Implementation-The essence of Nursing Process

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Implementation is the component of nursing process in which the actions necessary for achieving the goals and expected outcomes of nursing care are initiated and completed. At this point of nursing process, we are ready to perform the interventions and activities recorded in the patient’s plan of care.

A nursing intervention is any treatment, based on clinical judgement and knowledge, that a nurse performs to enhance patient outcomes. It is the action taken by the nurse to help the client move from a present health status to the health status described in the expected outcomes (Gordon 1994).

Implementation process includes performing, assisting or directing the performance of activities of daily living, counseling and teaching the client or family, giving direct care to achieve client centered goals, supervising and evaluating the work of staff members and recording and exchanging the information relevant to the client’s continued health care. It is continuous and interactive with the other components of nursing process. During this phase, the nurse reassess the client, modifies the care plan and rewrites expected outcomes as necessary. For effective implementation, the nurse must be knowledgeable about types of interventions, the implementation process and specific implementation methods.

Implementation of nurse initiated, physician initiated and collaborative interventions require critical nursing judgement and decision making. When encountering physician initiated or collaborative interventions, the nurse does not automatically implement the therapy, but must determine whether it is appropriate for the client. When choosing an intervention, the nurse must consider the following:

Characteristics of nursing diagnosis

Expected outcomes
Research base for the interventions

Feasibility of the intervention

Acceptability to the client

Competency of the nurse

To achieve this the nurse also reviews standardized care plans, policy or procedure manuals, text books, nursing and related health care literature and collaborates with other health care professionals. The nurse reviews the client needs, priorities and previous experiences to select nursing interventions that have the best potential for achieving the expected outcomes.

**Implementation Process**

Implementation process has six steps.

**a. Setting daily priorities**

- Make initial quick rounds on your patients. This helps you to identify problems requiring immediate attention.
- Immediately after shift report, verify critical information such as intra venous infusions, operation of equipments etc.
- Identify urgent problems (Those posing significant immediate threat to the patient eg. chest pain)
- List the nursing diagnoses and ask the following questions:
  - What problems must be resolved today and what happens if I wait until later?
  - What are the problems that I must monitor today and what could happen if I don’t monitor them?
- Determine the interventions that must be done to prevent, resolve or control the problems listed. List these interventions along with routine tasks. This helps you to get a picture of the tasks of the day. For eg. You may routine bath to promote hygiene and at the same time, discuss problem with coping.
- Make a detailed personal work sheet for getting things done for the day and refer to it frequently.
b. Reassessing the client

Assessment is a continuous process. Each time a nurse interacts with a client, additional data are gathered. When new data are obtained and a new need is identified, the nurse modifies the care. Assessing patient status before interventions and then reassessing to monitor the response provide key information about the appropriateness of the plan of care: How is the patient responding? Are you able to achieve the expected outcomes? If not, why not? Do you need to make changes in the plan? Monitor the patient continuously to collect additional data. As you talk to the patient, note changes in the tone of voice and expression. For example when providing a back rub, be aware of such abnormalities as a reddened area on the coccyx. All of these data to be noted and this information will be used to make decisions regarding the need for new diagnoses, goals, interventions and reprioritizing the plan of care during the evaluation process.

c. Reviewing and modifying the existing care plan

Although the nursing care plan was developed according to the nursing diagnoses identified during assessment, changes in the client’s status can necessitate modification of planned nursing care. Before beginning care, the nurse reviews the care plan and compares it with assessment data to validate the stated nursing diagnoses and determine whether the interventions are the most appropriate for the clinical situation. If the client’s status has changed and the nursing diagnoses and related interventions are no longer appropriate, the nursing care plan need to be modified.

d. Identifying the areas of assistance

Some nursing situations require the nurse to seek assistance. The assistance can be additional personnel, knowledge or nursing skills. Before implementing care, the nurse evaluates the plan to determine the need for assistance and the type required. For example additional personnel to turn the patient, additional knowledge to administer a new drug, and additional skill in implementing a new procedure. The assistance can come from another staff nurse, educator or a nurse specialist.

e. Implementing nursing interventions
Nursing practice is composed of cognitive, psychomotor and interpersonal skills. Each type of skill is needed to implement interventions.

Cognitive skills- Involve nursing knowledge. The nurse must know the rationale for each therapeutic intervention, understand normal and abnormal physiological and psychological responses, be able to identify client’s learning needs and illness prevention needs.

Interpersonal skills are required for effective nursing actions. The nurse must communicate clearly with the client, family and other members of health team. Client teaching and counseling must be done to the level of client’s understanding and expectations. Nurse also must be sensitive to the client’s emotional response to the illness and treatment.

Psychomotor skills
Involve direct care needs such as changing a dressing, giving an injection, suctioning a tracheostomy. Nurse has a professional responsibility to acquire these skills influencing the patient’s care.

Before implementing the interventions listed in the plan of care, you need to be sure that you:

- Understand the reason for doing the intervention, its expected effect and any potential hazards that can occur.
- Promote an environment conducive to carrying out the planned interventions (noise, temperature).
- Consider which interventions can be combined so that you can accomplish the activities within your time constraints.
- Decide whether you have the qualifications (knowledge, skill and authority)
- Find out if the facility has procedures, protocols, guidelines or standards that address how you should perform the interventions.
- Weigh risks and benefits
- Identify the ways to reduce risks of harm to the patient.
- Identify the ways to reduce the risks of harm to yourself.
- Obtain necessary resources.
- Involve the person and significant others.
Implementation methods

The nurse carries out the nursing care plan using several implementation methods.

1. **Assisting with activities of daily living**

Activities of daily living are activities usually performed in the course of a normal day. (Ambulating, eating, bathing, brushing, grooming). Conditions resulting in the need for assistance with ADL can be acute, chronic, temporary or permanent.

2. **Counseling**

Counseling is the process that helps the client to use a problem solving process to recognize and manage stress. It encourages the individuals to examine available alternatives, develop a sense of control and to manage stress.

3. **Teaching**

The nurse is responsible for assessing the learning needs of clients and is accountable for the quality of education delivered.

4. **Providing nursing care**

a. Life saving measures- are implemented when a client’s physiological or psychological state is threatened. These measures are for restoring physiological or psychological equilibrium. Eg. administering emergency medications, procedures.

b. Compensation for adverse reactions- Adverse reactions are harmful or unintended effects of a drug or diagnostic test. To intervene these activities, the nurse must have the knowledge of potential undesired effects. Eg. Managing hyper sensitivity reactions to antibiotics.

c. Preventive measures- are directed at promoting health and preventing illness.

5. **Supervising and evaluating the work of other staff members.**

The nurse who develop the care plan frequently does not perform all of the interventions. Some interventions may be deligated to other members of health team. Deligation is the transfer of responsibility for the performance of an activity while retaining accountability. The nurse assigning the task is responsible for assuring that each task is appropriately assigned and is
completed according to the standards of care. Remember the four rights of deligation:

- The right task
- To the right person
- Using the right communication
- Performing the right evaluation

When should you deligate?

- When the patient is stable.
- When task is within worker’s job description

You should not deligate:

- When complex assessment, thinking and judgement are required
- When the outcome of task is unpredictable
- When there is increased risks of harm (taking blood from an artery)
- When problem solving and creativity are required.

How should you deligate?

With full knowledge of:

- State nurse practice acts, standards and policies
- Worker’s capabilities and limitations
- The four rights of deligation

**Communicating nursing interventions**

It is legally required that all nursing observations, the care provided and the patient’s responses to be documented. This record serve as a communication tool and a resource to aid in determining the effectiveness of care and to assist in setting priorities for ongoing care. Important areas in the recording are;

- Abnormalities/ changes in assessment findings
- Diagnostic procedures and results
- Variations from usual routine
- Status of client problems
- Status of invasive treatments
Additions or changes to the plan of care
Interventions and nursing care performed
Activities not completed in your shift
The person’s ability to manage care needs after discharge

The purpose of your charting is to:

- Communicate care to other health care professionals who need to be able to find out what you have done
- Help identify patterns of responses and changes in status
- Provide a foundation for evaluation, research and improvement of the quality of care
- Create a legal document

Different ways of charting are:

1. Source oriented charting: Care givers from each discipline chart on separate sheets, writing narrative notes chronologically.
2. Focus charting: Nurses use key words to organize charting and subject of the note isn’t necessarily a problem (e.g., a change in client’s behavior)
3. Multidisciplinary charting: Care givers from all disciplines write on the same record.
4. Flow sheet charting:

In order to simplify record keeping and to promote timely and accurate charting, many agencies use flow sheets to document routine activities, monitoring and patient care (charting specific information in specific spaces). Flow sheets reduce the need to write detailed progress notes. Variations from the recorded baseline and any exceptions requiring more explanation are written in progress notes.

Guidelines for effective charting

- Chart as soon as possible after giving nursing care. Don’t rely on memory.
- Follow each facility’s charting policies and procedures
- Always record variations from norm (e.g., abnormalities in respiration, circulation)
- Be precise. Eg. 03/01/09
9 am - Ambulated for 15 minutes to the end of ward and back with wife’s assistance. Gait is steady. Says he is feeling stronger.

❖ Stick to the facts. Avoid judgemental language.
❖ Be specific. Don’t use vague terms.

Eg. Abdominal dressing has an area of light pink drainage about 6 inches in diameter – Right

Noted moderate amount of drainage on abdominal dressing – Wrong

❖ Be concise, yet descriptive. You don’t have to write complete sentences, but use adjectives and accepted abbreviations to give a good picture of activities and observations.

Eg. OOB to chair for half an hour- no side effects (right).

OOB to chair for half an hour. Seems to have tolerated it well because no obvious side effects were noted (wrong.

❖ Sign your name consistently using your first initial, last name and credentials after each entry.( eg. F. Nightingale,RN)

In addition to the written record, patient information is shared verbally with other health care providers. In verbal reports, the manner in which information is conveyed as well as the content itself can affect the way in which information is conveyed. This in turn can have an impact on the quality of health care provided. For this reason it is important to avoid judgemental language, tone of voice or body language.

For example: When Mrs. Sally talked to the nurse, expressing concern about going home, the nurse reported this to the next shift nurse by saying “I think Sally is trying to manipulate us. She says she is not ready to go home and thinks if she acts weak, she won’t have to leave the hospital” - Wrong

After listening to this judgemental report, the oncoming nurse’s response might be one of defensiveness. The nurse may also subconsciously stop listening and is likely to be less receptive to what Sally is saying.
Sally has expressed concern about her ability to manage at home. She was weak when we got her up this morning, requiring assistance with walking—Wight.

In this report problem is approached with an open mind, thus promoting a positive patient/nurse experience.

**Summary**

Implementation requires you to put the plan in to action with an active, open mind—a mind that constantly assessing and reassessing both patient responses and your own performance.

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