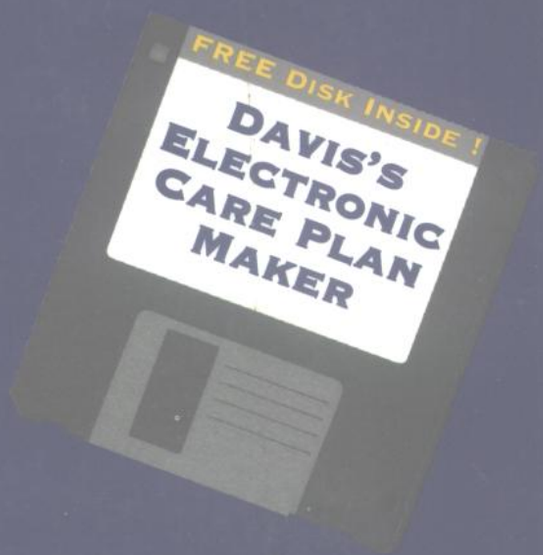
NURSING CARE PLANS

GUIDELINES FOR INDIVIDUALIZING PATIENT CARE



EDITION 4

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Edition 4

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CLASSIFICATION OF NANDA NURSING DIAGNOSES BY GORDON'S FUNCTIONAL HEALTH PATTERNS*

HEALTH PERCEPTION—HEALTH MANAGEMENT PATTERN
- Altered health maintenance
- Effective management of individual therapeutic regimen
- Ineffective management of individual therapeutic regimen
- Ineffective management of therapeutic regimen: community
- Ineffective management of family therapeutic regimen
- Total health management deficit
- Health management deficit (specify)
- Noncompliance (specify)
- High risk for noncompliance (specify)
- Health-seeking behaviors (specify)
- Risk for infection
- Risk for injury (trauma)
- Risk for poisoning
- Risk for suffocation
- Altered protection

NUTRITIONAL-METABOLIC PATTERN
- Adaptive capacity, intracranial: decreased
- Altered nutrition: potential for more than body requirements or high risk for obesity
- Altered nutrition: more than body requirements or exogenous obesity
- Altered nutrition: less than body requirements or nutritional deficit (specify)
- Ineffective breastfeeding
- Effective breastfeeding
- Interrupted breastfeeding
- Ineffective infant feeding pattern
- Risk for aspiration
- Impaired swallowing or uncompensated swallowing impairment
- Altered oral mucous membrane
- Risk for fluid volume deficit
- Fluid volume deficit
- Fluid volume excess
- Risk for impaired skin integrity or high risk for skin breakdown
- Impaired skin integrity
- Pressure ulcer (specify stage)
- Impaired tissue integrity
- Risk for altered body temperature
- Ineffective thermoregulation
- Hyperthermia
- Hypothermia

ELIMINATION PATTERN
- Constipation or intermittent constipation pattern
- Colonic constipation
- Perceived constipation
- Diarrhea
- Bowel incontinence
- Altered urinary elimination pattern
- Functional incontinence
- Reflex incontinence
- Stress incontinence
- Urge incontinence
- Total incontinence
- Urinary retention

ACTIVITY-EXERCISE PATTERN
- Risk for activity intolerance
- Activity intolerance (specify level)
- Fatigue
- Impaired physical mobility (specify level)
- Risk for disuse syndrome
- Risk for joint contractures
- Total self-care deficit (specify level)
- Self–bathing-hygiene deficit (specify level)
- Self–dressing-grooming deficit (specify level)
- Self–feeding deficit (specify level)
- Self–toileting deficit (specify level)
- Altered growth and development: self-care skills (specify)
- Diversional activity deficit
- Impaired home maintenance management (mild, moderate, severe, potential, chronic)
- Infant behavior, disorganized
- Risk for disorganized infant behavior
- Potential for enhanced organized infant behavior
- Dysfunctional ventilatory weaning response (DVWR)
- Inability to sustain spontaneous ventilation
- Ineffective airway clearance
- Ineffective breathing pattern
- Impaired gas exchange
- Decreased cardiac output
- Altered tissue perfusion (specify)
- Dysreflexia
- Risk for peripheral neurovascular dysfunction
- Altered growth and development

SLEEP-REST PATTERN
- Sleep-pattern disturbance

COGNITIVE-PERCEPTUAL PATTERN
- Pain
- Chronic pain
- Acute confusion
- Chronic confusion
- Pain self-management deficit (acute, chronic)
- Uncompensated sensory deficity (specify)
- Sensory-perceptual alterations: input deficit or sensory deprivation
- Sensory-perceptual alterations: input excess or sensory overload
- Unilateral neglect
- Impaired environmental interpretation syndrome
- Impaired thought processes
- Knowledge deficit (specify)
- Uncompensated short-term memory deficit
- Risk for cognitive impairment
- Decisional conflict (specify)

SELF-PERCEPTION–SELF-CONCEPT PATTERN
- Fear (specify focus)
- Anxiety
- Mild anxiety
- Moderate anxiety
- Severe anxiety (panic)
- Anticipatory anxiety (mild, moderate, severe)
- Fatigue
- Reactive depression (situational)
- Hopelessness
- Powerlessness (severe, low, moderate)
- Self-esteem disturbance
- Chronic low self-esteem
- Situational low self-esteem
- Body image disturbance
- Risk for self-mutilation
- Personal identity confusion

ROLE-RELATIONSHIP PATTERN
- Anticipatory grieving
- Dysfunctional grieving
- Disturbance in role performance
- Unresolved independence-dependence conflict
- Social isolation or social rejection
- Social isolation
- Impaired social interaction
- Altered growth and development: social skills (specify)
- Relocation stress syndrome
- Altered family processes
- Altered family process: alcoholism
- Altered parenting
- Risk for altered parent-infant-child attachment
- Risk for altered parenting
- Parental role conflict
- Parent-infant separation
- Weak mother-infant or parent-infant attachment
- Caregiver role strain
- Risk for caregiver role strain
- Impaired verbal communication
- Altered growth and development: communication skills (specify)
- Risk for loneliness
- High risk for violence

SEXUALITY-REPRODUCTIVE PATTERN
- Sexual dysfunction (specify type)
- Altered sexuality patterns
- Rape trauma syndrome
- Rape trauma syndrome: compound reaction
- Rape trauma syndrome: silent reaction

COPING-STRESS TOLERANCE PATTERN
- Coping, ineffective (individual)
- Avoidance coping
- Defensive coping
- Ineffective denial or denial
- Impaired adjustment
- Post-trauma response
- Family coping: potential for growth
- Ineffective family coping: compromised
- Ineffective family coping: disabling
- Ineffective community coping
- Potential for enhanced community coping
- Risk for self-harm
- Risk for self-abuse
- Risk for self-mutilation
- Risk for suicide
- Risk for violence

VALUE-BELIEF PATTERN
- Spiritual distress (distress of the human spirit)
- Potential for enhanced spiritual well-being

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* Based on Gordon, M: Nursing Diagnosis: Process and Applications. McGraw Hill, New York, 1996, with permission.

KEY TO ESSENTIAL TERMINOLOGY

PATIENT ASSESSMENT DATA BASE

Provides an overview of the more commonly occurring etiology and coexisting factors associated with a specific medical/surgical diagnosis as well as the signs/symptoms and corresponding diagnostic findings.

NURSING PRIORITIES

Establishes a general ranking of needs/concerns on which the Nursing Diagnoses are ordered in constructing the plan of care. This ranking would be altered according to the individual patient situation.

DISCHARGE GOALS

Identifies generalized statements that could be developed into short-term and intermediate goals to be achieved by the patient before being "discharged" from nursing care. They may also provide guidance for creating long-term goals for the patient to work on after discharge.

NURSING DIAGNOSES

The general problem/concern (diagnosis) is stated without the distinct cause and signs/symptoms, which would be added to create a patient diagnostic statement when specific patient information is available. For example, when a patient displays increased tension, apprehension, quivering voice, and focus on self, the nursing diagnosis of Anxiety could be stated: Anxiety, severe, related to unconscious conflict, threat to self-concept as evidenced by statements of increased tension, apprehension; observations of quivering voice, focus on self.

In addition, diagnoses identified within these guides for planning care as actual or risk can be changed or deleted and new diagnoses added, depending entirely on the specific patient information.

MAY BE RELATED TO/POSSIBLY EVIDENCED BY

These lists provide the usual/common reasons (etiology) why a particular problem may occur with probable signs/symptoms, which would be used to create the "related to" and "evidenced by" portions of the *patient diagnostic statement* when the specific patient situation is known.

When a risk diagnosis has been identified, signs/symptoms have not yet developed and therefore are not included in the nursing diagnosis statement. However, interventions are provided to prevent progression to an *actual* problem. The exception to this occurs in the nursing diagnosis *Violence, risk for,* which has possible indicators that reflect the patient's risk status.

DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL

These give direction to patient care as they identify what the patient or nurse hopes to achieve. They are stated in general terms to permit the practitioner to modify/individualize them by adding time lines and individual patient criteria so they become "measurable." For example, "Patient will appear relaxed and report anxiety is reduced to a manageable level within 24 hours."

ACTIONS/INTERVENTIONS

Activities are divided into independent and collaborative and are ranked in this book from most to least common. When creating the individual plan of care, interventions would normally be ranked to reflect the patient's specific needs/situation. In addition, the division of independent/collaborative is arbitrary and is actually dependent on the individual nurse's capabilities and hospital/community standards.

RATIONALE

Although not commonly appearing in patient plans of care, rationale has been included here to provide a pathophysiologic basis to assist the nurse in deciding about the relevance of a specific intervention for an individual patient situation.

CLINICAL PATHWAY

This abbreviated plan of care or care map is event- (task-)oriented and provides outcome-based guidelines for goal achievement within a designated length of stay. Several samples have been included to demonstrate alternative planning formats.

NURSING DIAGNOSES (THROUGH 12TH NANDA CONFERENCE)†

Activity Intolerance
Activity Intolerance, risk for
Adaptive Capacity: Intracranial, decreased
Adjustment, impaired
Airway Clearance, ineffective
Anxiety [specify level]*
Aspiration, risk for
Body Image disturbance
Body Temperature, altered, risk for
Bowel Incontinence
Breastfeeding, effective
Breastfeeding, ineffective
Breastfeeding, interrupted
Breathing Pattern, ineffective
Cardiac Output, decreased
Caregiver Role Strain
Caregiver Role Strain, risk for
Communication, impaired verbal
Community Coping, potential for enhanced
Community Coping, ineffective
Confusion, acute
Confusion, chronic
Constipation
Constipation, colonic
Constipation, perceived
Coping, defensive
Coping, Individual, ineffective
Decisional Conflict (specify)
Denial, ineffective
Diarrhea
Disuse Syndrome, risk for
Diversional Activity deficit
Dysreflexia
Energy Field disturbance
Environmental Interpretation Syndrome, impaired
Family Coping: ineffective, compromised
Family Coping: ineffective, disabling
Family Coping: potential for growth
Family Process, altered: alcoholism
Family Processes, altered
Fatigue
Fear
Fluid Volume deficit [active loss]*
Fluid Volume deficit [regulatory failure]*
Fluid Volume deficit, risk for
Fluid Volume excess
Gas Exchange, impaired
Grieving, anticipatory
Grieving, dysfunctional
Growth and Development, altered
Health Maintenance, altered
Health-Seeking Behaviors (specify)
Home Maintenance Management, impaired
Hopelessness
Hyperthermia
Hypothermia
Incontinence, functional
Incontinence, reflex
Incontinence, stress
Incontinence, total
Incontinence, urge
Infant Behavior, disorganized
Infant Behavior, disorganized, risk for
Infant Behavior, organized, potential for enhanced
Infant Feeding Pattern, ineffective
Infection, risk for
Injury, risk for
Knowledge deficit [learning need]* (specify)
Loneliness, risk for
Memory, impaired
Noncompliance [Compliance, altered]* (specify)
Nutrition: altered, less than body requirements
Nutrition: altered, more than body requirements
Nutrition: altered, risk for more than body requirements
Oral Mucous Membrane, altered
Pain [acute]
Pain, chronic
Parental Role Conflict
Parent/Infant/Child Attachment, altered, risk for
Parenting, altered
Parenting, altered, risk for
Perioperative Positioning Injury, risk for
Peripheral Neurovascular dysfunction, risk for
Personal Identity disturbance
Physical Mobility, impaired
Poisoning, risk for
Post-Trauma Response
Powerlessness
Protection, altered
Rape-Trauma Syndrome
Rape-Trauma Syndrome: compound reaction
Rape-Trauma Syndrome: silent reaction
Relocation Stress Syndrome
Role Performance, altered
Self Care Deficit, feeding, bathing/hygiene, dressing/grooming, toileting
Self Esteem, chronic low
Self Esteem disturbance
Self Esteem, situational low
Self-Mutilation, risk for
Sensory/Perceptual alterations (specify): visual, auditory, kinesthetic, gustatory, tactile, olfactory
Sexual dysfunction
Sexuality Patterns, altered
Skin Integrity, impaired
Skin Integrity, impaired: risk for
Sleep Pattern disturbance
Social Interaction, impaired
Social Isolation
Spiritual Distress (distress of the human spirit)
Spiritual Well-Being, potential for enhanced
Spontaneous Ventilation, inability to sustain
Suffocation, risk for
Swallowing, impaired
Therapeutic Regimen: Community, ineffective management
Therapeutic Regimen: Families, ineffective management
Therapeutic Regimen: Individuals, effective management
Therapeutic Regimen (Individuals), ineffective management
Thermoregulation, ineffective
Thought Processes, altered
Tissue Integrity, impaired
Tissue Perfusion, altered (specify): cerebral, cardiopulmonary, renal, gastrointestinal, peripheral
Trauma, risk for
Unilateral Neglect
Urinary Elimination, altered
Urinary Retention [acute/chronic]*
Ventilatory Weaning Response, dysfunctional (DVWR)
Violence, risk for, directed at self/others

* [Author recommendations]

To our spouses, children, parents, and friends, who much of the time have had to manage without us while we work as well as cope with our struggles and frustrations.

The Doenges families: Dean, Jim, Barbara, and Bob Lanza; David, Monita, Matthew, and Tyler; John, Holly, Nicole, and Kelsey; and the Daigle family, Nancy, Jim, Jennifer, and Jonathan.

The Moorhouse family: Jan, Paul, Jason, Ellaina, and Alexa.

To Mary and Marilynn, couldn't have done it without you—Alice.

In loving memory of my mother, Norma Loughmiller, who was my biggest promoter in my early days of writing.

To our FAD family, especially Bob Martone, Ruth De George, Herb Powell, and Bob Butler, whose support is so vital to the completion of a project of this magnitude.

To the nurses we are writing for, who daily face the challenge of caring for the acutely ill patient and are looking for a practical way to organize and document this care. We believe that nursing diagnosis and these guides will help.

To NANDA and to the International nurses who are developing and using nursing diagnoses—here we come!

Finally, to the late Mary Lisk Jeffries, who initiated the original project. The memory of our early friendship and struggles remains with us. We miss her and wish she were here to see the growth of the profession and how nursing diagnosis has contributed to the process.

PREFACE

One of the most significant achievements in the healthcare field during the past 20 years has been the emergence of the professional nurse as an active coordinator and initiator of patient care. While the transition from helpmate to healthcare professional has been painfully slow and is not yet complete, the importance of the nurse within the system can no longer be denied or ignored. Today's nurse designs nursing care interventions that will move the total patient toward the goal of improved health.

The current state of the theory of Nursing Process, Diagnosis, and Intervention has been brought to the clinical setting to be implemented by the nurse. This book gives definition and direction to the development and use of individualized nursing care. The book is therefore not an end in itself but a beginning for the future growth and development of the profession.

Professional care standards, other healthcare professionals, and patients will continue to increase expectations for nurses' performance as each day brings advances in the struggle to understand the mysteries of normal body function and human response to actual and potential health problems. With this increased knowledge comes greater responsibility for the nurse. To meet these challenges competently, the nurse must have up-to-date physical assessment skills and a working knowledge of pathophysiologic concepts concerning the more common diseases/conditions encountered in general healthcare. This book is a tool, a means of attaining that competency.

In the past, plans of care were viewed principally as learning tools for students and seemed to have little relevance after graduation. However, the need for a written format to communicate and document individualized patient care has been recognized in all care settings. In addition, governmental regulations and third-party payor requirements have created the need to validate the appropriateness of the care provided, as well as the need to justify patient care charges and staffing patterns. Thus, although the student's "case studies" were too cumbersome to be practical in the clinical setting, the patient plan of care meets the aforementioned identified needs. The practicing nurse, as well as the nursing student, will welcome this text as a ready reference in clinical practice. The book is designed for use in the acute medical/surgical setting, as well as the community setting, and is organized by systems for easy reference. Rationales (which state not only why an intervention is important but also provide a brief related pathophysiology, when applicable) enhance the reader's understanding of the intervention. This information also serves as a catalyst for thought in planning and evaluating the care being rendered.

Chapter 1 discusses some current issues and trends affecting the nursing profession. An overview of cultural, community, sociologic, and ethical concepts affecting the nurse is included. The important concept of cooperation and coordination with other healthcare professionals is integrated throughout the plans of care.

Chapter 2 reviews the historic use of the nursing process in formulating plans of

care and the nurse's role in the delivery of that care. Nursing diagnosis is discussed to assist the nurse in understanding its role in the nursing process.

Chapter 3 demonstrates construction of the plan of care and the use and adaptation of the guides for care planning presented in this book. A nursing-based assessment tool is presented with a sample patient situation, data base, and corresponding plan of care to aid the nurse to make the transition from theory to practice. Additionally, a clinical pathway reflecting the sample situation is included to demonstrate another method of evaluating and documenting the patient's response to care.

Chapters 4 through 15 present guides for planning care that include information from multiple disciplines to help the nurse provide holistic care. Each plan of care is developed by identifying nursing diagnoses with "related to" and "evidenced by" factors that provide an explanation of patient problems/needs. Each plan includes a patient assessment data base (presented in a nursing format) and associated diagnostic studies. After the data base is collected, nursing priorities are sifted from the information to help focus and structure the patient care provided. Discharge goals are also listed to identify the general goals that should be accomplished by the time of discharge from care. In addition, mean length of stay has been identified to provide a general idea of time constraints for achieving discharge goals in the inpatient setting. Desired patient outcomes are stated in behavioral terms that can be measured to evaluate the patient's progress and the effectiveness of care provided. (Time lines have been omitted here because they are individually determined by specific patient data.) The interventions are designed to assist with problem resolution. Rationales for these actions are provided to enable the nurse to decide whether the intervention applies to a particular patient situation. Additional information is provided to assist the nurse in identifying and planning for rehabilitation/care in the community setting as the patient progresses toward discharge. As in Chapter 3, samples of clinical pathways have been included to demonstrate alternative plan-of-care formats and enhance the learning experience.

As a final note, this book is not intended to be a procedure manual, and efforts have been made to avoid detailed descriptions of techniques/protocols that might be viewed as individual/regional in nature. Instead, the reader is referred to procedure manual/standards of care resources for in-depth direction for these concerns.

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