1990

Clinically Tested! *AJN* Recommended!

THIRD EDITION

CARE PLANNING POCKET GUIDE

A NURSING DIAGNOSIS APPROACH

LEDERER, MARCULESCU
MOCNIK, SEABY

NOW WITH

1988
NANDA Diagnoses
•
Pediatric, Perinatal,
Psychiatric Conditions
•
Related Diagnoses

Care Planning Pocket Guide

Third Edition

A Nursing Diagnosis Approach

Janet Reiss Lederer, MN, RN

Gail L. Marculescu, MS, RN, CETN

Barbara Mocnik, MS, RN

Nancy Seaby, MS, RN

ADDISON-WESLEY NURSING
A Division of The Benjamin/Cummings Publishing Company, Inc.

Redwood City, California • Fort Collins, Colorado
Menlo Park, California • Reading, Massachusetts • New York
Don Mills, Ontario • Wokingham, U.K. • Amsterdam • Bonn
Sydney • Singapore • Tokyo • Madrid • San Juan

Sponsoring Editor: Debra S. Hunter
Production Supervisors: Judy Johnstone, Wendy Earl, Mary Shields
Text Designer: Paul Quin
Cover Designer: Ken Scott
Illustrator: Rebecca Leer
Compositor: Thompson Type

Library of Congress Cataloging-in-Publication Data

Care planning pocket guide.
Bibliography: p. 229
Includes index.
1. Nursing care plans—Handbooks, manuals, etc.
2. Diagnosis—Handbooks, manuals, etc. I. Lederer, Janet Reiss, 1944–
RT49.C37 1989 610.73 89-6828

ISBN 0-201-58298-8

CDEFGHIJ-AL-8932109

Addison-Wesley Nursing
A Division of The Benjamin/Cummings Publishing Company, Inc.
390 Bridge Parkway
Redwood City, California 94065

Care Planning Pocket Guide

Third Edition

Janet Reiss Lederer, MN, RN
Manager, Patient Education
El Camino Hospital
Mountain View, California

Gail L. Marculescu, MS, RN, CETN
Enterostomal Therapy Nurse
El Camino Hospital
Mountain View, California

Barbara Mocnik, MS, RN
Staff Development Instructor, Psychiatry
El Camino Hospital
Mountain View, California

Nancy Seaby, MS, RN
Director, Quality Assurance & Education
Dialysis Services
El Camino Hospital
Mountain View, California

Preface

The *Care Planning Pocket Guide* is an educational tool designed to help nurses develop individualized nursing care plans. In this edition, the general format remains the same as the first edition of the book. However, the content has been expanded to include a revision of the original care plans found in the second edition, and the addition of new nursing diagnoses, which were recently developed by the North American Nursing Diagnosis Association (NANDA, March 1988). The content includes medical/surgical, psychiatric, perinatal, and pediatric patient populations as well. A variety of special features contributes to the book's usefulness and makes it an indispensable tool for writing care plans.

Features

Organized for easy use The book is divided into two main parts: (1) complete plans of care, written according to nursing diagnosis; and (2) a list of medical/surgical, psychiatric, perinatal, and pediatric conditions, each accompanied by suggested nursing diagnoses. This unique organization allows you to start with either a medical condition or a nursing diagnosis.

Suggested related diagnoses Most care plans have suggested alternative diagnoses that assist the nurse to determine the most appropriate nursing diagnosis.

Easy to individualize Each nursing diagnosis has suggested "related to" statements that make it easy to individualize the care plan to the specific patient situation. The authors encourage creativity by suggesting that nurses add specific outcomes, interventions, and "related to" statements to tailor the care plan to the individual patient.

Comprehensive Each plan of care is comprehensive and allows nurses to select specific content according to the patient's condition and situation. Each plan includes (1) a definition of the nursing diagnosis, (2) subjective and objective defining characteristics, (3) suggested related diagnoses, (4) the "related to" statements, (5) expected outcomes, (6) a reminder to specify the frequency of documentation and expected date of completion, and (7) suggested nursing interventions.

Audience This handbook was developed to facilitate care planning for nursing students, staff nurses in a variety of settings, and instructors in inservice education.

The novice care planner, or the experienced nurse less familiar with nursing diagnosis, may find it helpful to begin with the list of medical, surgical, psychiatric, perinatal, and pediatric conditions. Once the appropriate nursing diagnoses have been identified, the nurse can use the plans of care to formulate individualized, patient-centered care plans. The nurse who is more familiar with the care planning process will find the content in both sections useful in formulating new and creative care plans. The expert in nursing care planning will be able to use this book to extract information that further expresses the needs of the patient and/or family in a variety of settings.

Acknowledgments

We acknowledge those El Camino Hospital nurses who, as members of the Nurse Care Planning Committee, created the initial care plans that have been used at El Camino Hospital since 1975. These care plans were the basis for the work done on the first edition of this book.

We thank our reviewers:

Patricia Brien, MSN, RN Berkshire Community College, Pittsfield, Massachusetts

Patricia McKay Bufalino, RN, MN Riverside Community College, Riverside, California

Phyllis Carrol, MS, RN St. Joseph's Medical Center, Joliet, Illinois

Susan deWit, MSN El Centro College, Dallas, Texas

Verlinda J. Henry, RN, BSN Santa Rosa Memorial Hospital, Santa Rosa, California

Marva Mizell Price, MPH, RNC, BS North Carolina Department of Human Resources

Billie Rozell, DSN, RN University of Alabama at Birmingham

Janet Lederer
Gail Marculescu
Barbara Mocnik
Nancy Seaby

Mountain View, California

Contents

Introduction

History

In 1973, the American Nurses' Association mandated the use of nursing diagnosis in nursing practice. Soon after, interested clinicians, educators, researchers, and theorists from every area of nursing practice came together to offer labels for conditions they had observed in practice. From this beginning, the North American Nursing Diagnosis Association (NANDA) was established as the formal body for the promotion, review, and endorsement of the current list of nursing diagnoses used by practicing nurses (NANDA, 1988). The NANDA membership convenes every two years to consider revisions and additions to the list of nursing diagnoses. The current list of about 100 diagnoses will undoubtedly expand as nurses explore the breadth and depth of nursing practice.

As the list of nursing diagnoses has expanded, NANDA believing the alphabetized method of listing them to be cumbersome and difficult to use, has chosen to use a classification system, Taxonomy I. In the search for an organizing structure in which to classify the list of conditions, the Eighth National NANDA Conference General Assembly (held in St. Louis in March, 1988) has endorsed the NANDA Nursing Diagnosis Taxonomy I as an "investment by NANDA in a specific taxonomy which can be tested, refined, revised, and expanded" (1988 NANDA Taxonomy Committee Publication).

The value of nursing diagnosis

A common language for practicing nurses has long been needed. As nurses use the nursing diagnosis list, they will influence many aspects of patient care in their professional practice. Communication with other health care professionals will be enhanced, promoting comprehensive and consistent patient care from nurse to nurse, unit to unit, and institution to institution.

Nursing as a profession benefits from the use of nursing diagnosis because it helps to define the scope of nursing practice by describing conditions the nurse can independently and legally treat. The use of nursing diagnosis also highlights critical thinking and decision making, which occur in the nursing process.

The importance of nursing diagnosis in care planning is attested to by many nurses, both in professional literature and clinical practice. The use of nursing diagnosis in care planning formulation certainly makes care planning terminology consistent and universally understandable. Nurses working in various settings, including hospitals, the community, extended care facilities, occupational health, or private practice, will benefit from the use of nursing diagnosis.

Health care reimbursement is changing, leading to a shortened hospital stay. Governmental budget restraints and third-party payment reforms have led to new

payment structures. It has become increasingly important to quantify patient care for reimbursement. The use of nursing diagnosis and care planning will help the professional nurse to quantify the care given to patients.

Nursing process in relation to nursing diagnosis

Using the nursing process to create a plan of care provides a structure for nursing practice and is, in fact, the essence of nursing. The nursing process is put to use continuously during the rendering of nursing care in every clinical setting. Many components of the nursing process overlap and often are repeated, making all aspects of nursing care dynamic. It is important to consider the patient as the central figure in the plan of care. The nurse must confirm appropriateness of all aspects of nursing care by observing the patient's response to the interventions, be they medical, surgical, or psychosocial.

What process is used to determine the appropriate diagnostic statement for the patient? Data collection and assessment are imperative as the initial steps in the critical thinking and decision making that may lead to the identification of a nursing diagnosis. The definition and defining characteristics of the nursing diagnosis assist the nurse to validate the diagnosis. Once the nursing diagnosis and the "related to" statement are determined, the plan of care is created. The nurse selects the relevant patient outcome statement, including the patient's perceptions and suggestions for the outcome, if possible. Only those patient outcomes that are specific to the patient are selected. Not all outcomes apply to every situation.

Following the identification of the outcomes, the nurse includes the patient, whenever possible, in determining the interventions that will assist the patient to achieve the stated outcomes. It is necessary to choose only those interventions that address the etiology of the problem and provide assistance that will return the patient to optimal health.

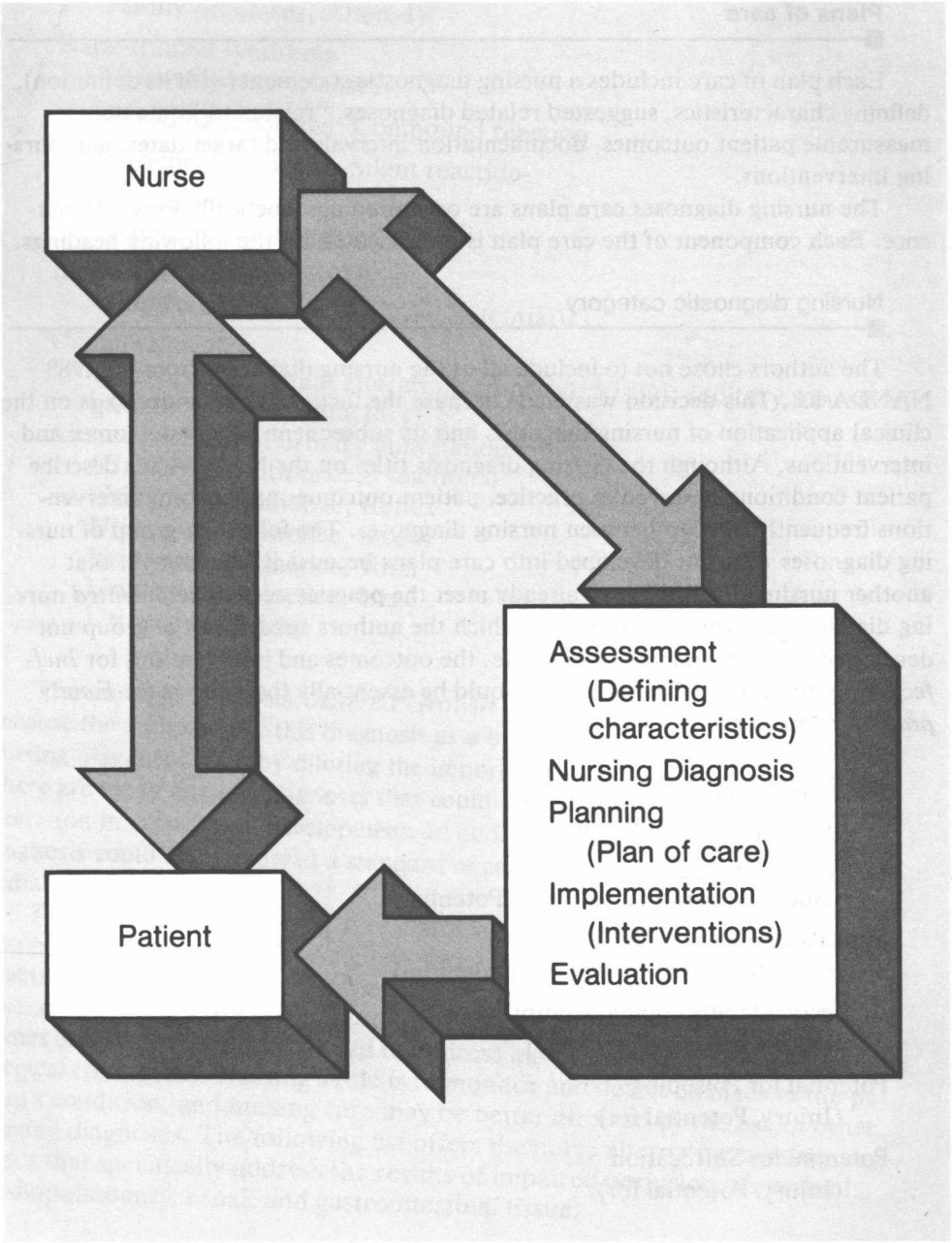
Evaluation is a component of each step of the nursing process. Is the nursing diagnosis still appropriate? Has the patient achieved the desired outcome? Are the documentation interval and the target date still appropriate and realistic? Are certain interventions no longer needed? The nurse needs to ask these questions to determine whether changes need to be made in the individualized plan of care. The figure on the facing page displays the relationship between the steps in the nursing process and the components of the nursing diagnosis plan of care.

Standards of care in relation to nursing diagnosis

In January, 1986, the authors participated in the implementation of nursing diagnosis care planning in an acute care setting. It became clear that there is an interrelationship between nursing diagnosis care planning and standards of care. Developing plans of care using nursing diagnosis points out the necessity of having written standards of care to use in conjunction with nursing diagnosis to reduce duplication in documenting problems that are identified repetitively.

Standards of care are developed for a group of patients about whom generalized predictions can be made. They direct a set of common nursing interventions

for specific patient groups. When an organization has written standards of care, nursing diagnosis care planning is not used to communicate routine nursing interventions. Nursing diagnosis care planning will be used for those exceptional patient problems that are not addressed in the standards of care.



Components of Nursing Diagnosis Care Plans

This book is organized into two parts: "Plans of care" and "Clinical conditions guide to nursing diagnosis." More specific information regarding these two parts of this book, with some examples of how to use them, follow.

Plans of care

Each plan of care includes a nursing diagnostic statement (with its definition), defining characteristics, suggested related diagnoses, "related to" statements, measurable patient outcomes, documentation intervals and target dates, and nursing interventions.

The nursing diagnoses care plans are organized alphabetically for easy reference. Each component of the care plan is described under the following headings.

Nursing diagnostic category

The authors chose not to include all of the nursing diagnoses from the 1988 NANDA list. This decision was made because the focus of this handbook is on the clinical application of nursing diagnosis and its subsequent patient outcomes and interventions. Although the nursing diagnosis titles on the NANDA list describe patient conditions observed in practice, patient outcomes and nursing interventions frequently overlap between nursing diagnoses. The following group of nursing diagnoses were not developed into care plans because it was thought that another nursing diagnosis may already meet the practice need. The *indented* nursing diagnoses are the diagnoses into which the authors subsumed the group not developed into care plans. For example, the outcomes and interventions for *Ineffective family coping: Compromised* would be essentially the same as for *Family processes, Altered.*

Anticipatory Grieving
(Grieving, Dysfunctional)

Hypothermia
(Body temperature, Altered: Potential)

Hyperthermia
(Body temperature, Altered: Potential)

Ineffective family coping: Compromised
(Family processes, Altered)

Potential for Poisoning
(Injury, Potential for)

Potential for Suffocation
(Injury, Potential for)

Potential for Trauma
(Injury, Potential for)

Parental role conflict
(Role performance, Altered
Coping, Ineffective family: Disabling
Parenting, Altered
Family processes, Altered)

Rape-trauma syndrome
(Post-trauma response)

Rape-trauma syndrome: Compound reaction

Rape-trauma syndrome: Silent reaction

Sexual dysfunction
(Altered sexuality patterns)

Ineffective Thermoregulation
(Body temperature, Altered: Potential)

Unilateral neglect
(Sensory/perceptual alterations (specify): Visual, auditory, kinesthetic, gustatory, tactile, olfactory)

Altered patterns of urinary elimination
(Urinary incontinence, Functional
Urinary incontinence, Reflex
Urinary incontinence, Stress
Urinary incontinence, Total
Urinary incontinence, Urge
Urinary retention)

The nursing diagnosis, *Altered Growth and development*, was not included because the authors view this diagnosis as a broad label that encompasses many nursing diagnoses, thereby diluting the importance of each individual diagnosis. There are many nursing diagnoses that could be identified when a person has an alteration in growth and development. In addition, interventions for this nursing diagnosis could be considered a standard of care and an assessment tool for pediatric patients.

Tissue perfusion, Altered: Peripheral was developed and included in the text because the outcomes and interventions fall within the realm of nursing practice. However, *Impaired tissue integrity* and *Altered tissue perfusion: Cerebral, cardiopulmonary, renal, gastrointestinal* were not included because outcomes and interventions designed to address inadequate perfusion are medical/surgical treatments. Nursing's role is to monitor and detect changes in the patient's condition, and nursing care may be better directed by the use of other nursing diagnoses. The following list offers the nurse alternative nursing diagnoses that specifically address the results of impaired perfusion of cerebral, cardiopulmonary, renal, and gastrointestinal tissue.

Cerebral (Sensory/perceptual alterations: Visual, auditory, kinesthetic, gustatory, tactile, olfactory; Injury, Potential for; Communication, Impaired: Verbal; Thought processes, Altered)

Cardiopulmonary (Cardiac output, Decreased)

Renal (Fluid volume excess)

Gastrointestinal (Authors consider this to be a surgical emergency with normal postoperative sequelae.)

The authors did not separate the nursing diagnosis *Self-care deficit: Bathing/hygiene, dressing/grooming, feeding, toileting* into distinct care plans because the format, as it stands, provides the opportunity to specify the self-care deficit and to select concomitant outcomes and interventions.

"Related to" statements

The "related to" portion of the diagnostic statement implies a link or connection to the nursing diagnosis. The "related to" statement delineates what must change for the patient to return to optimal health. The more specific the "related to" statement, the more specifically the interventions and outcomes can be stated.

Definition

The definition of each nursing diagnosis found at the beginning of the plan of care helps the nurse verify a particular nursing diagnosis. Most definitions were developed by NANDA (1986, Hurley, M., ed., Classification of Nursing Diagnoses: Proceedings of the Sixth Conference. 1987, McLane, A., ed., Classification of Nursing Diagnoses: Proceedings of the Seventh Conference, 1988 NANDA Conference Proceedings) while others were adapted by the authors from NANDA and other sources, and a few are the original definitions of the authors. The source is cited following each definition. Those definitions where no source is cited are the original work of the authors.

Defining characteristics

Defining characteristics are descriptors of patient behavior, either observed by the nurse or verbalized by the patient/family. Frequently discovered during the initial nursing history and assessment, the defining characteristics are organized into meaningful groups or patterns of information that alert the nurse to the possibility of an existing patient problem. Usually, the presence of two or three defining characteristics verifies a nursing diagnosis. Occasionally the same descriptors apply to several nursing diagnoses. For example, pallor, shortness of breath, and expressions of anxiety are defining characteristics of many nursing diagnoses.

Both subjective and objective descriptors are important in the validation of a nursing diagnosis. Subjective data originate with the patient and are perceived by the patient as true. Subjective data include expressions of emotions and physical sensations by the patient and family. Objective data are observable behaviors, characteristics, and information perceived by others. Objective data include nonverbal expressions by the patient and the patient's family or friends. Additionally, objective data include physical assessment data and chart information, such as laboratory values, radiology reports, physical and psychosocial assessment, the medical history and physical, and observations of ancillary personnel (occupational therapist, physical therapist, social worker, dietitian, and so on). Both subjective and objective information are necessary considerations during the assessment phase of the nursing process. Both help the nurse to select the appropriate nursing diagnosis.

Suggested related diagnoses

Suggested related diagnoses are alternative nursing diagnoses that may be considered when developing a care plan. When the nurse reviews the definition and defining characteristics and finds the nursing diagnosis inadequate, he/she may refer to the list of suggested related diagnoses for other options. This is particularly helpful for the nurse unfamiliar with the nuances of each nursing diagnosis. Some nursing diagnoses have no suggested related diagnoses because of their specificity.

Patient outcomes

Patient outcomes are statements of patient/family behaviors that are measurable, observable, and denote a desired goal. Patient outcome statements, like all components of the care planning process, are dynamic. Patient outcomes, therefore, are frequently changing goals. Some goals are easily achieved and, once accomplished, can be deleted. Others may take longer to achieve and need periodic reevaluation. Measurable patient outcome statements are critical. Without them, the care planning process has no evaluation component.

Not all patient outcomes listed will be appropriate for each patient. The nurse should be realistic when constructing patient outcome statements because partial behavior change may be the only attainable goal. With shortened length of hospital stay, patient outcomes may be completed after discharge by nurses in the community setting. At time of discharge, discussion with the patient may be initiated to determine patient/family outcomes still requiring completion with referral to appropriate community resources.

Patient outcomes may be selected from this handbook or developed specifically for the patient/family situation. Use as few patient outcomes as necessary to assist the patient achieve his/her goal. Prioritize outcomes with consideration

given to length of stay, patient condition, and/or what can reasonably be accomplished by the patient and family.

Target date

The target date is the estimated date the outcome will be accomplished. The date is individualized to the patient, is flexible, and should be reviewed periodically. Target dates are changed as necessary. The target date, and its subsequent review, helps the nurse evaluate the patient's progress toward outcomes.

Documentation interval

The documentation interval designates how often documentation should occur for each outcome. This interval should be determined during initial assessment and may change as patient behaviors indicate the completion of a goal (outcome). For example, in the care plan *Fluid volume deficit,* the documentation interval for the outcome, "patient has moist mucous membranes," could be specified as "q8 hours." This means that documentation must occur at least every eight hours until the outcome is accomplished.

The evaluation process is incomplete unless a target date and documentation interval accompany each outcome statement. The outcomes, documentation interval, and target date are reviewed for currency and applicability at least daily and updated as the patient's condition or situation changes.

Nursing interventions

The nursing interventions listed for each care plan include activities performed using the nursing process: assessment, planning, interventions, and evaluation. The interventions should be chosen only if they apply to the patient's condition and circumstance. Not every intervention will be appropriate for every patient. For example, it may be necessary to select only a few of the interventions at first and add others later as necessary. The nurse has the option to write interventions that are specific to the patient to ensure an individualized plan of care. In certain instances, "q ____" or "specify plan" is included in the intervention statement as a reminder to individualize the plan. The intervention is not complete without this specificity.

Often, assessment and documentation information is included in an intervention statement. Documentation is essential to quantify nursing actions. This documentation should include the type of nursing intervention, its frequency, and the patient's response. Without this documentation, the patient's progress cannot be evaluated.

Certain interventions require assessment of available laboratory values. Normal ranges for laboratory values vary with the clinical laboratory equipment used

in different facilities, and the nurse may need to refer to other resources to evaluate the patient's laboratory results.

As the patient's condition changes, interventions may be added, changed, or deleted. Frequent updating of this portion of the care plan is essential.

Clinical conditions guide to nursing diagnoses

The second part of this handbook is organized to help the nurse select nursing diagnoses when the patient's medical condition is known but the appropriate nursing diagnoses have not yet been established. In this section, medical, surgical, psychiatric, perinatal, and pediatric conditions are listed with suggested nursing diagnoses and "related to" statements. The suggested nursing diagnoses and "related to" statements are thought to occur frequently when the particular medical condition is present. When reviewing these lists, the nurse needs to remember that not all of the nursing diagnoses will apply to each patient situation and should select only those nursing diagnoses that are determined to be applicable from the assessment information collected.

The list of conditions does not include unusual disease conditions, and it may be necessary to refer to a more general title. For example, the patient's medical diagnosis may be scleroderma. Since this condition occurs rarely, the nurse should look under the general title *Autoimmune disorders* and review the nursing diagnoses listed there before developing the care plan.