Critical Thinking and Nursing Process NCLEX Review

Critical thinking involves mental strategies associated with problem-solving, decision making, use of the scientific method, and diagnostic reasoning. When critical thinking is applied to the practice of nursing, it is called the nursing process. Before one can employ the nursing process, consisting of assessment, analysis, planning, implementation/intervention, and evaluation, one must first have a better understanding of what is critical thinking.

A. Introduction to critical thinking

1. Critical thinking is a cognitive strategy by which you reflect on and analyze your thoughts, actions, and decisions; it requires internal cognitive and personal competencies.

2. Cognitive competencies.

- Cognitive competencies are the intellectual or reasoning processes used when thinking and include such skills as the ability to understand, analyze, interpret, correlate, investigate, compare and contrast, categorize, determine significance, query evidence, establish priorities, make inferences, and determine consequences, to name a few.
- The more internal cognitive competencies a person can bring to the thinking process, the more successful a person will be at thinking critically.

3. Personal competencies.

- Personal competencies are the attitudes and characteristics that are associated with successful critical thinkers, such as being an independent thinker, open-minded, imaginative, disciplined, committed, accountable, inquisitive, confident, reflective, objective, intuitive, rational, curious, honest, and moral, to name a few.
- The more personal competencies a person can bring to the thinking process, the more successful a person will be at thinking critically.

B. Maximize your critical thinking ability

1. Self-analysis: The competencies listed previously are just a few of the competences in each category. Make a list or your own competencies. This will enable you to identify additional skills and abilities that you need to work on acquiring.

2. Techniques to improve critical thinking.

- Study your textbooks and other resources. A strong knowledge base is essential to thinking critically.
- Reflect on your learning. Examine your performance: engage in post conferences, maintain a journal that objectively and subjectively explores your experience, ask faculty members to provide feedback on your progress and to make suggestions for improving critical thinking

abilities.
- Participate in a study group to dissect and examine information, work on case studies, and answer test questions and then identify rationales for right and wrong answers.

II. INTRODUCTION TO NURSING PROCESS

The nursing process is a critical thinking framework that involves assessing and analyzing human responses to plan and implement nursing care that meets client needs as evidenced by evaluation of client outcomes. Nurses use critical thinking throughout the nursing process, which involves both "thinking" and "doing," to meet complex client needs.

A. Components of the nursing process

1. Assessment.
2. Planning.
3. Analysis.
4. Implementation.
5. Evaluation.

B. Characteristics of the nursing process

1. Is client-centered.
2. Is interpersonal.
3. Is collaborative.
4. Is dynamic and cyclical.
5. Requires critical thinking.

III. ASSESSMENT

Assessment, the first step of the nursing process, is the ongoing, systematic collection, validation, and documentation of data. Data are information. Nursing assessment should be comprehensive, holistic, and accurate so that it provides all the necessary information about a client. In addition, it should reflect the client's responses to a health problem and stressors, not disease processes. Adequate assessment depends on collecting data using various methods, collecting both subjective and objective data, verifying that data are accurate, and communicating information about assessments to other members of the health team.

A. Methods of data collection

1. Physical examination: The use of inspection, auscultation, percussion, and palpation to collect data about a client's physical status.

2. Interviewing.

- Formal approach. (1) Used when collecting information in an arranged or official way, such as for a history and physical. (2) Usually involves direct rather than open-ended questions.
- Informal approach. (1) Used when collecting data in a casual and more relaxed manner, such as when exploring a client's feelings while providing other nursing care. (2) Usually involves open-ended questions.

3. Clinical record review.

- Involves monitoring information collected about the client in the clinical record.
- Gathers information about results of laboratory examinations, diagnostic procedures, consultations by other members of the health team, and progress notes.

B. Sources of data

1. Primary source.

- The client is the only primary source of data. The data include information such as feelings, physical and emotional perceptions, and beliefs.
- The client is the most valuable source because the data collected are most recent, unique, and specific to the client.

2. Secondary sources.

- These sources provide supplementary information about the client from some place other than the client but within the client's frame of reference.
- They include people other than the client (e.g., family members, friends, other health team
- A client's clinical record is also a secondary source, as it contains a vast amount of information about the client's physical, psychosocial, and economic history as well as information about the client's progress regarding physical and emotional responses to a health problem. members).

3. Tertiary sources.

- These sources produce data from outside the client's frame of reference.
- Examples include information from textbooks, surveys, medical and nursing journals, drug books, and policy and procedure manuals.

C. Types of data

1. Objective data.

- Objective data(also known as signs), are overt, measurable assessments collected via the senses, such as sight, touch, smell, and hearing, and compared to an accepted standard.
- Examples include body temperature, pulse and respiratory rates, blood pressure, vomiting, distended abdomen, presence of edema, lung sounds, crying, skin color, and presence of diaphoresis.

2. Subjective data.

- Subjective data(also known as symptoms) are covert information, such as feelings, perceptions, thoughts, sensations, or concerns that are shared by the client and can be verified only by the client.
- Examples include pruritus, nausea, pain, numbness, attitudes, beliefs, values, and perceptions of the health problem and life circumstances.

3. Verbal data.

- Verbal dataare spoken or written messages.
- Requires the nurse to listen to the pace of the communication pattern, tone of voice, vocabulary used, and presence of aggression, anxiety, or assertiveness.
- Allows for the assessment of difficulties such as slurring, lack of clarity, flight of ideas, difficulty finding the desired word, and inability to identify an item.
- Examples include statements made by the client or by a secondary source.

4. Nonverbal data.

- Nonverbal dataare observable behavior transmitting a message without words.
- Examples include client's appearance; facial expression; body language, such as posture, gestures, and eye contact or lack of eye contact.

D. Verifying collected data

1. Data must be double-checked (verified) after they are collected.

2. Ensures validity and accuracy.

3. Ensures that the nurse does not come to a conclusion without adequate data to support the conclusion.

4. Involves collecting additional information to support the initial data.

- If a client's pulse is increased above the expected range, the nurse should take the pulse again; if it is still increased, the nurse should collect other vital signs to supplement the original information.
- If a client says, "I feel that I am in a big, black hole," the nurse might use the communication technique of clarification to have the client explain in more detail what was meant: "Tell me more about this big, black hole that you feel you are in."

E. Communicating collected data

1. Outcomes of nursing assessments must be documented on correct forms and in appropriate places in the client's clinical record. Many forms are used to document data and are organized by topic or body systems.

2. Communicating data ensures that pertinent and current information relative to the client is shared with other members of the health team.

3. Data must be communicated in an objective and factual way and not be a summary of the nurse's interpretation of the data.

4. Value words, such as good, bad, adequate, poor, and tolerated well,should be avoided. For example, rather than saying that a client's appetite is poor, the nurse should document that the client ate half of a scrambled egg and a slice of toast. This manner of documentation communicates objective, measurable information about the client's appetite.

5. Value words related to a client's behavior, such as lazy, difficult, stubborn, rude, uncooperative,and foolish,should be avoided. These words reflect a value judgment made by the nurse that may be influenced by bias and personal values or beliefs. Nurses must always be nonjudgmental.

6. Subjective data should be documented in the exact words expressed by the client and put in quotation marks; this practice ensures that a client's meaning is not misinterpreted or inaccurately altered by words used by the nurse to describe an event.

IV. ANALYSIS

Analysis, the second step of the nursing process, requires the nurse to use critical thinking strategies to scrutinize data. Activities associated with this step include clustering data, interpreting data, and identifying and communicating a client's nursing diagnoses, problems, or needs.

A. Clustering data

1. Involves grouping information into related categories, a beginning effort to organize and manage information.

2. Data can be clustered into general categories, such as physiological, sociocultural, psychological, and spiritual. Then each category may be further reduced into specific categories, such as nutrition, mobility, elimination, and oxygenation.

3. Data can be easy or difficult to cluster depending on the amount and variety of data collected.

4. Easy-to-cluster information commonly involves only one body system. For example, a client reports feeling low abdominal pressure, has not voided in 8 hours, and has abdominal distention on palpation of the suprapubic area; these clinical indicators all relate to urinary elimination and lead to the interpretation that the client may have urinary retention.

5. Difficult-to-cluster information may at first seem unrelated because a variety of body systems are involved. For example, a client has a weak, thready pulse; decreased blood pressure; rapid respirations; pallor; and clammy skin; these clinical indicators cross body systems, but all are related to hypovolemic shock.

6. Inductive reasoning moves from the specific to the general. For example, if you identify that a client has a temperature and a wound with purulent drainage, you may come to the conclusion that the wound is infected.

7. Deductive reasoning moves from the general to the specific. For example, if you know that a newly admitted client has a wound infection, you might deduce that the client will have a temperature, purulent drainage, and a culture and sensitivity laboratory result identifying the causative agent.

8. Data must be clustered before it can be interpreted.

9. Established frameworks are available to provide structure for organizing clustered data. a. Abraham Maslow's hierarchy of human needs. b. Marjory Gordon's functional health patterns. c. NANDA International (formerly the North American Nursing Diagnosis Association) nursing diagnosis taxonomy.

10. Most health-care agencies have their own admission assessment forms, which commonly follow a systems approach to collecting and clustering data.

B. Interpreting data

1. Interpreting data requires identifying the significance of clustered data.

2. Determining significance requires a comparison of data collected with a wide range of standards and norms (e.g., expected vital signs and laboratory values, growth and development patterns and milestones, and cause-and-effect relationships). The nurse must then come to a conclusion about a specific identified pattern. It also involves querying evidence, exploring alternatives, and drawing initial conclusions.

3. Conclusions are drawn after the significance of data is determined. Conclusions are the opinions, perceptions, judgments, and inferences that result from the interpretation of data.

4. More data may be necessary to support an initial conclusion, thereby increasing validity and reliability.

- When a client has an increased blood pressure, pulse, and respiratory rate and is rubbing a shoulder, the nurse makes an inference that the client is experiencing pain. To validate this conclusion, the nurse asks, "I noticed that you are rubbing your shoulder. Is it causing you discomfort?"
- If a client says, "I feel as though my bladder will burst," the nurse makes the inference that the client might be experiencing urinary retention. To validate this, the nurse should palpate the client's abdomen for distention. The nurse also can ask questions that clarify the client's statement.

5. Nurses should ask the following questions after arriving at conclusions.

- "Did I miss anything?"
- "What else do I need to know?"
- "Has the client's condition or situation changed since I initially assessed the client?"
- "Are there any inconsistent or conflicting data that require clarification?"
- "Is my data cluster complete, or do I need to collect additional data to better support my conclusion?"

C. Identifying nursing diagnoses

1. Introduction to nursing diagnoses.

- Nursing diagnoses are statements of specific health problems that nurses are legally allowed to independently identify, prevent, and treat.
- They convert an initial conclusion into a diagnostic statement.

- They logically link the assessment step to the planning, implementation, and evaluation steps of the nursing process.
- NANDA International provides a taxonomy of diagnostic labels and etiologies.
- Each nursing diagnosis in the taxonomy follows the same organization for the presentation of information.
    - Diagnostic label (title or name): A word or phrase that is based on a pattern of interconnected data. For example, Impaired skin integrity.
    - Definition: Explains the meaning of the diagnostic label, which differentiates it from similar nursing diagnoses. For example, Altered epidermis and/or dermis.
    - Defining characteristics: Identifies clinical indicators (signs and symptoms) that support the diagnostic label. For example, Invasion of body structures, destruction of skin layers (dermis), disruption of skin surface (epidermis).
    - “Related to” factors: Situations, events, or conditions that precede, cause, affect, or are in some way associated with the diagnostic label. For example, Related to physical immobilization.The list of related factors in the taxonomy is not all-inclusive because it is impossible to list all possible factors.

D. Communicating client nursing diagnoses, problems, or needs

1. Nurses communicate client nursing diagnoses, problems, or needs in a written plan of care.

2. The plan of care may be kept in a variety of places (e.g., client’s clinical record, the medication administration record, and interdisciplinary clinical pathways).

V. PLANNING

Planning, the third step of the nursing process, provides direction for nursing interventions. It is concerned with identifying priorities, establishing goals and expected outcomes, and selecting nursing interventions that will help the client achieve those goals and expected outcomes. Planning begins when a client is admitted and is ongoing to meet the changing or emerging needs of the client. Effective planning includes collaboration with all appropriate health team members to facilitate continuity of care in a client-centered, individualized, and coordinated manner. Planning culminates in a document about the proposed plan of care that is communicated to all members of the health team.

A. Identifying priorities

1. A priority is something ranked highest in terms of importance or urgency.

2. A nurse must place a client’s nursing diagnoses, problems, and needs in order of importance when confronted with a variety of client issues.

3. A nurse must have a strong foundation of scientific theory, knowledge of the commonalities and differences in response to nursing interventions, and theories to determine the priority of a client’s needs.

4. Factors that promote the prioritization of care.

- Maslow’s hierarchy of needs.
    - Needs are placed in order from the most basic needs to the highest-level needs.
    - Physiological is the first-level need, followed by safety and security, love and belonging, self-esteem, and self-actualization.

- Urgency of the health problem.
    - Ranks problems based on the degree of threat to the client’s life. The nurse can use the ABCs of assessment (Airway, Breathing, Circulation) when determining priorities.
    - A high-priority problem poses the greatest threat and should be addressed first (e.g., an impaired airway).
    - A medium-priority problem follows a high-priority problem. It may be related to harmful physiological responses that are not an immediate threat to life (e.g., impaired mobility).
    - A low-priority problem should pose the least threat and be ranked last. It may require minimal support (e.g., nausea).
- Client’s priorities.
    - Ranks client needs based on what is most important to the client.
    - Although a client’s preference should always be taken into consideration, basic life-threatening needs require urgent interventions and override less important needs.
- Future impact of the client’s condition.
    - Although a problem might not be life threatening and is not recognized by the client as important, the nurse may determine that it can cause future negative consequences if not addressed.
    - For example, a nurse identifies that a client newly diagnosed with type 1 diabetes has dirty feet and is wearing sandals instead of shoes that enclose the feet. The nurse knows that people with diabetes are at risk for foot problems secondary to impaired circulation to the lower extremities. Therefore, the client has a potential for skin breakdown, which can lead to infection and even amputation. The nurse ranks this issue as a priority and plans interventions to educate the client about foot care.

B. Identifying goals and expected outcomes

1. Basic concepts.

- A goal is a broad statement about the status one expects a client to achieve.
- A goal generally is derived from the “diagnostic label” component of a nursing diagnosis. For example, if a client has the nursing diagnosis Ineffective airway clearance related to excessive respiratory secretions, the goal might be: “The client will maintain a patent airway.”
- An outcome identifies a specific change in a client’s condition as a result of nursing interventions. It is commonly influenced by the “related to” component of a nursing diagnosis. Also, it provides criteria to be used in the evaluation phase of the nursing process. For example, the outcome statement using the previously stated goal (“The client will maintain a patent airway”) might be: “The client will expectorate respiratory secretions while hospitalized”.
- Clients and nurses together should set goals and outcomes to ensure that these goals and outcomes are realistic, achievable, and in alignment with what the client and nurse want to achieve.

2. Criteria for goals and outcomes.

- Be client centered.
  - The client is the center of the health team; therefore, the client should be the subject of all goals and outcomes.
  - For example, “The client will transfer from the bed to a chair safely within 1 week.” Some agencies believe that the words the client are understood and therefore do not include them when stating a goal.
- Contain an action verb.
  - The goal or outcome should identify the action that the client will learn, do, or express or the physical status the client will attain.
  - For example, “The client will transfer from the bed to chair safely within 1 week.”
- Include performance criteria.
  - Actions must be specific and measurable. For example, “The client will transfer from the bed to chair safely within 1 week.”
  - Conditions may be included to describe the kind of assistance or resources needed by the client. For example, “The client will transfer from the bed to chair safely with a one-person assist within 1 week.”
- Include a time frame.
  - The goal must be achievable within a set time frame.
  - For example, “The client will transfer from the bed to chair safely within 1 week.” Additional examples of time frames include by discharge, within 24 hours, at all times, and will maintain(the word maintain implies continuously).
- Be realistic.
  - The performance criteria identified must be reasonable and feasible in light of the client’s emotional and physical status.
  - Goals are realistic when the outcomes can be achieved in the indicated time frames.
  - Example of a realistic outcome for a client who had abdominal surgery is: “The client will exhibit bowel sounds within 3 days after surgery.”
  - Example of an unrealistic outcome for a client with hemiplegia due to a brain attack is: “The client will perform active range-of-motion exercises independently within 1 week.”

C. Identifying nursing interventions

1. Selecting appropriate interventions depends on the accuracy and thoroughness of the data collected.

2. Nursing interventions generally address the “related to” part (etiology) of the client’s problem or nursing diagnosis. For example, if a person is at risk for impaired skin integrity related to urinary incontinence and immobility, the nursing interventions selected should keep the client clean and dry and relieve pressure.

3. Nursing interventions should include nursing assessments, nursing care to avoid complications, administration of prescribed treatments and medications, and health promotion and illness prevention activities, as appropriate.

4. Selected actions should have the greatest probability of achieving the desired goal/outcome with the least risk to the client. The nurse must consider:

- Cause: Planned action.
- Effect: Client's response.
- Risk: Potential for the client to have a negative consequence as a result of the planned action.
- Probability: Degree to which the client may have a positive consequence as a result of the planned action.
- Value of the consequences: Significance of results of the planned action to the client.

5. Selected interventions should be based on evidence-based practice—that is, interventions that have been proven to be effective based on rigorous scientific evidence and clinical effectiveness studies rather than on tradition, intuition, or anecdotal information. Nursing practice based on evidence improves the quality of client care and justifies nursing interventions.

D. Communicating the plan of care

1. Plans of care promote communication and coordination among health team members, improving the continuity of client care.

2. Information that should be included on a comprehensive plan of care includes:

- Client nursing diagnoses, problems, or needs and related independent and dependent nursing interventions.
- Activities of daily living (ADLs) and basic needs.
- Medical prescriptions and the nursing interventions required to implement them.
- Requirements to prepare the client for discharge, such as teaching, equipment, and services.

3. Various types of care plans are used.

- Computer-generated care plans can be standardized or individualized. The nurse chooses a nursing diagnosis or health problem, and the computer presents potential goals/outcomes and nursing interventions. The nurse can then select interventions that are appropriate for the client. The computer then generates a written printout of the plan of care.
- Multidisciplinary care plans (collaborative care plans, critical or clinical pathways) sequence care that is to be delivered each day during a client's length of stay. Each day has a column and vertical boxes that address specific care that is to be delivered by each health-care discipline.

E. Modifying the plan of care

1. Plans of care are dynamic and require modification to keep them current and relevant.

2. The original plan of care may require changes because the original plan was inadequate or inappropriate or because additional assessments provide new information.

3. A plan of care may require modification after the evaluation step of the nursing process when it

is identified that the client did not achieve an expected outcome or because the client's status improved.

VI. IMPLEMENTATION

Implementation, the fourth step of the nursing process, is the actual performance of nursing actions. It is the execution of the plan of care and involves thinking and doing. Therefore, nurses must have not only a strong knowledge base of the sciences, nursing theory, nursing practice, and legal parameters of nursing interventions but also the psychomotor skills to implement procedures safely. Nurses must implement only nursing actions that are described in their state's nurse practice act and conform to professional nursing standards of care.

A. Legal parameters of nursing interventions

1. A nurse must know the legal parameters of nursing interventions, which include:

a. Dependent nursing interventions.

- Require a prescription from a primary health-care professional with prescriptive privileges (e.g., physicians, podiatrists, dentists, physician's assistants, nurse practitioners).
- Nurses must ensure that prescribed interventions and medications are appropriate to meet the needs of a client. If a nurse implements an inappropriate intervention or prescription, the nurse can be held legally accountable as a contributor to the initial error made by the primary healthcare provider. Nurses must question inappropriate prescribed interventions or prescriptions and not follow them blindly.
- Examples of dependent nursing interventions include:
    - Administering medications or intravenous solutions.
    - Implementing activity prescriptions.
    - Inserting or removing a urinary retention catheter.
    - Providing a diet.
    - Implementing wound or bladder irrigations.

b. Independent nursing interventions:

- Registered nurses can legally plan and implement independent nursing interventions without supervision or direction from a person with a prescriptive license.
- Each state's nurse practice act defines the scope of nursing practice within the state.
- Examples of independent nursing interventions include:
    - Assessing a client.
    - Diagnosing a client's nursing needs.
    - Planning, implementing, and evaluating nursing care.
    - Assisting with ADLs.
    - Teaching any subject associated with health promotion and illness prevention.
    - Counseling.
    - Advocating for a client.
    - Encouraging a client to express concerns and feelings.
    - Encouraging coughing and deep breathing.
    - Referring a client to community resources.

c. Interdependent nursing interventions:

- Nurses work in collaboration with primary health-care providers to implement dependent nursing interventions that have set parameters.
- Some settings, such as intensive care units and birthing units, have standing protocols that delineate the parameters within which the nurse can implement a dependent nursing intervention.
- Examples of interdependent nursing interventions include:
    - A prescription says, “Out of bed as tolerated.” The nurse determines whether the client is tolerating an activity and therefore the amount of activity in which to engage the client.
    - A prescription for a pain medication states, “acetaminophen (Tylenol) 650 mg every 6 hours prn for mild lower back pain.” The nurse assesses the level of the client’s pain and then decides whether to administer the prescribed dose.

B. Types of nursing interventions:

1. Assisting with ADLs.

- Nurses assist clients with activities that people perform daily to promote comfort, health, and well-being.
- Problems interfering with these actions can be acute or chronic, temporary, or permanent, and require teaching or assistance to restore function.
- Examples include helping a debilitated client eat, ambulating a client after surgery, providing range-of-motion exercises, turning, and positioning a bed-bound client, and dressing and toileting a client.

2. Teaching.

- Nurses provide teaching in relation to the cognitive, psychomotor, and affective domains.
- Examples include conducting a class about the signs and symptoms of hyperglycemia (cognitive domain), teaching a client how to self-administer insulin (psychomotor domain), and facilitating a group session of adolescents discussing and role-playing how to say no when pressured to engage in alcohol or drug misuse (affective domain).

3. Responding to life-threatening events.

- Nurses use clinical judgment to identify and respond to life-threatening changes in a client’s condition.
- The related interventions generally are associated with meeting a client’s basic physiological needs.
- Examples include performing abdominal thrusts for a client who is choking, implementing cardiopulmonary resuscitation for a client who has no palpable pulse and is not breathing, and discontinuing a blood transfusion when a client has clinical indicators of a transfusion reaction.

4. Implementing health promotion and illness prevention activities.

- Nurses provide interventions that assist people to maintain health and avoid health

problems.
- They aim to help people who are at an increased risk for illness because of their developmental level, such as neonates, young children, and dependent older adults. In addition, they help people who are at an increased risk for negative consequences of their behaviors, such as people who smoke, drink alcohol excessively, misuse drugs, have multiple sexual partners, or overeat. They also aim to help people limit exacerbations of illnesses and subsequent health problems as a result of an initial illness.
- Examples include administering a vaccine, teaching a class about healthy nutrition, promoting smoking cessation or weight reduction, using standard precautions, and turning and positioning an immobile client.

5. Performing technical skills.

- Nurses must competently perform technical psychomotor skills associated with a procedure.
- The nurse should know the steps, principles, rationales, and expected outcomes relative to nursing procedures to implement them in the appropriate situation safely.
- Examples include administering medications via various routes, suctioning a client's respiratory tract, changing a wound dressing, and irrigating a colostomy.

6. Employing psych sociocultural interventions.

- Nurses use therapeutic interviewing techniques to encourage clients to express feelings and concerns. Once the nurse identifies a client's emotional needs, the nurse continues to support the client emotionally while exploring potential coping strategies. In addition, the nurse uses interpersonal interventions when working as an advocate for the client, coordinating health-care activities, and collaborating with others on the client's behalf.
- Examples include using nondirective interviewing techniques, gently addressing a client's behavior, collaborating with a client to identify a goal, and explaining to family members that their loved one's angry behavior is associated with the anger stage of grieving in response to the diagnosis of cancer.

7. Delegating, supervising, and evaluating delegated nursing interventions.

- Delegation is transferring the authority to act to another while retaining accountability for the outcome.
- Nurses may delegate nursing care to:
    - **Unlicensed assistive nursing personnel:**
        - Uncomplicated, basic interventions.
        - Examples: Bathing a bed-bound client, ambulating a stable postoperative client, obtaining vital signs from clients who are stable.
    - **Licensed practical nurse (LPN):**
        - Routine nursing care for clients who are stable and whose care is uncomplicated.
        - Examples: Administering medications, changing a sterile dressing, instilling an enema.
    - **Registered nurse:**
        - Complex nursing interventions.
        - Examples: Performing a physical assessment, teaching a client how to self-

administer insulin, formulating a client's plan of care.

The nurse delegating care is responsible for:

- Assuming responsibility for the care that is delegated and its consequences.
- Ensuring that the person implementing the care is legally permitted to provide the delegated care, is knowledgeable, and can deliver the care safely.
- Ensuring that the care is implemented according to standards of care.
- Evaluating the client's responses to the interventions implemented.

8. Reporting and documenting nursing interventions and client responses:

- Nurses communicate information verbally and in writing to other members of the health team to provide continuity of client care. Written documentation also establishes a permanent legal record of the care provided and the client's response.
- Examples include documenting vital signs on a client's graphic record, indicating the characteristics of a client's skin integrity on a pressure ulcer flow sheet, providing a verbal report regarding the status of clients to a nurse arriving for the next shift, and documenting the administration of medications and client responses to medications.
- If interventions are not documented, they are considered not done.

VII. EVALUATION

Evaluation, the fifth step of the nurse process, involves issues related to structure, process, and client outcomes. The nurse first reassesses the client to identify client responses to interventions (actual outcomes) and then compares the actual outcomes with the planned outcomes (expected outcomes) to determine goal achievement. It is a continuous process that requires the plan of care to be modified as often as necessary either during or after care.

A. Components of evaluation

1. Structure.

- Associated with the setting and effect of organizational features on the quality or excellence of nursing care.
- Based on such things as policy and procedures, economic resources, available equipment, and the number, credentials, and experiential background of members of the nursing team.
- Example of a structure goal against which the delivery of nursing care can be assessed: A controller pump is used for administration of intravenous medication.

2. Process.

- Associated with evaluation of clinical performance of nursing team members.
- Example of a process goal against which the care delivered by a nurse can be assessed: The client's privacy is maintained by pulling the curtain and draping the client when assessing a client's wound.

3. Client outcome.

- Associated with measurable changes in a client's status as a result of care implemented by a nurse.
- Example of an expected client outcome against which an actual client outcome can be assessed: The client's skin will remain clean, dry, and intact.

B. Types of evaluation activities

1. Routine evaluations.

- Occur at preset regular time frames.
- For example, obtaining clients' vital signs every shift; documenting intake and output every shift and every 24 hours.

2. Ongoing evaluations.

- Occur during and immediately after administering nursing care or after interacting with a client.
- For example, assessing a client's response to irrigation of a colostomy; determining whether a client understands the content in a teaching session.

3. Intermittent evaluations. a. Occur in specific situations. b. For example, obtaining daily weights to monitor a client receiving a diuretic; assessing the degree of pain relief after a client receives an analgesic.

4. Terminal evaluations.

- Occur in preparation for a client's discharge; health-care agencies generally have a comprehensive discharge form that provides structure and consistency within an agency.
- For example, evaluating a client's physical and emotional status; determining progress toward goal/outcome achievement; and formulating a plan of care to be implemented in the community setting, including topics such as medications, treatments, diet, and scheduled follow-up care.

C. Nursing interventions to ensure thorough evaluation of client responses to nursing care

1. Reassess the client to identify actual outcomes (client responses).

- The nurse must reassess the client to collect data, organize the data, and determine the significance of the data.
- Actual outcomes are then compared to the expected outcomes identified in the written plan of care to determine whether the client successfully achieved the goals/outcomes.

2. Compare an actual outcome with an expected outcome to determine goal achievement.

- If they are the same, then the nurse can infer that the nursing care was effective in assisting the client to achieve the expected outcome. In other words, a positive evaluation is indicated when an actual outcome meets the expected outcome.

- If they are not the same, then the nurse can infer that the nursing care was not effective in assisting the client to achieve the expected outcome. In other words, a negative evaluation is indicated when an actual outcome does not meet the expected outcome.
- Once it is determined that the expected outcome was not achieved, the nurse must analyze factors that may have affected the actual outcomes of care.

3. Analyze factors that may have influenced nonachievement of expected goals/outcomes.

- Each step of the nursing process must be examined to determine what contributed to the failure to achieve expected goals/outcomes. For example, the nurse must ask important questions such as:
    - Was the data cluster thorough and accurate?
    - Was the nursing diagnosis, problem, or need identified correctly?
    - Was the goal realistic and attainable?
    - Were the expected outcomes specific and measurable?
    - Did the planned interventions address all the etiological factors of the problem?
    - Were the nursing interventions consistently implemented as planned?
- The specific reason for not achieving a goal/ expected outcome should be identified. A variety of reasons may have influenced the nonachievement of a goal/expected outcome. For example, the client might not have shared important information, the staff might not have completed all tasks as planned, the client might not have been motivated to participate adequately in the planned care, or the client's condition may have changed.

D. Modifying the plan of care

1. Plans of care are dynamic and require modification to keep them current and relevant.

2. The plan of care must be modified as soon as a nurse identifies that a plan of care is ineffective.

3. The plan will have to be modified when an expected goal/outcome is met. Goals and expected outcomes advance to address evolving needs as the client moves toward health on the health-illness continuum.

4. Once a new plan of care is implemented, the step of evaluation beings again.