves choosing appropriate nursing interventions and documenting the plan.
- Nursing orders are the interventions chosen that will best assist the patient in achieving the expected outcomes.
- A concept map can be constructed showing the areas of need, nursing diagnoses, goals, and nursing interventions. A complete nursing care plan can be constructed from the assessment data and the concept map.
- A nursing care plan should be documented in the medical record soon after the admission assessment.

Additional Learning Resources

SG Go to your Study Guide for additional learning activities to help you master this chapter content.

evolve Go to your Evolve website (http://evolve.elsevier.com/deWit/fundamental) for the following FREE learning resources:

- Animations
- Answer Guidelines for Think Critically boxes and Critical Thinking Questions and Activities
- Answers and Rationales for Review Questions for the NCLEX® Examination
- Glossary with pronunciations in English and Spanish
- Interactive Review Questions for the NCLEX® Examination and more!

Online Resources

- *Concept Mapping,* www.snjourney.com/ClinicalInfo/CarePlans/CarePlanN.htm
- *Nursing Concept Map,* www.ehow.com/how_5526833_make-nursing-concept-map.html
- *Clinical Concept Care Map Format,* www.nah.southtexascollege.edu/ADN/assets/docs/Shartle/Clinical%20Concept%20Map%20sample%20format%20RNSG%201162%20revised.pdf
- *Medical vs. Nursing Diagnosis,* www.wisc-online.com/Objects/ViewObject.aspx?ID=nur2803

Review Questions for the NCLEX® Examination

*Choose the **best** answer for each question.*

1. A nursing diagnosis differs from a medical diagnosis. A nursing diagnosis:
   1. labels the illness.
   2. clarifies the symptoms.
   3. indicates the patient's health status.
   4. indicates the importance of the problem.

2. Which is the etiologic factor in the nursing diagnosis Impaired physical mobility r/t left-sided muscular weakness, as evidenced by the inability to use the left arm for activities of daily living?
   1. Impaired physical mobility
   2. Left-sided muscular weakness
   3. As evidenced by
   4. Inability to use the left arm

3. An example of an approved, correctly written NANDA-I nursing diagnosis for the patient is:
   1. Pain r/t abdominal surgery as evidenced by surgical report.
   2. Risk for injury r/t neurologic impairment as evidenced by paralysis of right leg.
   3. Risk for deficient fluid volume r/t nausea and vomiting.
   4. Constipation r/t complaint of no BM yesterday.

4. The patient's temperature is 100.4° F (38° C). The skin on her forehead is warm and dry. She has been incontinent, and her bed is wet. She complains of being very tired. Which of the data are subjective? *(Select all that apply.)*
   1. Temperature is 100.4° F (38° C).
   2. States, "I'm very uncomfortable."
   3. Bed is wet.
   4. Complains of being very tired.
   5. Skin is warm and dry.
   6. States, "I have a headache."

5. Which nursing intervention for the patient in question 4 would you rank as the *highest* priority?
   1. Allow patient to rest.
   2. Change the bed linens and gown.
   3. Medicate for headache pain.
   4. Apply lotion to skin.

6. The role of the LPN/LVN in the patient admission procedure differs from that of the RN and might include: *(Select all that apply.)*
   1. writes nursing diagnoses for the patient's care plan.
   2. obtains an ordered urine specimen.
   3. takes the patient's history.
   4. assists with physical data collection.
   5. orients the patient to the unit.
   6. performs a thorough admission assessment.