EVALUATION- A KEY FOR EFFECTIVE NURSING CARE

INTRODUCTION

Evaluation is the 5th and final phase of the nursing process. Evaluate is to judge or to appraise. Evaluation is an important aspect of the nursing Process because conclusions drawn from the evaluation determine whether the nursing interventions should be terminated, continued or changed. It is evaluating the patients response to the care delivered to make sure the desired outcomes developed in the planning step and documented in the plan of care.

Evaluation step of the nursing process measures the client’s response to nursing actions and client’s progress towards achieving goals.

DEFINITION

- Evaluation is a planned, ongoing, purposeful activity in which clients and health care professionals determine the client’s progress toward achievement of goals and outcomes and effectiveness of the nursing care plan.
- Evaluation is step of nursing process measure the client’s response to nursing actions and the client progress towards achieving goal or expected outcome.

PURPOSES OF EVALUATION

- It helps to examine the client behavioural response to nursing interventions.
It provides a basis for the revision of the nursing plan of care.

Monitor the effectiveness of nursing care on client health

Evaluation is essential for sound decision making

It clarifies the aims of nursing care

Evaluation provides opportunity to practice critical thinking, the application of scientific principles and making clinical judgment.

Evaluation is continuous. Evaluation is done while or immediately after implementing a nursing order, enables the nurse to make on the spot modifications in an intervention.

Evaluation performed at specified intervals shows the extent of progress toward goal achievement and enables the nurse to correct any deficiencies and modify the care plan as needed.

Evaluation continues until the client achieves the health goals or is discharged from nursing care.

Through evaluating, nurses demonstrate responsibility and accountability for their actions, indicate interest in the results of nursing activities, and demonstrate a desire not to perpetuate ineffective actions, but to adopt more effective ones

Critical evaluation - the key to excellence in health care delivery

Critical evaluation is the careful, deliberate and detailed evaluation of various aspects of patient care is the key to excellence in health care delivery. It can make the difference between care practices that are doomed to repeat errors and care practices that are progressive, and constantly improving.

PROCESS OF EVALUATING CLIENT RESPONSES

Before evaluation, the nurse identifies the desired outcomes that will be used to measure client goal achievement.
The evaluation process has five components

- Collecting data related to the desired outcomes
- Comparing the data with outcomes
- Relating nursing activities to outcomes
- Drawing conclusions about problem status
- Continuing, modifying, or terminating the nursing care plan

EVALUATIVE PROCESS

1. COLLECTING DATA RELATED TO THE DESIRED OUTCOMES

- It is clearly stated, precise and measurable
- Nurse collects data so that conclusions can be drawn whether goals have been met
- Some data require interpretation.
- Data is of 2 types, subjective data and objective data
Data must be recorded concisely and accurately to facilitate next part of the evaluating process.

The sequence of critically evaluating and revising therapies continues until problems are appropriately resolved. Frequent evaluation is required as the client’s health status is continuously changing. Priority diagnoses are evaluated first.

E.g. evaluate client’s acute pain before evaluating the status of deficient knowledge.

Sufficient data is collected to evaluate client’s progress towards expected outcome.

- The primary source of data for evaluation is the client
- Use the family and care givers
- Nursing progress notes, charts
- Change of shift reports

These data should communicate a client’s progress towards meeting expected outcomes\goal. The intent of evaluation is to determine if the nursing interventions have been effective minimizing or resolving the problems.

**Steps for evaluating outcome achievement**

1. Determine current health status and readiness to test for outcome achievement
2. List the outcomes set forth in planning
   
   Example-Will walk unassisted the length of hall by 7/3
3. Compare what the person is able to do in relation to the outcomes
   
   Example – can walk unassisted the length of hall, but becomes unsteady toward the end of the hall
4. Decide the extent of outcome achievement by asking the following questions
   ✓ Have the outcomes been completely met? Have the outcomes been partially met?
   ✓ Have the outcomes not at all been met?
   ✓ Record your findings on the patient or client record like progress notes, plan of care?

**Identifying variables affecting outcome achievement**

Identifying the variables affecting outcome achievement requires analyzing information gained from assessing the patient and chart. You need to answer the following questions

✓ Were the outcomes and interventions realistic and appropriate for this individual?
✓ Were the interventions implanted consistently as prescribed?
✓ Were new problems or adverse responses detected early, and were appropriate changes made?
✓ What is the persons opinion concerning outcome achievement and the plan of care?
✓ What factors impeded progress?
✓ What factors enhanced progress?

   Was the literature searched for applicable research and practice articles?

**2. COMPARING DATA WITH OUTCOMES**

After collecting data nurse get a clear picture about nursing intervention which she follows. The data collected during evaluation are critically analyzed and compared with expected outcomes to determine
whether changes occurred. Compare the client responses with outcome criteria to determine whether predicted changes have occurred.

To evaluate the degree of success in achieving the goal following steps should be followed.

 ✓ Identify the exact desired client behaviour or responses
 ✓ Assess the client for the presence of the behaviour or response
 ✓ Compare with established outcome criteria and behaviour or response assesses what are the barriers or enhancers.

After determining whether a goal has been met, the nurse writes an evaluative statement. There are 3 possible judgements can be made.

❖ The goal is completely met
❖ The goal is partially met
❖ The goal is not met.

3. RELATING NURSING ACTIVITIES TO OUTCOMES

Determining nursing activities had any relation to the outcomes. Assume that a nursing activity was the cause factor in meeting, partially meeting, or not meeting.

One purpose of nursing care is to assist the client in minimizing or resolving actual health problems, preventing occurrence of potential problems and promoting the maintenance of health state.

E.g. During initial assessment, a client may report acute abdominal pain (rate at 8/10) and grimace or hold the abdomen during the attempts to move in bed. This data is used to support the nursing diagnosis of acute pain and established the goal. The goal established is client will have reduced pain within 48 hours.

Evaluation determines if the outcomes that reflect goal accomplishment were met.
Did the interventions of positioning, proper and timely administration of analgesics and use of relaxation successfully reduce the client's pain.

Outcome established is client will verbalize pain at 3/10 and client will position self within nonverbal signs of discomfort.

After providing appropriate comfort measure, evaluate the client by measuring the subject report of pain, observe facial expressions and note if the client initiates turning and repositioning.

Compare the client’s responses with outcome to determine whether the predicted changes occurred.

4. DRAWING CONCLUSIONS ABOUT PROBLEM STATUS

The nurse uses the judgments about goal achievement to determine whether the care plan was effective in resolving, reducing, and preventing client problems.

When goals have been met, the nurse can draw one of the following conclusions about the statement of the client’s problem:

- The actual problem stated in the nursing diagnosis has been resolved, or the potential problem is being prevented and the risk factors no longer exist.

- The potential problem stated in the nursing diagnosis is being prevented, but the risk factors are still present.

- The actual problem still exists even though some goals are being met.

When goals have been partially met or when goals have not been met, two conclusions may be drawn:

- The care plan need to be revised, since the problem is only partially resolved.
The revisions may need to occur during assessing, diagnosing, or planning phases as well as implementing

Or

The care plan does not need revision, because the client merely needs more time to achieve the previously established goals.

5. CONTINUING, MODIFYING, AND TERMINATING THE NURSING CARE PLAN

After drawing conclusions about the status of the client’s problems, the nurse modifies the care plan as indicated. Before making modifications, the nurse determines if the plan as a whole was not completely effective. This requires review of the entire care plan and critique of each step of the nursing process involved in its development.

- **Continue the plan**- Unmet and partially met goals require you to reactivate the nursing process sequence. After you reassess the client, nursing diagnoses may be modified or added with appropriate goals, expected outcomes and interventions established.

- **Modify the plan**- When goals are not met, identify the factors that interfered with goal achievement. Usually a change in the client’s condition, needs or abilities makes alteration of the care plan necessary. When outcomes have not been achieved, when you identify new problems or risk factors, or when you identify ways to make care more effective.

- **Terminate the plan**- If a goal was successfully met, that portion of the care plan is considered resolved. If the person has achieved outcomes, has no a new problem or risk factors and demonstrates ability to care for herself

   **Steps for terminating the plan of care**
• Determine how health care will be managed at home
• Give verbal and written instructions for
  ✓ Treatments, medications, activities, diet
  ✓ What signs and symptoms must be reported
  ✓ How to reach relevant community resources
• Once you have taught the patient and significant others the above information, ask them to repeat the information, using the written instructions, if necessary
• If the patient and significant others demonstrate knowledge of how to manage health care at home, discharge the patient according to facility policy.

**Evaluation of the data determines**

✓ The appropriateness of the nursing actions
✓ The need to revise the interventions
✓ The development of new patient problem/needs
✓ The need for referral to other resources
✓ The need to rearrange priorities to meet the changing demands of care
✓ Direct observation
✓ Patient interview
✓ Review of records

**Evaluation measures to determine the success of goals and expected outcome**

**Eg.**

<table>
<thead>
<tr>
<th>Goals</th>
<th>Evaluation measures</th>
<th>Expected outcome</th>
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</table>
| Clients pressure ulcer will demonstrate healing within 7 days | - Inspect color, condition, and location of pressure ulcer  
- Measure diameter of ulcer                          | - Erythema will be reduced in 2 days                    |
<p>|                                                    |                                                          | - Diameter of ulcer will               |</p>
<table>
<thead>
<tr>
<th>Client will tolerate ambulation</th>
<th>ulcer daily</th>
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<tbody>
<tr>
<td>▪ Note odour and colour of drainage from ulcer</td>
<td>decrease in 5 days</td>
</tr>
<tr>
<td>▪ Palpate clients radial pulse before exercise</td>
<td>-Skin overlying ulcer will begin to close in 7 days</td>
</tr>
<tr>
<td>▪ Palpate clients radial pulse 10 minutes after exercise</td>
<td>-Pulse will remain below 110 beats per minute during exercise</td>
</tr>
<tr>
<td>▪ Assess respiratory rate during exercise</td>
<td>-Pulse rate will return to resting baseline within 10 minutes after exercise</td>
</tr>
<tr>
<td>▪ Observe client for dyspnoea or breathlessness during exercise</td>
<td>-Respiratory rate will remain within 2 breaths of clients baseline rate</td>
</tr>
<tr>
<td></td>
<td>-Client will deny feeling of breathlessness</td>
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**Modified nursing care plan following implementation and evaluation**

**Nursing diagnosis**

Ineffective airway clearance related to viscous secretions and shallow chest expansion.

**Desired outcomes**

- Absence of pallor and cyanosis (skin and mucous membranes)
- Use of correct breathing and coughing technique after instruction
- Productive cough
- Symmetric chest excursion of at least 4 cm
- Lungs clear to auscultation within 48-72 hours
- Respirations 12-22/min pulse<100 beats/min
- Inhaling normal volume of air on incentive Spirometer

**Evaluative statements**

- Partially met. Skin and mucous membranes are not cyanotic, but still pale.
- Partially met. Uses correct technique when pain well controlled by narcotic analgesics
- Not met. Chest excursion is 3cm.
- Not met. Scattered inspiratory crackles auscultated throughout right anterior and posterior chest.
- Partially met. Respirations 26/ min, pulse 96/min
- Not met. Tidal volume only 350ml

**Nursing interventions**
- Monitor respiratory status, 4th hourly- rate, depth, effort, skin colour, mucous membranes, amount and colour of sputum.
- Monitor results of gases, chest x-ray studies, pulseoximetry, and incentive Spirometer volume
- Monitor level of consciousness
- Auscultate lungs 4th hourly
- Assist with postural drainage as prescribed
- Assist with postural drainage daily
- Administer prescribed antibiotics

**Continue or modify the care plan**
Retain nursing interventions to continue to identify progress. Goal status indicates problem not resolved.
- Does not need to be reinstructed as client demonstrated correct techniques. May still need support and encouragement because of fatigue and difficulty in breathing

**SUMMARY**
Critical evaluation is the careful, deliberate, and detailed evaluation of various aspects of patient care is the key to effective nursing care.
Evaluation in the context of nursing process usually refers to determining the effectiveness of an individual plan of care

Reference:

- Marilynn E Doenges,, Mary Frances Moorhouse, Joseph T Burly. Application of Nursing practice and nursing Diagnosis, An integrative text for Diagnosis Reasoning, 2nd edition, Jaypee Brothers; New Delhi, pg no.109-149
- Patricia A Potter, Anne Griffin Perry. Fundamentals of Nursing, 7th ed, Mosby; Missouri, 2009, pg no.291-298