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SPARKS & TAYLOR'S

NURSING DIAGNOSIS POCKET GUIDE

Third Edition







Wolters Kluwer

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Nursing Diagnosis Pocket Guide

Third Edition

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PREFACE

From student nurses to expert clinicians, *Sparks and Taylor's Nursing Diagnosis Pocket Guide,* third edition, offers a clearly written, authoritative care plan for each of the NANDA International (NANDA-I)–approved nursing diagnoses to meet patient health care needs. The guide is organized using a unique assessment framework based on the *NNN Taxonomy of Nursing Practice: A Common Unifying Structure for Nursing Language* (Dochterman & Jones, 2003) and the intervention terms from the *International Classification for Nursing Practice* (ICNP, Version 1; International Council of Nurses, 2005). The framework provides a comprehensive, easy-to-use format for writing plans of care. The book also includes the linkages between NANDA-I, the Nursing Interventions Classification (NIC), and Nursing Outcomes Classification (NOC) labels. The care plans in this book are presented in a color-coded, easy-to-navigate format and are invaluable for any health care setting. An additional set of diagnoses, the Readiness for Enhanced nursing diagnoses, is provided online, at thePoint.

GUIDELINES FOR USING SPARKS AND TAYLOR'S NURSING DIAGNOSIS POCKET GUIDE

All care plans contain the following sections:

- **Diagnostic statement.** Each diagnostic statement includes a NANDA-I–approved diagnosis. The *Sparks and Taylor's Nursing Diagnosis Pocket Guide,* third edition, contains all the diagnoses approved by NANDA-I through 2017.
- **Definition.** Each diagnosis is explained with a NANDA-I–approved definition.
- **Defining characteristics.** The defining characteristics are clinical findings that confirm the diagnosis. For diagnoses expressing the possibility of a problem, such as "Risk for Injury," this section is labeled Risk Factors.
- **Assessment.** This section contains suggested parameters for collecting data to ensure an accurate diagnosis. Complete assessment parameters are presented in Table A of the appendix. The parameters are based on the NNN Taxonomy of Nursing Practice and include four domains: functional, physiological, psychosocial, and environmental (see appendix, Table A). The domains are subdivided into

classes; each class includes key subjective and objective data to be assessed. The parameters that are most necessary for the diagnosis are indicated in each plan.

- **Expected outcomes.** Several realistic goals, written in measurable behavioral terms, are included for resolving or improving the patient's health problem. Outcomes are arranged to flow logically from admission to discharge; outcomes should be selected that are appropriate to the condition of the patient. Outcomes identified by NOC research are included for consideration.
- **Interventions and rationales.** This section describes specific activities performed to attain expected outcomes. Interventions are organized using the following terms: *determine*, *perform*, *inform*, *attend*, and *manage*. The intervention categories are based on the International Classification of Nursing Practice taxonomy, which is explained in more detail later in these guidelines. Each intervention contains a rationale highlighted by italics. Rationales form the premise for every nursing action, and it is beneficial to consider rationales before intervening. Understanding why an action is taken improves critical thinking and reduces errors. Interventions from NIC research are included for consideration.
- **Reference.** Each plan concludes with references that may be useful if further information is needed about the nursing diagnosis.

NURSING PROCESS OVERVIEW

The cornerstone of clinical nursing, the nursing process is a systematic method for taking independent nursing action. Steps in the nursing process include the following:

- Assessing patient problems
- Forming a diagnostic statement
- Identifying expected outcomes
- Creating a plan to achieve expected outcomes
- Implementing the plan or assigning steps for implementation to others
- Evaluating the plan's effectiveness.

The phases of the nursing process—assessment, nursing diagnosis formation, outcome identification, care planning, implementation, and evaluation—are dynamic, flexible, and commonly overlap.

Becoming familiar with the nursing process is beneficial to practice. It allows for application of knowledge and skills in an organized, goal-oriented manner and enables communication about professional topics with colleagues from all clinical specialties and practice settings. Using the nursing process is essential for documenting nursing's role in the provision of comprehensive, quality patient care.

By clearly defining problems a nurse may treat independently, the nursing process has helped dispel the notion that nursing practice is based solely on carrying out physician's orders. Nurse researchers and expert practitioners continue to develop a body of knowledge specific to the field. Nursing literature provides direction to students and seasoned practitioners for evidence-based practice. A strong foundation in the nursing process enables better assimilation of emerging concepts and incorporation of concepts into practice.

Assessment

The vital first phase in the nursing process—assessment—consists of the patient history, the physical examination, and pertinent diagnostic studies. The other phases of the nursing process are dependent on quality assessment data for effectiveness.

The initial patient assessment begins with the collection of data and ends with a statement of the patient's nursing diagnosis(es).

Building a Database

The information collected in taking the patient's history, performing a physical examination, and analyzing test results serves as an assessment database. The goal is to gather and record information that will be most helpful in assessing the patient. Realistically, *all* the information that exists about the patient cannot be collected or used. To appropriately limit the database, consider the following questions:

- What data should be collected?
- How should the data be collected?
- How should the data be organized to make care planning decisions?

The answers will be beneficial for selecting and collecting meaningful data during patient assessment.

The well-defined database for a patient may begin with admission signs and symptoms, chief complaint, or medical diagnosis.

The database may also center on the type of patient care given in a specific setting, such as the intensive care unit, the emergency department, or an outpatient care center. For example, a trauma victim in the emergency department would not be asked whether there is a family history of breast cancer, nor would a routine breast examination be performed. These types of assessment would, however, be performed during a comprehensive health checkup in an outpatient care setting.

In a setting where patients with similar diagnoses are treated, choose the database from information pertinent to the specific patient population. Even when addressing patients with similar diagnoses, complete a thorough assessment to make sure that unanticipated problems don't go unnoticed.

Collecting Subjective and Objective Data

The collected and analyzed assessment data fall into two important categories: subjective and objective. The patient's *history*, embodying a *personal perspective* of problems and strengths, provides *subjective data* and is the most important assessment data source. Because it's also the most subjective source of patient information, it must be interpreted carefully.

The *physical examination* of a patient—involving inspection, palpation, percussion, and auscultation—is one form of *objective data* about the patient's health status or about the pathologic processes that may be related to illness or injury. In addition to adding to the patient's database, this information aids in the interpretation of the patient's history more accurately by providing a basis for comparison. Use it to validate and amplify the historical data. However, don't allow the physical examination to assume undue importance—formulate the nursing diagnosis by considering *all* the elements of the assessment, not just the examination.

Laboratory test results are another objective form of assessment data and the third essential element in developing the assessment. Laboratory values will help interpret—and usually clarify—the history and physical examination findings. The advanced technology used in laboratory tests enables assessment of anatomic, physiologic, and chemical processes that can't be assessed subjectively or by physical examination alone. For example, if the patient complains of fatigue (history) and conjunctival pallor (physical examination) is observed, check the patient's hemoglobin level and hematocrit (laboratory data).

Both subjective (history) and objective (physical examination and laboratory test results) data are essential for comprehensive patient assessment. They validate each other and together provide more data than either can provide alone. By considering history, physical examination, and laboratory data in their appropriate relationships to one another, a nursing diagnosis can be developed on which to formulate an effective care plan.

A patient may request a complete physical checkup as part of a periodic (perhaps annual) health maintenance routine. Such a patient may not have a chief complaint; therefore, this patient's health history should be comprehensive, with detailed information about lifestyle, self-image, family and other interpersonal relationships, and degree of satisfaction with current health status.

Be sure to record health history data in an organized fashion so that the information will be meaningful to everyone involved in the patient's care. Some health care facilities provide patient questionnaires or computerized checklists. (See assessment parameters based on NNN Taxonomy of Nursing Practice in appendix, Table A.)

When documenting the health history, be sure to record negative findings as well as positive ones; that is, note the absence of symptoms that other

history data indicate might be present. For example, if a patient reports abdominal pain and burning, ask about experiencing nausea and vomiting or noticing blood in stools. Record the presence or absence of these symptoms.

Remember that the recorded information will be used by others who will care for the patient. Recorded information can even be used as a legal document in a liability case, a malpractice suit, or an insurance disability claim. With these considerations in mind, record history data thoroughly and precisely. Continue questioning until sufficient detail is obtained.

Don't be satisfied with inadequate answers, such as "a lot" or "a little"; such subjective terms must be explained within the patient's context to be meaningful. If taking notes seems to make the patient anxious, explain the importance of keeping a written record. To facilitate accurate recording of the patient's answers, become familiar with standard history data abbreviations.

When the patient's health history is completed, it becomes part of the permanent written record. It will serve as a database with which you and other health care professionals can monitor the patient's progress. Remember that history data must be specific and precise. Avoid generalities. Instead, provide pertinent, concise, detailed information that will help determine the direction and sequence of the physical examination—the next phase in the patient assessment.

After taking the patient's health history, the next step in the assessment process is the *physical examination*. During this assessment phase, objective data that usually confirms or rules out suspicions raised during the health history interview is obtained.

Use four basic techniques to perform a physical examination: *inspection, palpation, percussion,* and *auscultation* (IPPA). These skills require using the senses of sight, hearing, touch, and smell to formulate an accurate appraisal of the structures and functions of body systems. Using IPPA skills effectively lessens the chances that something important during the physical examination is overlooked. In addition, each examination technique collects data that validate and amplify data collected through other IPPA techniques.

Accurate and complete physical assessments depend on two interrelated elements. One is the critical act of sensory perception, by which external stimuli is received and perceived. The other element is the conceptual, or cognitive, process by which these stimuli are related to the knowledge base. This two-step process gives meaning to the assessment data.

Develop a system for assessing patients that identifies their problem areas in priority order. Performing physical assessments systematically and efficiently, instead of in a random or indiscriminate manner, saves time and identifies priority problems quickly. First, choose an *examination method*. The most commonly used methods for completing a total systematic physical assessment are *head-to-toe* and *major body systems*.

The head-to-toe method is performed by systematically assessing the patient by—as the name suggests—beginning at the head and working toward the toes. Examine all parts of one body region before progressing to the next region to save time and to avoid tiring the patient or yourself. Proceed from left to right within each region to make symmetrical comparisons; that is, when examining the head, proceed from the left side of the head to the right side. After completing both sides of one body region, proceed to the next.

The major body systems method of examination involves systematically assessing the patient by examining each body system in priority order or in an established sequence.

Both the head-to-toe and major body systems methods are systematic and provide a logical, organized framework for collecting physical assessment data. They also provide the same information; therefore, neither is more correct than the other. Choose the method (or a variation of it) that works well and is appropriate for the patient population. Follow this routine whenever assessing a patient and try not to deviate from it.

Consider planning the physical examination around the patient's *chief complaint* or *concern*. To do this, begin by examining the body system or region that corresponds to the chief complaint. This allows identification of priority problems promptly and reassures the patient that the chief complaint is considered.

Physical examination findings are crucial to arriving at a nursing diagnosis and, ultimately, to developing a sound nursing care plan. Record examination results thoroughly, accurately, and clearly. Although some examiners don't like to use a printed form to record physical assessment findings, preferring to work with a blank paper, others believe that standardized data collection forms can make recording physical examination results easier. These forms simplify comprehensive data collection and documentation by providing a concise format for outlining and recording pertinent information. They also serve as a reminder to include all essential assessment data.

When documenting, describe exact findings from inspection, palpation, percussion, and/or auscultation. Don't use general terms such as *normal, abnormal, good,* or *poor*. Instead, be specific. Include positive and negative findings. Try to document as soon as possible after completing the assessment. Remember that abbreviations aid conciseness.

Nursing Diagnosis

According to NANDA-I, the nursing diagnosis is a "clinical judgment concerning a human response to health conditions/life processes, or vulnerability for that response, by an individual, family, group, or community.

A nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse has accountability" (Herdman & Kamitsuru, 2014, p. 464). The nursing diagnosis must be supported by clinical information obtained during patient assessment.

Each nursing diagnosis describes a patient problem that a nurse can professionally and legally manage. Becoming familiar with nursing diagnoses enables a better understanding of how nursing practice is distinct from medical practice. Although the identification of problems commonly overlaps in nursing and medicine, the approach to treatment clearly differs. Medicine focuses on curing disease; nursing focuses on holistic care that includes care and comfort.

Nurses can independently diagnose and treat the patient's response to illness, certain health problems and risk for health problems, readiness to improve health behaviors, and the need to learn new health information. Nurses comfort, counsel, and care for patients and their families until they're physically, emotionally, and spiritually ready to provide self-care.

The nursing diagnosis expresses professional judgment of the patient's clinical status, responses to treatment, and nursing care needs. The diagnosis is determined to develop the plan of care. In effect, the nursing diagnosis *defines* the practice of nursing. Translating the history, physical examination, and laboratory data about a patient into a nursing diagnosis involves organizing the data into clusters and interpreting what the clusters reveal about the patient's ability to meet basic needs. In addition to identifying the patient's needs in coping with the effects of illness, consider what assistance the patient requires to grow and develop to the fullest extent possible. The nursing diagnosis describes the cluster of signs and symptoms indicating an actual or potential health problem that the nurse can identify—and that the nurse's care can resolve. Nursing diagnoses that indicate potential health problems can be identified by the words "risk for" that appear in the diagnostic label. There are also nursing diagnoses that focus on prevention of health problems and enhanced wellness.

Creating a nursing diagnosis is the logical extension of collecting assessment data. To develop the nursing diagnosis, use the collected assessment data to develop a problem list. Less formal in structure than a fully developed nursing diagnosis, this list describes the patient's problems or needs. It's easy to generate such a list by using a conceptual model or an accepted set of criterion norms. Examples of such norms include normal physical and psychological development and the assessment parameters based on the NNN Taxonomy of Nursing Practice (see appendix, Table A).

Identify the patient's problems and needs with simple phrases, such as *poor circulation, high fever,* or *poor hydration*. Next, prioritize the problems on the list and then develop the working nursing diagnosis.

Some nurses are confused about how to document a nursing diagnosis because they think the language is too complex. However, remembering the following basic guidelines will ensure that the diagnostic statement is correct:

- Use proper terminology that reflects the patient's *nursing* needs.
- Make the statement concise so it's easily understood by other health care team members.
- Use the most precise words possible.
- Use a problem-and-cause format, stating the problem and its related cause.

Whenever possible, use the terminology recommended by NANDA-I.

NANDA-I diagnostic headings, when combined with suspected etiology, provide a clear picture of the patient's needs. Thus, for clarity in charting, start with one of the NANDA-I categories as a heading for the diagnostic statement. The category can reflect an actual or potential problem. Consider this sample diagnosis:

- *Heading*: Disturbed Sleep Pattern
- *Etiology*: Select the appropriate "Related To" phrase from the choices in the care plan
- *Signs and symptoms*: "I don't get enough sleep." "My husband wakes me several times during the night to assist him." Note dark circles under eyes and some jitteriness.

Do not state a direct cause-and-effect relationship (which may be hard to prove). Remember to state only the patient's problems and the probable origin. Omit references to possible solutions. (The solutions are derived from the nursing diagnosis, but they aren't part of it.) Errors can also occur when nurses take shortcuts in the nursing process, either by omitting or hurrying through assessment or by basing the diagnosis on inaccurate assessment data.

Keep in mind that a nursing diagnosis is a statement of a health problem that a nurse is licensed to treat—a problem for which the nurse assumes responsibility for therapeutic decisions and accountability for the outcomes. A nursing diagnosis is **not** a:

- diagnostic test ("schedule for cardiac angiography")
- piece of equipment ("set up intermittent suction apparatus")
- problem with equipment ("the patient has trouble using a commode")
- nurse's problem with a patient ("Mr. Jones is a difficult patient; he's rude and won't take his medication.")
- nursing goal ("encourage fluids up to 2,000 mL/day")

- nursing need ("I have to get through to the family that they must accept the fact that their father is dying.")
- medical diagnosis ("cervical cancer")
- treatment ("catheterize after each voiding for residual urine").

At first, these distinctions may not be clear. The following examples should help clarify what a nursing diagnosis is:

- Don't state a need instead of a problem.
  - *Incorrect*: Fluid replacement related to fever
  - *Correct*: Deficient fluid volume related to fever
- Don't reverse the two parts of the statement.
  - *Incorrect*: Lack of understanding related to noncompliance with diabetic diet
  - *Correct*: Noncompliance with diabetic diet related to lack of understanding
- Don't identify an untreatable condition instead of the problem it indicates (which can be treated).
  - *Incorrect*: Inability to speak related to laryngectomy
  - *Correct*: Social isolation related to inability to speak because of laryngectomy
- Don't write a legally inadvisable statement.
  - *Incorrect*: Skin integrity impairment related to improper positioning
  - *Correct*: Impaired skin integrity related to immobility
- Don't identify as unhealthful a response that would be appropriate, allowed for, or culturally acceptable.
  - *Incorrect*: Anger related to terminal illness
  - *Correct*: Ineffective therapeutic regimen management related to anger over terminal illness
- Don't make a tautological statement (one in which both parts of the statement say the same thing).
  - *Incorrect*: Pain related to alteration in comfort
  - *Correct*: Acute pain related to postoperative abdominal distention and anxiety
- Don't identify a nursing problem instead of a patient problem.
  - *Incorrect*: Difficulty suctioning related to thick secretions
  - *Correct*: Ineffective airway clearance related to thick tracheal secretions

Outcome Identification

During this phase of the nursing process, expected outcomes for the patient are identified. Expected outcomes are measurable, patient-focused goals

that are derived from the patient's nursing diagnoses. These goals may be short- or long-term. Short-term goals include those of immediate concern that can be achieved quickly. Long-term goals take more time to achieve and usually involve prevention, patient teaching, and rehabilitation.

In many cases, expected outcomes can be identified by converting the nursing diagnosis into a positive statement. For instance, for the nursing diagnosis "impaired physical mobility related to a fracture of the right hip," the expected outcome might be "The patient will ambulate independently before discharge."

When writing the care plan, state expected outcomes in terms of the patient's behavior—for example, "the patient correctly demonstrates turning, coughing, and deep breathing." Also identify a target time or date by which the expected outcomes should be accomplished. The expected outcomes will serve as the basis for evaluating your nursing interventions. Keep in mind that each expected outcome must be stated in measurable terms. If possible, consult with the patient and family when establishing expected outcomes. As the patient progresses, expected outcomes should be increasingly directed toward planning for discharge and follow-up care.

Outcome statements should be tailored to the practice setting. For example, in the intensive care unit, the focus may be on maintaining hemodynamic stability, whereas on a rehabilitation unit, the focus would be on maximizing the patient's independence and preventing complications.

When writing expected outcomes in the care plan, always start with a specific action verb that focuses on the patient's behavior. Indicating how the patient should *look, walk, eat, drink, turn, cough, speak,* or *stand,* for example, gives a clear picture of how to evaluate progress.

The expected outcomes in the *Sparks and Taylor's Nursing Diagnosis Pocket Guide,* third edition, all start with the phrase "The patient will . . ." and list several appropriate outcomes. It is necessary to choose the outcome appropriate for the patient. Specify to whom the goals refer when family, friends, or others are directly concerned.

The Expected Outcome section is followed by selected outcomes from the Nursing Outcomes Classification (NOC) list.

Understanding NOC

The NOC is a standardized language of patient–client outcomes that was developed by a nursing research team at the University of Iowa. It contains 490 outcomes organized into 32 classes and 7 domains. Each outcome has a definition, a list of measurable indicators, and references. NOC outcomes are research based; studies are ongoing to evaluate their reliability, validity, and sensitivity (Moorhead, Johnson, Maas, & Swanson, 2013). More information about NOC can be found at the Center for Nursing Classification and Clinical Effectiveness (www.nursing.uiowa.edu/cnc).

Planning

The nursing care plan refers to a written plan of action designed to help deliver quality patient care. It includes relevant nursing diagnoses, expected outcomes, and nursing interventions. Keep in mind that the care plan usually forms a permanent part of the patient's health record and will be used by other members of the nursing team. The care plan may be integrated into an interdisciplinary plan for the patient. In this instance, clear guidelines should outline the role of each member of the health care team in providing care.

A written care plan gives direction by providing colleagues with goals for the patient and clear instructions for helping achieve them. If the patient is discharged from one health care facility to another, the care plan can help ease this transition.

Selecting appropriate nursing actions (interventions): Next, one or more nursing interventions will be selected to achieve each of the expected outcomes identified for the patient. For example, if one expected outcome statement reads "The patient will transfer to chair with assistance," the appropriate nursing interventions include placing the wheelchair facing the foot of the bed and assisting the patient to stand and pivot to the chair. If another expected outcome statement reads "The patient will express feelings related to recent injury," appropriate interventions might include spending time with the patient each shift, conveying an open and nonjudgmental attitude, and asking open-ended questions. Interventions used in the *Sparks and Taylor's Nursing Diagnosis Pocket Guide,* third edition, are organized according to the ICNP types (Description of NNN Taxonomy of Nursing Practice and ICNP, 2005). Because all nursing activities are based on assessment data, "Determine" is listed first. The intervention types will appear in the following order: Determine, Perform, Inform, Attend, and Manage. Carefully consider each of the intervention types to provide comprehensive care.

Reviewing the second part of the nursing diagnosis statement (the part describing etiologic factors) may help guide the choice of nursing interventions. For example, for the nursing diagnosis "Impaired individual resistance related to poor impulse control," determine the best nursing interventions for techniques to manage behavior. Try to think creatively during this step in the nursing process. This is an opportunity to describe specific needed activities and to establish the criteria against which further nursing actions will be judged.

The planning phase culminates when the care plan is written and the nursing diagnoses, expected outcomes, and nursing interventions are documented. Write the care plan in concise, specific terms so that other health care team members can follow it. Keep in mind that because the patient's problems and needs will change, the care plan must be reviewed frequently and modified when necessary.

Implementation

During this phase, the care plan is put into action. Implementation encompasses all nursing interventions directed toward solving the patient's nursing problems and meeting health care needs. While implementation is coordinated, also seek help from other caregivers, the patient, and the patient's family.

Implementation requires some (or all) of the following types of interventions:

- **Determine:** assessing and monitoring (e.g., recording vital signs)
- **Perform:** providing care
- **Inform:** teaching and counseling
- **Attend:** making the patient more comfortable, giving emotional support
- **Manage:** referring the patient to appropriate agencies or services

Although it may be brief or narrowly focused, reassessment should confirm that the planned interventions remain appropriate.

Implementation isn't complete until each intervention, the time it occurred, the patient's response, and any other pertinent information are documented. Make sure each entry relates to a nursing diagnosis. Remember that any action not documented may be overlooked during quality assurance monitoring or evaluation of care. Thorough documentation offers a way to take rightful credit for contributing in helping a patient achieve the highest possible level of wellness. After all, nurses use a unique and worthwhile combination of interpersonal, intellectual, and technical skills when providing care.

Understanding Nursing Interventions Classification

The Nursing Interventions Classification (NIC) is a standardized language of treatments that was developed by a nursing research team at the University of Iowa. It contains 542 interventions organized into 30 classes and 7 domains.

Each intervention has a definition, a list of detailed activities, and references. The interventions are research based, and studies are ongoing to evaluate the effectiveness and cost of nursing treatments (Bulechek, Butcher, Dochterman, & Wagner, 2013).

Evaluation

The effectiveness of the care plan can be assessed by answering such questions as:

- How has the patient progressed in terms of the plan's projected outcomes?
- Does the patient have new needs?
- Does the care plan need to be revised?

Evaluation also helps determine whether the patient received high-quality care from the nursing staff and the health care facility. Many facilities base nursing quality assurance systems on nursing evaluations.

Include the patient, family members, and other health care professionals in the evaluation. Then, follow the following steps:

- *Select evaluation criteria.* The care plan's projected outcomes—the desired effects of nursing interventions—form the basis for evaluation.
- *Compare the patient's response with the evaluation criteria.* Did the patient respond as expected? If not, the care plan may need revision.
- *Analyze findings.* If the plan wasn't effective, determine why. It may be concluded, for example, that several nursing diagnoses were inaccurate.
- *Modify the care plan.* Make revisions (e.g., change inaccurate nursing diagnoses) and implement the new plan.
- *Re-evaluate.* Like all steps in the nursing process, evaluation is ongoing. Continue to assess, plan, implement, and evaluate for as long as the patient requires care.

DESCRIPTION OF NNN TAXONOMY OF NURSING PRACTICE AND ICNP

Two organizing frameworks are used in the *Sparks and Taylor's Nursing Diagnosis Pocket Guide*: The NNN Taxonomy of Nursing Practice and intervention terms from the International Classification of Nursing Practice. Each of the frameworks is described in this section. It is recommended that you obtain more information about these from the references cited.

NNN Taxonomy of Nursing Practice

The NNN Taxonomy of Nursing Practice (NNNTNP) consists of nursing diagnoses, nursing interventions, and nursing outcomes developed as the result of an invitational conference funded by the National Library of Medicine in 2001 (Dochterman & Jones, 2003). Leaders in nursing language development from NANDA-I for nursing diagnoses, the Center for Nursing Classification and Clinical Effectiveness at the University of Iowa for nursing outcomes and nursing interventions, and selected other experts convened to develop a common unifying taxonomy to further the development, testing, and refinement of nursing language. Results of their efforts were published in *Unifying Nursing Languages: The Harmonization of NANDA, NIC, and NOC* (Dochterman & Jones, 2003) and *NANDA International Nursing Diagnoses: Definitions and Classification* 2003–2004 (Ralph, Craft-Rosenberg, Herdman, & Lavin, 2003). Since that time, the NANDA Taxonomy Committee has placed new diagnoses in the taxonomy (Herdman & Kamitsuru, 2014).

The NNNTNP has 4 domains and 28 classes. The domains, classes, and their definitions are depicted in Table B of the appendix. Assessment parameters based on the taxonomy were developed for the *Sparks and Taylor's Nursing Diagnosis Pocket Guide, third edition.*

International Classification for Nursing Practice

There has been universal agreement among nurses about the importance of recognizing our practice parameters since the time of Florence Nightingale. A resolution to establish an International Classification for Nursing Practice (ICNP) was passed by the International Council of Nurses (ICN) in 1989. The components of the ICNP describe the elements of nursing practice: "what nurses **do** relative to certain **human needs** to produce certain **results** (nursing interventions, diagnoses, and outcomes)" (ICN, 2005, p. 11).

The ICNP is a unified nursing language system. It consists of a multiaxial model intended to be a resource in developing information systems for nursing globally. The seven axes include Focus, Judgment, Means, Action, Time, Location, and Client. The *Sparks and Taylor's Nursing Diagnosis Pocket Guide,* third edition, uses the Action Axis for the basis of selecting nursing interventions. The terms used are *Determine*, *Perform*, *Inform*, *Attend*, and *Manage*. Each of these terms is further defined in Table C of the appendix. Each care plan in the *Sparks and Taylor's Nursing Diagnosis Pocket Guide,* third edition, uses at least one of each type of intervention, and they are always listed in the order mentioned above.

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Nursing diagnoses, definitions, and characteristics from Herdman, T. H., and Kamitsuru, S. (Eds.). Nursing Diagnoses: Definitions and Classification 2015–2017. Copyright © 2014, 1994–2014 by NANDA International. Used by arrangement with John Wiley & Sons Limited throughout this book.

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Finally, I dedicate this book to the nurses who, with full bladders and empty stomachs, have devoted their lives to providing quality patient care and to student nurses who are working diligently to become members of the profession.

Linda Lee Phelps, DNP, RN

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*The Readiness for Enhanced nursing diagnoses related to the diagnoses in these sections are found on thePoint.

PART I

Nursing Diagnoses Care Plans

2 ACTIVITY INTOLERANCE

DEFINITION

Insufficient physiological or psychological energy to endure or complete required or desired daily activities

DEFINING CHARACTERISTICS

- Abnormal blood pressure response to activity
- Abnormal heart rate response to activity
- ECG change (e.g., arrhythmia, conduction abnormality, ischemia)
- Exertional discomfort
- Exertional dyspnea
- Fatigue
- Generalized weakness

RELATED FACTORS

- Bed rest
- Generalized weakness
- Imbalance between oxygen supply/demand
- Immobility
- Sedentary lifestyle

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Cardiac function
- Respiratory function

EXPECTED OUTCOMES

- The patient will regain and maintain muscle mass and strength.
- The patient will maintain maximum joint range of motion (ROM).
- The patient will perform isometric exercises.
- The patient will help perform self-care activities.
- The patient will maintain heart rate, rhythm, and blood pressure within expected range during periods of activity.
- The patient will state understanding of and willingness to cooperate in maximizing the activity level.
- The patient will perform self-care activities to tolerance level.

SUGGESTED NOC OUTCOMES

Activity Tolerance; Endurance; Energy Conservation; Self-Care: Activities of Daily Living (ADLs); Self-Care: Instrumental Activities of Daily Living (IADLs)

INTERVENTIONS AND RATIONALES

Determine: Monitor physiologic responses to increased activity level, including respirations, heart rate and rhythm, and blood pressure, *to ensure that these return to normal within 2 to 5 minutes after stopping exercise.*

Perform: Perform active or passive ROM exercises to all extremities every 2 to 4 hours. *These exercises foster muscle strength and tone, maintain joint mobility, and prevent contractures.*

Turn and reposition patient at least every 2 hours. Establish a turning schedule for the dependent patient. Post schedule at bedside and monitor frequency. *Turning and repositioning prevent skin breakdown and improve lung expansion and prevent atelectasis.*

Maintain proper body alignment at all times *to avoid contractures and maintain optimal musculoskeletal balance and physiologic function.*

Encourage active exercise: Provide a trapeze or other assistive device whenever possible. *Such devices simplify moving and turning for many patients and allow them to strengthen some upper-body muscles.*

Inform: Teach about isometric exercises *to allow patients to maintain or increase muscle tone and joint mobility.*

Teach caregivers to assist patients with ADLs in a way that maximizes patients' potential. *This enables caregivers to participate in patients' care and encourages them to support patients' independence.*

Attend: Provide emotional support and encouragement *to help improve patient's self-concept and motivate patient to perform ADLs.*

Involve patient in planning and decision making. *Having the ability to participate will encourage greater compliance with the plan for activity.*

Have patient perform ADLs. Begin slowly and increase daily, as tolerated. *Performing ADLs will assist patient to regain independence and enhance self-esteem.*

Manage: Refer to case manager/social worker to ensure that a home assessment has been done and that whatever modifications were needed to accommodate the patient's level of mobility have been made. *Making adjustments in the home will allow the patient a greater degree of independence in performing ADLs, allowing better conservation of energy.*

SUGGESTED NIC INTERVENTIONS

Activity Therapy; Ambulation; Body Mechanics Promotion; Energy Management; Exercise Promotion: Strength Training; Exercise Therapy: Balance, Joint Mobility, Muscle Control

REFERENCES

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RISK FOR ACTIVITY INTOLERANCE 5

DEFINITION

Vulnerable to experiencing insufficient physiological or psychological energy to endure or complete required or desired daily activities, which may compromise health

RISK FACTORS

- Circulatory problems
- History of previous intolerance
- Inexperience with an activity
- Physical deconditioning
- Respiratory condition

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Cardiac function
- Respiratory function

EXPECTED OUTCOMES

- The patient will maintain muscle strength and joint ROM.
- The patient will carry out isometric exercise regimen.
- The patient will communicate understanding of rationale for maintaining activity level.
- The patient will avoid risk factors that may lead to activity intolerance.
- The patient will perform self-care activities to tolerance level.
- The patient will maintain blood pressure, pulse, and respiratory rate within prescribed range during periods of activity (specify).

SUGGESTED NOC OUTCOMES

Activity Tolerance; Endurance; Energy Conservation; Self-Care: ADLs; Self-Care: IADLs

INTERVENTIONS AND RATIONALES

Determine: Assess patient's level of functioning using the functional mobility scale *to determine patient's capabilities.*

Assess patient's physiologic response to increased activity (blood pressure, respirations, heart rate, and rhythm). *Monitoring vital signs helps assess tolerance for increased exertion and activity.*

Perform: Position patient *to maintain proper body alignment.* Use assistive devices as needed *to maintain joint function and prevent musculoskeletal deformities.*

Turn and reposition patient at least every 2 hours. Establish turning schedule for the dependent patient. Post schedule at bedside and monitor frequency. *Turning helps prevent skin breakdown by relieving pressure.*

Unless contraindicated, perform ROM exercises every 2 to 4 hours. Progress from passive to active, according to patient tolerance. *ROM exercises prevent joint contractures and muscular atrophy.*

Encourage active movement by helping patient use trapeze or other assistive devices *to improve muscle tone and enhance self-esteem.*

Inform: Teach patient how to perform isometric exercises *to maintain and improve muscle tone and joint mobility.*

Teach patient, family member, or other caregiver skills such as placing joints in proper body alignment or positioning correctly *to maximize patient's participation in self-care. Informed caregivers can encourage patient to become more independent.*

Teach patient symptoms of overexertion, such as dizziness, chest pain, and dyspnea, *to help take responsibility for monitoring the patient's own activity level.*

Assist patient in carrying out self-care activities. Increase patient's participation in self-care, as tolerated, *to foster independence and improve mobility.*

Attend: Encourage patient to become involved in planning care and making decisions related to treatment. *Participation in planning enhances patient compliance.*

Explain rationale for maintaining or improving activity level. Discuss factors that increase the risk of activity intolerance. *Education helps patient avoid activity intolerance.*

Encourage patient to carry out ADLs. Provide emotional support, and offer positive feedback when the patient displays initiative. *Offering emotional support enhances patient's self-esteem and motivation.*

Manage: Communicate patient's level of functioning to all staff. *Communication among staff members ensures continuity of care and enables patient to preserve the identified level of independence.*

SUGGESTED NIC INTERVENTIONS

Activity Therapy; Ambulation; Body Mechanics Promotion; Energy Management; Exercise Promotion: Strength Training; Exercise Therapy: Balance, Joint Mobility, Muscle Control

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8 INEFFECTIVE ACTIVITY PLANNING

DEFINITION

Inability to prepare for a set of actions fixed in time and under certain conditions

DEFINING CHARACTERISTICS

- Absence of plan
- Excessive anxiety about a task to be undertaken
- Fear about a task to be undertaken
- Insufficient organizational skills
- Insufficient resources (e.g., financial, social, knowledge)
- Pattern of failure
- Pattern of procrastination
- Unmet goals for chosen activity
- Worried about a task to be undertaken

RELATED FACTORS

- Flight behavior when faced with proposed solution
- Hedonism
- Insufficient information-processing ability
- Insufficient social support
- Unrealistic perception of personal abilities

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication
- Roles/relationships
- Self-perception

EXPECTED OUTCOMES

- The patient will demonstrate improved self-confidence to accomplish tasks.
- The patient will demonstrate improved concentration in task planning and execution.
- The patient will minimize procrastination.
- The patient will articulate personal goals for activity planning and completion.
- The patient will verbalize diminished fear and anxiety concerning task planning and execution.

SUGGESTED NOC OUTCOMES

Cognition; Cognition Orientation; Concentration; Decision Making; Information Processing; Memory

INTERVENTIONS AND RATIONALES

Determine: Assess patient's concerns related to activity planning and execution *to be able to suggest strategies to overcome challenges.*

Perform: Model effective techniques for planning and executing activities. *Patients who are challenged by planning and executing activities often find it helpful to observe practical approaches instead of solely hearing theoretical information.*
Inform: Teach behavior management strategies *to help the person minimize fears of failure.*
Attend: Praise successes in any steps of planning or executing activities; *positive reinforcement enhances self-confidence.*
Manage: Refer or collaborate with physical and/or occupational therapists in managing the patient's activity. *Colleagues in related disciplines bring valuable additional perspectives to these complex clinical situations.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Behavior Management; Behavior Modification; Calming Technique; Memory Training; Activity Therapy

REFERENCES

Barz, M., Parschau, L., Warner, L. M., Lange, D., Fleig, L., Knoll, N., & Schwarzer, R. (2014). Planning and preparatory actions facilitate physical activity maintenance. *Psychology of Sport & Exercise, 15*(5), 516–520. doi:10.1016/j.psychsport.2014.05.002

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10 RISK FOR INEFFECTIVE ACTIVITY PLANNING

DEFINITION

Vulnerable to an inability to prepare for a set of actions fixed in time and under certain conditions, which may compromise health

RISK FACTORS

- Flight behavior when faced with proposed solution
- Hedonism
- Insufficient information-processing ability
- Insufficient social support
- Pattern of procrastination
- Unrealistic perception of events
- Unrealistic perception of personal abilities

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication
- Roles/relationships
- Self-perception

EXPECTED OUTCOMES

- The patient will express an interest in activity planning.
- The patient will minimize procrastination.
- The patient will set attainable realistic goals for activity planning and completion.
- The patient will demonstrate ability to make decisions and resolve problems.

SUGGESTED NOC OUTCOMES

Information Processing; Decision-Making; Concentration; Motivation

INTERVENTIONS AND RATIONALES

Determine: Assess patient's concerns related to activity planning and execution and support system *to be able to suggest strategies to overcome challenges.*

Perform: Model effective techniques for planning and executing activities. *Patients who are challenged by planning and executing activities often find it helpful to observe practical approaches.*

Inform: Teach importance of behavior management strategies *to help the person minimize fears of failure.*

Attend: Praise successes in any steps of planning or executing activities; *positive reinforcement enhances self-confidence.*

Manage: Prepare to refer or collaborate with physical and/or occupational therapists in managing the patient's activity. *Colleagues in related disciplines bring valuable additional perspectives to these complex clinical situations.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Behavior Management; Behavior Modification

REFERENCES

Barz, M., Parschau, L., Warner, L. M., Lange, D., Fleig, L., Knoll, N., & Schwarzer, R. (2014). Planning and preparatory actions facilitate physical activity maintenance. *Psychology of Sport & Exercise, 15*(5), 516–520. doi:10.1016/j.psychsport.2014.05.002

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12 DECREASED INTRACRANIAL ADAPTIVE CAPACITY

DEFINITION

Intracranial fluid dynamic mechanisms that normally compensate for increases in intracranial volumes are compromised, resulting in repeated disproportionate increases in intracranial pressure (ICP) in response to a variety of noxious and non-noxious stimuli

DEFINING CHARACTERISTICS

- Baseline ICP equal to or greater than 10 mm Hg
- Disproportionate increase in ICP following stimuli
- Elevated P2 ICP waveform
- Repeated increase in ICP equal to or greater than 10 mm Hg for equal to or more than 5 minutes following external stimuli
- Volume–pressure response test variation (volume:pressure ratio 2, pressure–volume index less than 10)
- Wide-amplitude ICP waveform

RELATED FACTORS

- Brain injuries (e.g., cerebrovascular impairment, neurologic illness, trauma, tumor)
- Decreased cerebral perfusion ≥50 to 60 mm Hg
- Sustained increase in ICP of 10 to 15 mm Hg
- Systemic hypotension with intracranial hypertension

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac functioning
- Comfort
- Elimination
- Fluid and electrolytes
- Neurocognition
- Pharmacologic function
- Respiratory functioning
- Values/beliefs

EXPECTED OUTCOMES

- The patient will maintain patent airway, effective breathing pattern, and normal arterial blood gas (ABG) levels.
- The patient will show no evidence of fever.
- The patient will modify environment to eliminate noxious stimuli.
- The patient will maintain regular bowel function.
- The patient will maintain skin integrity.
- The patient will remain free of signs and symptoms of infection.
- The patient will not show evidence of neurologic compromise.

SUGGESTED NOC OUTCOMES

Electrolyte & Acid/Base Balance; Fluid Balance; Neurological Status: Central Motor Control, Consciousness, Cranial Sensory/Motor Function, Peripheral, and Spinal Sensory/Motor Function; Wound Healing: Primary Intention; Bowel Elimination; Infection Severity; Tissue Perfusion: Cerebral

INTERVENTIONS AND RATIONALES

Determine: Assess vital signs, temperature, pulses, heart sounds, jugular vein distension; electrocardiogram, history of hypertension; mental status, reflexes, response to pain, papillary size, and response to light; respiratory rate, depth, and pattern; ABG; pulse oximetry; monitor ICP wave forms for trends over time. Monitor for damped waves. Assess cerebral perfusion pressure. *Assessment information will assist in identifying appropriate interventions.*

Perform: Maintain ICP monitoring systems if used. *Careful attention must be paid to ensure that the system is functioning to provide accurate information.* Use sterile technique for dressing changes *to prevent contamination of equipment and infection.*

Maintain a patent airway and suction only if needed. *Suctioning stimulates coughing and Valsalva maneuver; Valsalva increases intrathoracic pressure, decreases cerebral venous drainage, and increases cerebral blood volume, resulting in increased ICP.* Elevate head of the bed 15 to 30 degrees or as ordered, and use sandbags, rolled towels, or small pillows *to keep head in a neutral position. Reposition patient by using a draw sheet to prevent friction.* Use minimal amount of stimuli when caring for the patient. Turn and reposition patient every 2 hours *to prevent atelectasis.*

Perform ROM exercises *to maintain muscle tone.*

Provide uninterrupted rest periods as much as possible. Avoid awakening patient during rapid eye movement (REM) sleep. *Cerebral blood flow increases during REM sleep.*

Inform: Teach patient and family those aspects of care in which they can participate without feeling anxious. Instruct family members of gentle stroking of patient's face, arms, or hand. *Touch by family members may lower the ICP in some cases.*

Attend: Provide nursing care in a calm, reassuring manner. Avoid discussion of upsetting topics near the bedside. *This helps prevent emotional upset that can increase ICP.* Encourage patient and family to express feelings associated with diagnosis, treatment, and recovery. *Expression of feelings helps patient and family cope with treatment.*

Manage: Arrange for frequent multidisciplinary/family care conference *to keep care goal-oriented.* Refer patient and family to support group *to help deal with the injury, diagnosis, or recovery.* Refer to social worker/case manager *for follow-up care, home assessment, home visits, and referral to community agencies.*

SUGGESTED NIC INTERVENTIONS

Acid–Base Management; Bedside Laboratory Testing; Cerebral Edema Management; Fluid/Electrolyte Management; Intracranial (ICP) Monitoring; Cerebral Perfusion Monitoring; Consultation; Referral; Presence; Surveillance; Technology Management

REFERENCES

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RISK FOR ADVERSE REACTION TO IODINATED CONTRAST MEDIA

DEFINITION

Vulnerable to noxious or unintended reaction associated with the use of iodinated contrast media that can occur within 7 days after contrast agent injection, which may compromise health

RISK FACTORS

- Anxiety
- Chronic illness
- Concurrent use of pharmaceutical agents (e.g., β-blockers, interleukin-2, metformin, nephrotoxins)
- Contrast media precipitates adverse event (e.g., iodine concentration, viscosity, high osmolality, ion toxicity)
- Dehydration
- Extremes of age
- Fragile vein (e.g., chemotherapy/radiation in limb to be injected, indwelling line for >24 hours, axillary lymph node dissection in limb to be injected, distal intravenous access site)
- Generalized debilitation
- History of allergy
- History of previous adverse effect from iodinated contrast media
- Unconsciousness

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Risk management
- Pharmacological function
- Physical regulation
- Knowledge

EXPECTED OUTCOMES

- The patient will not experience an adverse reaction to iodinated contrast media.
- The patient will recognize personal risk factors for adverse reaction.
- The patient will ask questions if new information requires clarification.

SUGGESTED NOC OUTCOMES

Risk Control; Risk Detection; Knowledge: Treatment Procedure(s); Immune Hypersensitivity Response; Allergic Response: Systemic or Localized

INTERVENTIONS AND RATIONALES

Determine: Assess for any previous adverse reaction to contrast media.

Identify preexisting disease states and current medication history that may trigger reaction to iodinated contrast media. *This is essential for the safe administration of contrast media and prevention of adverse effects.*

Assess for history of asthma food allergies or other allergies *that may increase likelihood of an adverse reaction.* Assess for presence of other

medical conditions *that may increase risk of adverse reaction*, including heart failures and renal insufficiency.

Perform: Consider prehydration with normal saline solution *to decrease risk of renal damage.*

Withhold metformin before any administration of contrast media, and resume after 48 hours once renal function has been evaluated. *This will reduce any medication-associated renal tissue damage due to contrast media.*

Premedication with corticosteroids or antihistamines may be indicated *to reduce incidence of reaction in patients with known risk factors.*

Inform: Educate patient regarding risk factors associated with adverse reaction to iodinated contrast media. *Knowledge of risk factors is essential in preventing adverse reaction and possible organ damage.*

Ensure patient is aware of personal risk factors to share with future providers. *This will promote continued safe administration of iodinated contrast media.*

Attend: Encourage patient to share concerns about procedures requiring use of iodinated contrast media *to reduce anxiety.*

Manage: Collaborate with other members of the health care team regarding presence of risk factors associated with adverse reaction to iodinated contrast media. *This will allow for modifications in the preparation for the procedure and prevent complications.*

SUGGESTED NIC INTERVENTIONS

Risk Identification; Teaching: Individual; Allergy Management

REFERENCES

Burchardt, P., Synowiec, T., Jerzykowska, S., Angerer, D., & Zurawski, J. (2015). Early renal dysfunction after iodine contrast administration: New insight into the actual problem. *Polish Heart Journal*, *73*(3), 233–234. doi:10.5603/KP.2015.0050

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INEFFECTIVE AIRWAY CLEARANCE 17

DEFINITION

Inability to clear secretions or obstructions from the respiratory tract to maintain a clear airway

DEFINING CHARACTERISTICS

- Absence of cough
- Adventitious breath sounds
- Alteration in respiratory pattern
- Alteration in respiratory rate
- Cyanosis
- Difficulty verbalizing
- Diminished breath sounds
- Dyspnea
- Excessive sputum
- Ineffective cough
- Orthopnea
- Restlessness
- Wide-eyed look

RELATED FACTORS

- *Environmental*: Exposure to smoke, second-hand smoke, smoking
- *Obstructed airway*: Airway spasm, chronic obstructive pulmonary disease, exudate in the alveoli, excessive mucus, foreign body in airway, hyperplasia of the bronchial walls, presence of artificial airway, retained secretions
- *Physiological*: Allergic airways, asthma, infection, neuromuscular impairment

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Cardiac function
- Respiratory function

EXPECTED OUTCOMES

- The patient will maintain patent airway.
- The patient will have no adventitious breath sounds.
- The patient will have a normal chest X-ray.
- The patient will have an oxygen level in normal range.
- The patient will breathe deeply and cough to remove secretions.
- The patient will expectorate sputum.
- The patient will demonstrate controlled coughing techniques.
- The patient will have adequate ventilation.
- The patient will demonstrate skill in conserving energy while attempting to clear airway.
- The patient will state understanding of changes needed to diminish oxygen demands.

18 INEFFECTIVE AIRWAY CLEARANCE

SUGGESTED NOC OUTCOMES

Aspiration Prevention; Respiratory Status: Airway Patency; Respiratory Status: Ventilation

INTERVENTIONS AND RATIONALES

Determine: Assess respiratory status at least every 4 hours or according to established standards. *Obstruction in the airway leads to atelectasis, pneumonia, or respiratory failure.* Monitor arterial blood gas values and hemoglobin levels *to assess oxygenation and ventilatory status.* Report deviations from baseline levels; oxygen saturation should be higher than 90%.

Monitor sputum, noting amount, odor, and consistency. *Sputum amount and consistency may indicate hydration status and effectiveness of therapy. Foul-smelling sputum may indicate respiratory infection.*

Perform: Turn patient every 2 hours; place the patient in lateral, sitting, prone, and upright positions as much as possible *for maximal aeration of lung fields and mobilization of secretions.*

Mobilize patient to full capabilities *to facilitate chest expansion and ventilation.*

Suction, as ordered, *to stimulate cough and clear airways.* Be alert for progression of airway compromise. Perform postural drainage, percussion, and vibration *to facilitate secretion movement.*

Provide adequate humidification *to loosen secretions.* Administer expectorants, bronchodilators, and other drugs, as ordered, and monitor effectiveness. Provide bronchodilator treatments before chest physiotherapy to optimize results of the treatment. Administer oxygen, as ordered, *to promote oxygenation of cells throughout the body.*

Inform: Teach patient an easily performed cough technique *to clear airway without fatigue.*

Attend: Avoid placing patient in a supine position for extended periods *to prevent atelectasis.*

When helping the patient cough and deep-breathe, use whatever position best ensures cooperation and minimizes energy expenditure, such as high Fowler's position or sitting on side of bed. *Such positions promote chest expansion and ventilation of basilar lung fields.*

Encourage adequate water intake (3 to 4 L/day) *to ensure optimal hydration and loosening of secretions*, unless contraindicated. Encourage sputum expectoration *to remove pathogens and prevent spread of infection.* Provide tissues and paper bags for hygienic disposal *to prevent spreading infection.*

Manage: If conservative measures fail to maintain partial pressure of arterial oxygen (PaO_2) within an acceptable range, prepare for endotracheal intubation, as ordered, *to maintain artificial airway and optimize PaO_2 level.*

SUGGESTED NIC INTERVENTIONS

Airway Management; Aspiration Precautions; Cough Enhancement; Oxygen Therapy; Respiratory Monitoring; Ventilation Assistance

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20 RISK FOR ALLERGY RESPONSE

DEFINITION

Vulnerable to an exaggerated immune response or reaction to substances, which may compromise health

RISK FACTORS

- Allergy to insect sting
- Exposure to allergen (e.g., pharmaceutical agent)
- Exposure to environmental allergen (e.g., dander, dust, mold, pollen)
- Exposure to toxic chemical
- Food allergy (e.g., avocado, banana, chestnut, kiwi, peanut, shellfish, mushroom, tropical fruit)
- Repeated exposure to allergen-producing environmental substances

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Respiratory function
- Tissue integrity

EXPECTED OUTCOMES

- The patient will not experience an adverse reaction to allergen.
- The patient will recognize personal risk factors for allergic reaction.
- The patient will express awareness of personal allergy.
- The patient will ask questions if new information requires clarification.

SUGGESTED NOC OUTCOMES

Risk Control; Risk Detection; Knowledge: Medication; Knowledge: Diet; Immune Hypersensitivity Response; Allergy Response: Localized

INTERVENTIONS AND RATIONALES

Determine: Determine whether patient has had any previous allergic reaction to substances, and explore related details of the reaction. *Thorough history will provide a more effective prevention plan.*

Monitor respiratory status; include rate, rhythm, skin color, and breath sounds. Be particularly alert for signs of bronchospasms and complaints of dyspnea. Assess heart rate, rhythm, and blood pressure. Check skin carefully for urticaria. Document findings. *These measures detect changes in status to more accurately determine interventions.*

Remove any known allergens from patient environment if possible *to reduce risk of reaction in patient.*

Assess for presence of any other conditions that may indicate an altered immune response, for example, multiple food intolerances and sensitivity to flowers or perfumes. *This will help to identify those at risk and promote early interventions for risk reduction.*

Perform: Assist with any allergy testing and any prescribed treatment interventions such as long-term prophylaxis, *and reinforce treatment plan as needed.*

Assist patient to modify environment *to minimize exposure to allergens.*

Administer prescribed drugs and treatments as ordered. *Wheezing and shortness of breath can quickly deteriorate to respiratory distress and failure. Skin with urticaria and itching is uncomfortable and unsightly, and so patients appreciate timely administration of treatment.*

Inform: Teach patient and patient's family to avoid allergy-producing products *to prevent future contact and allergic reactions.* Provide instruction about foods, household items, environmental items, and plants that contain allergens (provide a written list). *Prevention is the foundation of treatment of allergies.*

For food allergens: Encourage patient to read all food labels *to minimize exposure.* Suggest development of a food allergen card to use when dining out. *This will help chefs prepare a safe meal.*

For airborne allergens: Encourage frequent washing of bed linens and using vacuum with special filter *to minimize exposure.*

Instruct patient and patient's family about importance of seeking immediate medical treatment for allergic reactions *to foster timely intervention.*

Attend: Provide emotional support and encouragement *to help* improve patient's self-concept.

Involve patient in planning and decision making, and have patient perform self-care activities. *Having the ability to participate will encourage greater compliance with the plan for activity.*

Manage: Refer patient to primary provider to discuss possible need for emergency medication in event of emergency, for example, EpiPen. *This will ensure immediate treatment for severe allergic reaction.*

When allergy is confirmed, document and label record clearly *to prevent future contact with the allergen.*

Provide documentation of latex allergy for the patient to take to employer; with the patient's permission, communicate with employee health department and discuss patient's need to avoid contact with latex products *to prevent further contamination.*

Suggest that patient keep a diary noting when symptoms occur. *This will help in the development of a risk reduction plan.*

Instruct patient and patient's family to inform health care providers of allergy to medications and consider wearing a warning bracelet *to further protect patient from unnecessary harm.*

SUGGESTED NIC INTERVENTIONS

Allergy Management; Risk Identification; Teaching: Individual

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DEFINITION

Vague uneasy feeling of discomfort or dread accompanied by an autonomic response (the source is often nonspecific or unknown to the individual); a feeling of apprehension caused by anticipation of danger. It is an alerting signal that warns of impeding danger and enables the individual to take measures to deal with that threat

DEFINING CHARACTERISTICS

- *Behavioral*: Decrease in productivity, extraneous movement, fidgeting, glancing about, hypervigilance, insomnia, poor eye contact, restlessness, scanning behavior, worried about change in life event
- *Affective*: Anguish, apprehensiveness, distress, fear, feeling of inadequacy, helplessness, increase in wariness, irritability, jitteriness, overexcitement, rattled, regretful, self-focused, uncertainty, worried
- *Physiological*: Facial tension, hand tremors, increase in perspiration, increase in tension, shakiness, trembling, voice quivering
- *Sympathetic*: Alteration in respiratory pattern, anorexia, brisk reflexes, cardiovascular excitation, diarrhea, dry mouth, facial flushing, heart palpitations, increase in blood pressure, increase in heart rate, increase in respiratory rate, pupil dilation, superficial vasoconstriction, twitching, weakness
- *Parasympathetic*: Abdominal pain, alteration in sleep pattern, decrease in heart rate, decreased blood pressure, diarrhea, faintness, fatigue, nausea, tingling in extremities, urinary frequency, urinary hesitancy, urinary urgency
- *Cognitive*: Alteration in attention, alteration in concentration, awareness of physiologic symptoms, blocking of thoughts, confusion, decrease in perceptual field, diminished ability to learn, diminished ability to problem solve, fear, forgetfulness, preoccupation, rumination, tendency to blame others

RELATED FACTORS

- Conflict about life goals
- Exposure to toxin
- Family history of anxiety
- Heredity
- Interpersonal contagion
- Interpersonal transmission
- Major change (e.g., economic status, environment, health status, role function, role status)
- Maturational crisis
- Situational crisis
- Stressors
- Substance abuse

- Threat of death
- Threat to current status
- Unmet needs
- Value conflict

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Communication
- Coping
- Emotional status
- Psychological status

EXPECTED OUTCOMES

- The patient will identify factors that elicit anxious behaviors.
- The patient will participate in activities that decrease feelings of anxious behaviors.
- The patient will practice relaxation techniques at specific intervals each day.
- The patient will cope with current medical situation without demonstrating severe signs of anxiety.
- The patient will demonstrate observable signs of reduced anxiety.
- The patient will state that the level of anxiety has decreased.

SUGGESTED NOC OUTCOMES

Anxiety Level; Coping; Anxiety Self-Control; Hyperactivity Level; Impulse Self-Control; Psychosocial Adjustment: Life Change; Social Interaction Skills; Stress Level; Symptom Control

INTERVENTIONS AND RATIONALES

Determine: Listen attentively to patient to determine exactly what the patient is feeling. *Listening on the part of the nurse helps the patient identify anxious behaviors more easily and discover the source of anxiety.*

Assess types of activities *that help reduce patient's stress levels.*

Monitor physiologic responses, including respirations, heart rate and rhythm, and blood pressure.

Perform: Reduce environmental stressors (including people), and remain with patient during severe anxiety. *Anxiety often results from lack of trust in the environment and/or fear of being alone.*

Offer relaxing types of music for quiet listening periods. *Listening to relaxing music may have a calming effect.*

Promote proper body alignment *to avoid contractures and maintain optimal musculoskeletal balance and physiologic function.* Encourage active exercise to promote *a sense of well-being.*

Inform: Teach patient relaxation techniques (guided imagery, progressive muscle relaxation, and meditation) to be performed at least every

4 hours *to restore psychological and physical equilibrium by decreasing autonomic response to anxiety.*

Attend: Provide emotional support and encouragement *to improve self-concept and encourage frequent use of relaxation techniques.*

Allow extra visiting times with family *if this seems to allay patient's anxiety about activities of daily living.*

Involve patient in planning and decision making to encourage interest and compliance. Encourage patient to talk about the kinds of activities that promote feelings of comfort. Assist patient to create a plan to try engaging in at least one of these activities each day. *This gives the patient a sense of control.*

Make sure that patient has clear explanations for everything that will happen to the patient. Ask for feedback to ensure that the patient understands. *Anxiety may impair patient's cognitive abilities.*

Manage: Refer to case manager/social worker or professional mental health caretaker to provide mental health assistance. *Encouraging the use of community mental health resources reinforces the fact that anxiety reduction is a long-term process.*

SUGGESTED NIC INTERVENTIONS

Anger Control Assistance; Anticipatory Guidance; Anxiety Reduction; Behavior Modification: Social Skills; Calming Technique; Coping Enhancement; Simple Guided Imagery; Support Group; Active Listening

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26 RISK FOR ASPIRATION

DEFINITION

Vulnerable to entry of gastrointestinal secretions, oropharyngeal secretions, solids, or fluids to the tracheobronchial passages, which my compromise health

RISK FACTORS

- Barrier to upper body
- Decrease in gastrointestinal motility
- Decrease in level of consciousness
- Delayed gastric emptying
- Decreased gag reflex
- Enteral feedings
- Facial surgery
- Facial trauma
- Impaired ability to swallow
- Incompetent lower esophageal sphincter
- Increase in gastric residual
- Increase in intragastric pressure
- Ineffective cough
- Neck surgery
- Neck trauma
- Oral surgery
- Oral trauma
- Presence of oral/nasal tube (e.g., tracheal, feeding)
- Treatment regimen
- Wired jaw

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Elimination
- Neurocognition
- Respiratory function

EXPECTED OUTCOMES

- The patients will have clear breath sounds on auscultation.
- The patients will have normal bowel sounds.
- The patients will maintain patent airway.
- The patients will breathe easily, cough effectively, and show no signs of respiratory distress or infection.
- The patients will demonstrate measures to prevent aspiration.
- The patients will maintain respiratory rate within normal limits for age.
- The patients will describe plan for home care.

SUGGESTED NOC OUTCOMES

Aspiration Prevention; Knowledge: Treatment Procedure(s); Respiratory Status: Ventilation; Risk Control; Swallowing Status

INTERVENTIONS AND RATIONALES

Determine: Assess for gag and swallowing reflexes. *Impaired reflexes may cause aspiration.*

Assess respiratory status at least every 4 hours or according to established standards; begin cardiopulmonary monitoring *to detect signs of possible aspiration* (increased respiratory rate, cough, sputum production, and diminished breath sounds).

Auscultate bowel sounds every 4 hours and report changes. *Delayed gastric emptying may cause regurgitation of stomach contents.*

Elevate the head of the bed or place the patient in Fowler's position *to aid breathing.*

Recognize the progression of airway compromise, and report your findings *to detect complications early.*

Perform: Help patient turn, cough, and deep-breathe every 2 to 4 hours. Perform postural drainage, percussion, and vibration every 4 hours, or as ordered. Suction, as needed, to stimulate cough and clear upper and lower airways. *These measures promote drainage of secretions and full expansion of lungs.*

Perform chest physiotherapy before feeding *to decrease the risk of emesis leading to aspiration.*

Elevate patient during feeding, and use an upright position after feeding. *Such positioning uses gravity to prevent regurgitation of stomach contents and promotes lung expansion.*

Place patient in the lateral or prone position, and change position at least every 2 hours *to reduce the potential for aspiration by allowing secretions to drain.*

Inform: Instruct patient and family members on home care plan. They must demonstrate the ability to carry out measures to prevent or respond to aspiration events *to ensure adequate home care before discharge.*

Attend: Encourage fluids within prescribed restrictions. Provide humidification, as ordered (such as a nebulizer). *Fluids and humidification liquefy secretions.*

SUGGESTED NIC INTERVENTIONS

Airway Management; Aspiration Precautions; Feeding; Positioning; Respiratory Monitoring; Vital Signs Monitoring; Vomiting Management; Airway Suctioning

REFERENCES

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DEFINITION

Vulnerable to disruption of the interactive process between parent/significant other and child that fosters the development of a protective and nurturing reciprocal relationship

RISK FACTORS

- Anxiety
- Child's illness prevents effective initiation of parental contact
- Disorganized infant behavior
- Inability of parent to meet personal needs
- Insufficient privacy
- Parental conflict resulting from disorganized infant behavior
- Parent–child separation
- Physical barrier (e.g., infant in Isolette)
- Prematurity
- Substance abuse

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Communication
- Coping
- Emotional status
- Role/relationships
- Sleep and rest
- Values and beliefs

EXPECTED OUTCOMES

- The parents will initiate positive interaction with child.
- The parents will hold child and talk to the child.
- The parents will express confidence in their ability to respond to child's needs.
- The parents will respond appropriately to child.
- The parents will express positive feelings about child.
- The parents will express confidence in their ability to care for child.
- The parents will recognize when they need assistance.
- The child will respond positively to parents.
- The child will show interest in parents' faces.
- The child will become calm when soothed by parents.

SUGGESTED NOC OUTCOMES

Parenting Performance; Role Performance

INTERVENTIONS AND RATIONALES

Determine: Assess composition of family and ages of members; ability of family to meet physical and emotional needs of its members; knowledge of growth and developmental patterns; energy levels of parents; recent

life changes; child's neurologic and sensory status, including vision and hearing; sleep patterns of parents and child. *This information will assist in establishing appropriate interventions.*

Perform: Reduce environmental stressors (including people) where it is possible *to observe whether the parents' responses to the child are appropriate.*

Provide parents and child with periods of privacy *to promote attachment.*

Provide physical care to child when appropriate. This may be to demonstrate to the family *the appropriate way to perform ADLs.*

Inform: Teach parents to observe and understand behavioral cues from the child. For example, the child may become fussy when ready for a nap or may pull his or her ear if he or she has an earache. Explain the range of options for responding to these cues positively. *It is important that the parents have a variety of options made available to them.*

Teach parents to give physical care when the needs exist *to increase their self-confidence and self-competence.*

Teach relaxation techniques (guided imagery, progressive muscle relaxation, and meditation) that can be done by the parents *to restore psychological and physical equilibrium by decreasing autonomic response to anxiety.*

Attend: Provide emotional support and encouragement *to help improve parents' self-concept and self-confidence in parental roles.*

Initiate discussions with parents on life changes precipitated by the birth of the child. *Parents are often confused and blame themselves because the stress of birth causes frustration and anger.*

Encourage parents to talk about the kinds of activities that promote feelings of comfort. Assist parents to create a plan to engage in at least one of these activities each day. *This provides parents with a sense of control over their own lives.*

Make sure parents have clear explanations for everything that is expected of them. Ask for feedback to ensure parents understand. *Anxiety may impair their cognitive abilities.*

Manage: Provide the name of professionals and/or agencies where parents can receive assistance *to continue developing attachment skills and/or ongoing support.* Refer to case manager/social worker to assess the home environment *to enable the parents to make modifications that will be needed.*

SUGGESTED NIC INTERVENTIONS

Abuse Protection Support: Child; Child Coping Enhancement; Developmental Enhancement; Parenting Promotion; Guided Imagery

REFERENCES

Falk, N., Norris, K., & Quinn, M. (2014). The factors predicting stress, anxiety and depression in the parents of children with autism. *Journal of Autism & Developmental Disorders*, *44*(12), 3185–3203. doi:10.1007/s10803-014-2189-4

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32 AUTONOMIC DYSREFLEXIA

DEFINITION

Life-threatening, uninhibited sympathetic response of nervous system to a noxious stimulus after a spinal cord injury at T7 or above

DEFINING CHARACTERISTICS

- Blurred vision
- Bradycardia
- Chest pain
- Chilling
- Conjunctival congestion
- Diaphoresis (above the injury)
- Headache (diffuse pain in different areas of the head and not confined to any nerve distribution area)
- Horner's syndrome
- Metallic taste in mouth
- Nasal congestion
- Pallor (below injury)
- Paresthesia
- Paroxysmal hypertension
- Pilomotor reflex
- Red blotches on skin (above the injury)
- Tachycardia

RELATED FACTORS

- Bladder distension
- Bowel distension
- Insufficient caregiver knowledge of disease process
- Insufficient knowledge of disease process
- Skin irritation

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Elimination
- Neurocognition
- Risk management

EXPECTED OUTCOMES

- The patient will have cause of dysreflexia identified and corrected.
- The patient will experience cardiovascular stability as evidenced by ____ systolic range, ____ diastolic range, and _____ heart rate range.
- The patient will avoid bladder distension and urinary tract infection (UTI).
- The patient will have no fecal impaction.
- The patient will have no noxious stimuli in environment.
- The patient will state relief from symptoms of dysreflexia.
- The patient will have few, if any, complications.

- The patient will maintain normal bladder elimination pattern.
- The patient will maintain normal bowel elimination pattern.
- The patient will demonstrate knowledge and understanding of dysreflexia and will describe care measures.
- The patient will experience few or no dysreflexic episodes.

SUGGESTED NOC OUTCOMES

Neurologic Status; Neurologic Status: Autonomic; Sensory Function Status; Vital Signs Status

INTERVENTIONS AND RATIONALES

Determine: Assess for signs of dysreflexia (especially severe hypertension) *to detect condition so that prompt treatment may be initiated.* Take vital signs frequently *to monitor effectiveness of prescribed medications.*
Perform: Place patient in a sitting position or elevate the head of bed *to aid venous drainage from brain, lower intracranial pressure, and temporarily reduce blood pressure.*

Ascertain and correct probable cause of dysreflexia. Check for bladder distension and patency of catheter. If necessary, irrigate catheter with small amount of solution, or insert a new catheter immediately. *A blocked urinary catheter can trigger dysreflexia.*

Check for fecal mass in rectum. Apply dibucaine ointment (Nupercainal) or another product, as ordered, to anus and 1 in. (2.5 cm) into rectum 10 to 15 minutes before removing impaction. *Failure to use ointment may aggravate autonomic response.*

Check environment for cold drafts and objects putting pressure on patient's skin, *which could act as dysreflexia stimuli.* Send urine for culture if no other cause becomes apparent *to detect possible UTI.*

Implement and maintain bowel and bladder elimination programs *to avoid stimuli that could trigger dysreflexia.*
Inform: Instruct patient, family members, or caregiver about dysreflexia, including its causes, signs and symptoms, and care measures *to prepare them to handle possible emergencies related to condition.* Suggest patient carry an AD emergency card such as the one from www.sci-info-pages.com *to provide information quickly for responders unfamiliar with autonomic dysreflexia.*
Attend: Reassure patient that everyone involved in the care will be instructed in management of this problem *to relieve anxiety.*
Manage: If hypertension persists despite other measures, administer ganglionic blocking agent, vasodilator, or other medication as ordered. *Drugs may be required if hypertension persists or if noxious stimuli can't be removed.*

SUGGESTED NIC INTERVENTIONS

Dysreflexia Management; Neurologic Monitoring; Surveillance; Temperature Management; Vital Signs Monitoring

REFERENCES

Colangelo, J. (2014). Care considerations for patients with spinal cord injuries. *Radiologic Technology, 86*(1), 33–58.

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RISK FOR AUTONOMIC DYSREFLEXIA 35

DEFINITION

Vulnerable to life-threatening, uninhibited response of the sympathetic nervous system, postspinal shock, in an individual with spinal cord injury or lesion at T6 or above (has been demonstrated in patients with injuries at T7 and T8), which may compromise health

RISK FACTORS

- *Cardiopulmonary Stimuli:* Deep vein thrombosis, pulmonary emboli
- *Gastrointestinal Stimuli:* Bowel distension, constipation, difficult passage of feces, digital stimulation, enemas, esophageal reflux disease, fecal impaction, gallstones, gastric ulcer, gastrointestinal system pathology, hemorrhoids, suppositories
- *Musculoskeletal-Integumentary Stimuli:* Cutaneous stimulation (e.g., pressure ulcer, ingrown toenail, dressings, burns, rash), fracture, heterotopic bone, pressure over bony prominence, pressure over genitalia, range of motion exercises, spasm, sunburn, wound
- *Neurological Stimuli*: Irritating stimuli below level of injury, painful stimuli below level of injury
- *Regulatory Stimuli*: Extreme environmental temperatures, temperature fluctuations
- *Reproductive Stimuli:* Ejaculation, labor and delivery, menstruation, ovarian cyst, pregnancy, sexual intercourse
- *Situational Stimuli*: Constrictive clothing (e.g., straps, stockings, shoes), pharmaceutical agent, positioning, substance withdrawal (e.g., narcotic, opiate)
- *Urological Stimuli*: Bladder distension, bladder spasm, cystitis, detrusor sphincter dyssynergia, epididymitis, instrumentation, renal calculi, surgical procedure, urethritis, urinary catheterization, urinary tract infection

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Elimination
- Neurocognition
- Risk management

EXPECTED OUTCOMES

- The patient will identify and reduce risk factors for dysreflexia.
- The patient will avoid bladder distension.
- The patient will not experience an urinary tract infection.
- The patient will maintain normal urinary and bowel elimination patterns.
- The patient will be free from fecal impaction.

- The patient will have an environment free from noxious stimuli that may cause dysreflexia.
- The patient will express understanding of causes of dysreflexia.
- The patient will demonstrate understanding of measures to prevent dysreflexia.

SUGGESTED NOC OUTCOMES

Neurologic Status: Autonomic; Symptom Severity; Vital Signs Status

INTERVENTIONS AND RATIONALES

Determine: Assess for risk factors of dysreflexia, such as constipation, fecal impaction, distended bladder, and presence of noxious stimuli. *Identifying risk factors can prevent or minimize dysreflexic episodes.*

Monitor and record intake and output accurately *to ensure adequate fluid replacement, thereby helping to prevent constipation.*

Monitor vital signs frequently *to ensure effectiveness of preventive measures. Severe hypertension may indicate dysreflexia.*

Perform: Check for bladder distension and patency of catheter. *A blocked catheter can trigger dysreflexia.*

Check for abdominal distension and assess bowel sounds. Monitor and record characteristics and frequency of stools. *Fecal impaction may lead to dysreflexia.*

Administer laxative, enema, or suppositories, as prescribed, *to promote elimination of solids and gases from GI tract.* Monitor effectiveness.

Implement and maintain bowel and bladder programs *to avoid stimuli that could trigger dysreflexia.*

Inform: Instruct patient, family member, or caregiver about risk factors, signs and symptoms, and care measures for dysreflexia *to help prevent a possible dysreflexic episode and help the patient respond appropriately should dysreflexia occur.* Suggest patient carry an AD emergency card such as the one from www.sci-info-pages.com *to provide information quickly for responders unfamiliar with autonomic dysreflexia.*

Attend: Encourage fluid intake of 2.5 L daily, unless contraindicated. *Adequate fluid intake helps maintain patency of catheter and aids bowel elimination.*

Manage: Consult with dietitian about increasing fiber and bulk in diet to maximum prescribed by physician *to improve intestinal muscle tone and promote comfortable elimination.*

SUGGESTED NIC INTERVENTIONS

Dysreflexia Management; Neurologic Monitoring; Vital Signs Monitoring

REFERENCES

Colangelo, J. (2014). Care considerations for patients with spinal cord injuries. *Radiologic Technology, 86*(1), 33–58.

Putz, C., Helbig, L., Gerner, H., Zimmermann-Stenzel, M., & Akbar, M. (2014). Autonomic dysreflexia: A possible trigger for the development of heterotopic ossifications after traumatic spinal cord injury? *European Journal of Trauma & Emergency Surgery, 40*(6), 721–726. doi:10.1007/s00068-013-0353-8

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38 DISORGANIZED INFANT BEHAVIOR

DEFINITION

Disintegrated physiological and neurobehavioral responses of infant to the environment

DEFINING CHARACTERISTICS

- *Attention–Interaction System:* Impaired response to sensory stimuli (e.g., difficult to soothe, unable to sustain alertness)
- *Motor System:* Alteration in primitive reflexes, exaggerated startle response, finger splaying, fisting, hands to face, hyperextension of extremities, impaired motor tone, jitteriness, tremor, twitching, uncoordinated movements
- *Physiological:* Abnormal skin color (e.g., pale, dusky, cyanosis), arrhythmia, bradycardia, desaturation, feeding intolerance, tachycardia, time-out signals (e.g., gaze, hiccough, sneeze, slack jaw, open mouth, tongue thrust)
- *Regulatory Problems:* Inability to inhibit startle reflex, irritability
- *State-Organizational System:* Active–awake (e.g., fussy, worried gaze), diffuse alpha EEG activity with eyes closed, irritable crying, quiet–awake (e.g., starting, gaze aversion), state–oscillation

RELATED FACTORS

- *Caregiver:* Cue misreading, environmental overstimulation, insufficient knowledge of behavioral cues
- *Environmental:* Inadequate physical environment, insufficient containment within environment, insufficient sensory stimulation, sensory deprivation, sensory overstimulation
- *Individual:* Illness, immature neurologic functioning, low postconceptual age, prematurity
- *Postnatal:* Feeding intolerance, impaired motor functioning, invasive procedure, malnutrition, oral impairment, pain
- *Prenatal:* Congenital disorder, exposure to teratogen, genetic disorder

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Elimination
- Neurocognition
- Nutrition
- Physical regulation
- Role/relationships
- Sensation/perception
- Sleep/rest

EXPECTED OUTCOMES

- The parents will learn to identify and understand infant's behavioral cues.
- The parents will identify their own emotional responses to infant's behavior.

- The parents will identify means to help infant overcome behavioral disturbance.
- The parents will identify ways to improve their ability to cope with infant's responses.
- The parents will express positive feelings about their ability to care for infant.
- The parents will identify resources for help with infant.
- The infant will begin to show appropriate signs of maturation.

SUGGESTED NOC OUTCOMES

Knowledge: Infant Care; Neurological Status; Preterm Infant Organization; Sleep; Child Development: 1 Month; Family Coping; Family Functioning; Parenting Performance

INTERVENTIONS AND RATIONALES

Determine: Monitor infant's responses *to ensure effectiveness of preventive measures.*

Inform: Explain to parents that infant maturation is a developmental process. *Their participation is crucial to help them understand the importance of nurturing the infant.*

Explain to parents that their actions can help modify some of infant's behavior; however, make it clear that infant maturation isn't completely within their control. *This explanation may help decrease the parents' feelings of incompetence.*

Explain to parents that infant gives behavioral cues that indicate needs. Discuss appropriate ways to respond to behavioral cues—for example, providing stimulation that doesn't overwhelm the infant; stopping stimulation when the infant gives behavioral cues (such as yawning, looking away, or becoming agitated); and finding methods to calm the infant if the infant becomes agitated (such as swaddling, gentle rocking, and quiet vocalizations). *Monitoring responses aids in gauging effectiveness of meeting needs.*

Help parents identify and cope with their responses to infant's behavioral disturbance *to help them recognize and adjust their response patterns. When the infant doesn't respond positively, the parents may feel inadequate or become frustrated. They need to understand that these reactions are normal.*

Attend: Explore with parents ways to cope with stress imposed by infant's behavior *to help them develop better coping skills.*

Praise parents when they demonstrate appropriate methods of interacting with the infant *to provide positive reinforcement.*

Manage: Provide parents with information on sources of support and special infant services *to promote coping with infant's long-term needs.*

SUGGESTED NIC INTERVENTIONS

Environmental Management; Neurologic Monitoring; Newborn Care; Parent Education: Infant; Positioning; Sleep Enhancement; Attachment Promotion; Developmental Care; Family Integrity Promotion; Teaching: Infant Stimulation 0–12 Months

REFERENCES

Brown, L. F., Pridham, K. A., & Brown, R. (2014). Sequential observation of infant regulated and dysregulated behavior following soothing and stimulating maternal behavior during feeding. *Journal for Specialists in Pediatric Nursing, 19*(2), 139–148. doi:10.1111/jspn.12062

Heun, N. (2014). Improving newborn pain management: Systematic pain assessment and operators' compliance with potentially better practices. *Journal of Clinical Nursing, 23*(3/4), 596–599. doi:10.1111/jocn.12036

Lopez, O., Subramanian, P., Rahmat, N., Theam, L. C., Chinna, K., & Rosli, R. (2015). The effect of facilitated tucking on procedural pain control among premature babies. *Journal of Clinical Nursing, 24*(1/2), 183–191. doi:10.1111/jocn.12657

RISK FOR DISORGANIZED INFANT BEHAVIOR

DEFINITION

Vulnerable to alteration in integration and modulation of the physiological and behavioral systems of functioning (i.e., autonomic, motor, state–organization, self-regulatory, and attentional–interactional systems), which may compromise health

RISK FACTORS

- Impaired motor functioning
- Insufficient containment within environment
- Invasive procedure
- Oral impairment
- Pain
- Parent expresses desire to enhance environmental conditions
- Prematurity
- Procedure

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Elimination
- Neurocognition
- Nutrition
- Physical regulation
- Role/relationships
- Sensation/perception
- Sleep/rest

EXPECTED OUTCOMES

- The parents will identify factors that place infant at risk for behavioral disturbance.
- The parents will identify potential signs of behavioral disturbance in infant.
- The parents will identify appropriate ways to interact with infant.
- The parents will identify their reactions to infant (including ways of coping with occasional frustration and anger).
- The parents will express positive feelings about their ability to care for infant.
- The parents will identify resources for help with infant.
- The infant will maintain physiologic stability.
- The infant will maintain an organized motor system.
- The infant will respond to sensory information in an adaptive way.

SUGGESTED NOC OUTCOMES

Knowledge: Child Development: 1 Month, 2 Months, 4 Months, 6 Months, and 12 Months; Knowledge: Infant Care; Neurological Status; Child Development: 1 Month; Family Coping; Family Functioning; Parenting Performance; Knowledge: Parenting; Preterm Infant Organization; Sleep

INTERVENTIONS AND RATIONALES

Determine: Monitor infant's responses *to ensure effectiveness of preventive measures.*

Perform: Demonstrate appropriate ways of interacting with the infant *to help parents identify and interpret the infant's behavioral cues and respond appropriately.* For example, help them recognize when the infant is awake and alert, and help them understand when the infant needs more stimulation, such as being spoken to or held.

Inform: Explain to parents that infant maturation is a developmental process and that their participation is crucial to their understanding of the importance of nurturing the infant. *Participation in the process by the parents will both stimulate the developmental process and alert to delays in development.*

Explain to parents that their actions can help modify some of their infant's behavior; however, make it clear that infant maturation isn't completely within their control. *This explanation may decrease the parent's' feelings of incompetence.*

Explain to parents that certain risk factors may interfere with the infant's ability to achieve optimal development. These risk factors include overstimulation, lack of stimulation, lack of physical contact, and painful medical procedures. *Educating the parents will help them understand their role in interpreting the infant's behavioral cues and providing appropriate stimulation.*

Describe to the parents the potential signs of a behavioral disturbance in the infant: inappropriate responses to stimuli, such as the failure to respond to human contact or tendency to become agitated with human contact; physiologic regulatory problems, such as a breathing disturbance in a premature infant; and apparent inability to interact with the environment. *Education will help the parents recognize whether the infant has a problem in behavioral development.*

Attend: Explore with parents ways to cope with the stress imposed by the infant's behavior *to increase their coping skills.*

Help parents identify their emotional responses to the infant's behavior *to help them recognize and adjust their response patterns.* Explain that it is normal for parents to experience feelings of inadequacy, frustration, or anger if the infant does not respond positively to them.

Praise the parents when they demonstrate appropriate methods of interacting with the infant *to provide positive reinforcement.*

Manage: Provide the parents with information on sources of support and special infant services *to help them cope with the infant's long-term needs.*

SUGGESTED NIC INTERVENTIONS

Infant Care; Newborn Monitoring; Parent Education: Infant; Positioning; Surveillance; Attachment Promotion; Developmental Care; Family Integrity Promotion; Teaching: Infant Stimulation 0–12 Months

REFERENCES

Baylis, R., Ewald, U., Gradin, M., Hedberg Nyqvist, K., Rubertsson, C., & Thernström Blomqvist, Y. (2014). First-time events between parents and preterm infants are affected by the designs and routines of neonatal intensive care units. *Acta Paediatrica (Oslo, Norway: 1992), 103*(10), 1045–1052. doi:10.1111/apa.12719

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Poehlmann, J., Burnson, C., & Weymouth, L. A. (2014). Early parenting, represented family relationships, and externalizing behavior problems in children born preterm. *Attachment & Human Development, 16*(3), 271–291. doi:10.1080/14616734.2014.884610

44 RISK FOR BLEEDING

DEFINITION

Vulnerable to a decrease in blood volume, which may compromise health

RISK FACTORS

- Aneurysm
- Circumcision
- Disseminated intravascular coagulopathy
- GI condition (e.g., ulcer, polyps, varices)
- History of falls
- Impaired liver function (e.g., cirrhosis, hepatitis)
- Inherent coagulopathy (thrombocytopenia)
- Insufficient knowledge of bleeding precautions
- Postpartum complications (e.g., uterine atony, retained placenta)
- Pregnancy-related complications (e.g., premature rupture of membranes, placenta previa/abruption, multiple gestation)
- Trauma
- Treatment regimen

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Fluid and electrolytes
- Pharmacologic function/treatments
- Reproduction
- Tissue perfusion

EXPECTED OUTCOMES

- The patient will receive screening to alert clinicians about existing risk factors for bleeding.
- The patient will receive follow-through intervention.
- The patient will receive appropriate clinician staffing and surveillance for a rapid response to rescue the patient before serious bleeding occurs.
- The patient will maintain heart rate, rhythm, blood pressure, and tissue perfusion within expected ranges during episodes of risk.
- The patient will identify and avoid risk situations with potential for trauma injury.

SUGGESTED NOC OUTCOMES

Maternal Status: Antepartum; Maternal Status: Postpartum; Blood Coagulation; Blood Loss Severity; Circulation Status; Vital Sign; Fluid Balance; Electrolyte & Acid Base Balance; Tissue Perfusion: Cellular

INTERVENTIONS AND RATIONALES

Determine: Interview/screen each individual for risk factors for bleeding; some individuals know of their risks for bleeding, whereas others do not. *Assessment findings may indicate need for protective measures.*

Anticipate conditions and episodes of care that may precipitate bleeding especially in high-risk patient care areas *to provide early intervention.* Monitor physiologic responses for values that exceed expected or normal ranges; *early bleeding compensatory mechanisms alter respirations, pulse, and blood pressure and may be present as subtle changes.* Monitor for occult and for frank bleeding—urine, feces, wounds, and dressings—by visual inspection or point-of-care testing *to identify need for intervention.*
Perform: Correlate findings, risk factors, and current episode of care and patient condition *to determine the imminent level of risk for bleeding.*

Perform vital signs and basic physical assessments for the patient who is at risk for bleeding until assured the risk is past *to provide data needed for early intervention.* Obtain laboratory tests (hemoglobin, hematocrit, complete blood cell count, thrombin time, prothrombin time, activated partial thromboplastin time, etc.) and point-of-care tests (stool, urine, gastric) as ordered; *these tests provide data that may be indications of a bleed.*

Examine dressings, drainage tubes, and collection canisters for presence of blood; report findings *to support need for changes in therapy.*
Inform: Teach patient about intended and unintended effects of medications (heparin, enoxaparin [Lovenox], warfarin [Coumadin], clopidogrel [Plavix], aspirin) that increase the risk of bleeding or prolong clotting. This enables the patient to avoid bleeding-risk situations.

Discuss patterns of risk management *to promote a lifestyle that focuses on health promotion/injury avoidance to diminish injuries.*

Discuss alternatives in ADLs *to avoid trauma-causing injury and bleeding.*
Attend: Provide care protecting an individual from injury *to prevent bleeding.* Implement interventions that reverse or remove the risk of bleeding or bleeding condition *to prevent bleeding or stabilize the patient's physiologic condition and assist in recovery.*

Provide emotional support to the patient who is bleeding and is experiencing physiologic compensatory responses of anxiety, fear, and a sense of dread, *as this support provides assurance and is calming.*

Support participation in decisions about the treatment placing the patient at risk for bleeding. *Active participation encourages fuller understanding of the rationale and compliance with the treatment.*
Manage: Refer to case manager or APN those at risk for bleeding secondary to treatment (i.e., warfarin INR) for monitoring and regime adherence. Monitor the recovery of the individual who experienced a bleeding episode *because weakness causes a safety risk for falls or injury.*

SUGGESTED NIC INTERVENTIONS

Bleeding Precautions; Bleeding Reduction; Blood Products Administration; Circulatory Precautions; Fluid/Electrolyte Management; Risk Identification; Teaching; Prescribed Medications; Vital Sign Monitoring

REFERENCES

Forslund, T., Wettermark, B., Wändell, P., Euler, M., Hasselström, J., & Hjemdahl, P. (2014). Risks for stroke and bleeding with warfarin or aspirin treatment in patients with atrial fibrillation at different CHADSVASc scores: Experience from the Stockholm region. *European Journal of Clinical Pharmacology, 70*(12), 1477–1485. doi:10.1007/s00228-014-1739-1

Kärkkäinen, J. M., Koskela, J. M., & Jyrkkä, J. (2015). Alcohol abuse increases rebleeding risk and mortality in patients with non-variceal upper gastrointestinal bleeding. *Digestive Diseases & Sciences, 60*(12), 3707–3715. doi:10.1007/s10620-015-3806-6

Mounce, M., Essel, C., Kim, T., & Harris, C. M. (2015). Risk factors for bleeding in hospitalized patients with elevated INR: No vitamin K therapy received versus vitamin K received. (2015). *Hospital Pharmacy, 50*(10), 894–899. doi:10.1310/hpj5010-894

RISK FOR UNSTABLE BLOOD GLUCOSE LEVEL 47

DEFINITION

Vulnerable to variation in blood glucose/sugar levels from the normal range, which may compromise health

RISK FACTORS

- Alteration in mental status
- Average daily physical activity is less than recommended for gender and age
- Compromised physical health status
- Delay in cognitive development
- Does not accept diagnosis
- Excessive stress
- Excessive weight gain
- Excessive weight loss
- Inadequate blood glucose monitoring
- Ineffective medication management
- Insufficient diabetes management
- Insufficient dietary intake
- Insufficient knowledge of disease management
- Nonadherence to diabetes management plan
- Pregnancy
- Rapid growth period

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Emotional
- Physical regulation
- Neurocognition
- Nutrition
- Tissue integrity

EXPECTED OUTCOMES

- The patient will be free from symptoms of hypoglycemia/hyperglycemia.
- The patient will have serum glucose within the prescribed range.
- The patient will verbalize understanding of how to control blood glucose level.

SUGGESTED NOC OUTCOMES

Blood Glucose Level; Diabetes Self-Management; Knowledge: Diabetes Management, Weight Control; Diabetes Self-Management

INTERVENTIONS AND RATIONALES

Determine: Assess patient for symptoms of low serum glucose level and maintain a patient airway, if indicated. *A low serum glucose may not be detected in some patients until moderate to severe central nervous*

system impairment occurs, which can lead to a compromised airway and cardiac arrest.

Assess for the underlying cause (e.g., inadequate dietary intake; illness such as nausea, vomiting, or diarrhea; and too much insulin) *to help patient prevent future episodes and adapt treatment strategies and lifestyle changes.*

Monitor or instruct patient to monitor glucose levels with a glucometer at regular intervals *to identify and respond early to fluctuations in glucose levels that occur outside normal parameters.*

Assess family understanding of prescribed treatment regimen. *The family plays an important role in supporting the patient.*

Assess patient's knowledge of hypo/hyperglycemia *to ensure adequate management and prevent future episodes.*

Monitor for signs and symptoms of hyperglycemia (polyuria, polydipsia, polyphagia, lethargy, malaise, blurred vision, and headache). *Early detection ensures prompt intervention and management.*

Assess for the underlying cause of elevated serum glucose level, including inadequate dietary intake, illness, and poor medication management *to prevent future episodes and develop treatment strategies such as changes in lifestyle.*

Perform: Perform immediate finger stick with a glucometer to *determine glucose level, which will guide treatment strategies.* Administer insulin, as prescribed, *to treat elevated blood glucose levels.*

Provide patient with glucose tablets or gel if patient is conscious and has ability to swallow. Administer intravenous glucose if patient is unconscious or cannot swallow. *Immediate treatment in the form of oral or intravenous glucose must be administered to reverse the low serum glucose level.* If patient becomes nauseated, turn patient on side *to prevent aspiration.*

Protect patient from injuries, such as falls. *Symptoms of low serum glucose place patient at risk for injury especially when driving and performing other potentially dangerous activities.*

Evaluate serum electrolyte levels. Administer potassium, as prescribed. *With elevated blood glucose levels, potassium and sodium levels may be low, normal, or high, depending on the amount of water loss.* Consider performing serum testing for $HgbA_{1c}$ (glycosylated hemoglobin A_{3C} level) *to evaluate average blood glucose levels over a period of approximately 2 to 3 months and to assess the adherence and effectiveness of the treatment regimen.*

Inform: Teach patient and family self-management of hypoglycemia and hyperglycemia including glucose monitoring at regular intervals *to treat abnormal glucose levels early* and medication management, nutritional

intake, exercise, and regular follow-up visits with the physician *to ensure adequate understanding and management of the treatment regimen to prevent future hyperglycemic events*. Patient and family teaching may include referrals to a diabetic educator, diabetic education classes, and a dietitian.

Manage: Consult physician if signs and symptoms persist. *Changes in prescribed medications may be needed, such as with oral hypoglycemic agents or insulin dosing*. Call for emergency medical services if patient is unstable outside the hospital.

SUGGESTED NIC INTERVENTIONS

Bedside Laboratory Testing; Health Education; Health Screening; Nutritional Counseling; Teaching: Disease Process, Prescribed Medications, and Prescribed Diet

REFERENCES

Cheng, A. Y. (2014). Achieving glycemic control in special populations in hospital: perspectives in practice. *Canadian Journal of Diabetes, 38*(2), 134–138. doi:10.1016/j.jcjd.2014.02.021

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Kubacka, B. (2014). A balancing act. *Nursing, 44*(1), 30–38. doi:10.1097/01.NURSE.0000438706.66979.52

50 DISTURBED BODY IMAGE

DEFINITION

Confusion in mental picture of one's physical self

DEFINING CHARACTERISTICS

- Absence of body part
- Alteration in body function
- Alteration in body structure
- Alteration in view of one's body (e.g., appearance, structure, function)
- Avoids looking at one's body
- Behavior of acknowledging one's body
- Behavior of monitoring one's body
- Change in ability to estimate spatial relationship of body to environment
- Change in lifestyle
- Change in social involvement
- Depersonalization of body part by use of impersonal pronouns
- Emphasis on remaining strengths
- Extension of body boundary (e.g., includes external object)
- Fear of reaction by others
- Focus on past appearance
- Focus on past function
- Focus on previous strength
- Heightened achievement
- Hiding body part
- Negative feeling about body
- Nonverbal response to perceived change in body (e.g., appearance, structure, function)
- Overexposure of body part
- Perceptions that reflect an altered view of one's body appearance
- Personalization of body part by name
- Personalization of loss by name
- Preoccupation with change
- Preoccupation with loss
- Refusal to acknowledge change
- Trauma to nonfunctioning body part
- Alteration in body function (due to anomaly, disease, medication, pregnancy, radiation, surgery, trauma, etc.)
- Alteration in cognitive functioning
- Alteration in self-perception
- Cultural incongruence
- Developmental transition
- Illness
- Impaired psychosocial functioning
- Injury

- Spiritual incongruence
- Surgical procedure
- Trauma
- Treatment regimen

RELATED FACTORS

- Alteration in body function (due to anomaly, disease, medication, pregnancy, radiation, surgery, trauma, etc.)
- Alteration in cognitive functioning
- Alteration in self-perception
- Cultural incongruence
- Developmental transition
- Illness
- Impaired psychosocial functioning
- Injury
- Spiritual incongruence
- Surgical procedure
- Trauma
- Treatment regimen

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Knowledge
- Sensory perception
- Sexuality
- Values/beliefs

EXPECTED OUTCOMES

- The patient will identify physical changes without making disparaging comments.
- The patient will identify at least one positive aspect of aging.
- The patient will use vision or hearing aids appropriately.
- The patient will demonstrate increased flexibility and willingness to consider lifestyles changes.
- The patient will participate in at least one social activity regularly.
- The patient will exercise and engage in other physical activity at level consistent with desire, ability, and safety.
- The patient will perform self-care activities to tolerance level.

SUGGESTED NOC OUTCOMES

Body Image; Grief Resolution; Self-Esteem; Life Change

INTERVENTIONS AND RATIONALES

Determine: Monitor physiologic responses to increased activity level, including respirations, heart rate and rhythm, and blood pressure. Assess

understanding of the current health problem and desire to participate in treatment. *Assessment information is helpful in determining appropriate interventions.*

Perform: Perform activities of daily living (ADLs) measures that the patient is unable to perform for self while *promoting as much independence as possible.*

Inform: Provide patient with information on appropriate self-care activities (e.g., maintaining proper diet; bathing as needed; using alcohol-free skin lotions to combat dryness; exercising appropriately to maintain muscle mass, bone strength, and cardiorespiratory health; avoiding fractures related to osteoporosis) *to ensure that the patient will be able to perform self-care measures.*

Teach patient about isometric exercises *to maintain or increase muscle tone and joint mobility.*

Teach caregivers to assist patient with self-care activities in a way that maximizes patient's potential. *This enables caregivers to participate in patient's care while supporting patient's independence.*

Attend: Provide emotional support and encouragement *to improve patient's self-concept and promote motivation to perform ADLs.*

Assist patient to learn how to perform self-care activities. Begin slowly and increase daily, as tolerated. *Performing self-care activities will assist patient to regain independence and enhance self-esteem.*

Involve patient in planning and decision making. *Having the ability to participate will encourage greater compliance with the plan for activity.*

Focus on patient's strengths and what the patient is able to do for self.

Encourage patient to engage in social activities with people of all age groups. *Participation once a week will help relieve patient's sense of isolation.*

Manage: Refer to case manager/social worker *to ensure patient receives long-term assistance with body image problem.*

Refer patient to a support group. *In the context of a group, the patient may develop a more positive view of present situation.*

Refer for corrective eyewear and hearing aids *to address sensory deficits.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Body Image Enhancement; Grief Work Facilitation; Self-Esteem Enhancement

REFERENCES

Aguilar Cordero, M. J., Mur Villar, N., Neri Sánchez, M., Pimentel-Ramírez, M. L., García-Rillo, A., Gómez Valverde, E. (2015). Breast cancer and body image as a prognostic factor of depression: A case study in México City. *Nutricion Hospitalaria, 31*(1), 371–379. doi:10.3305/nh.2015.31.1.7863

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Rhoten, B. A., Deng, J., Dietrich, M. S., Murphy, B., & Ridner, S. H. (2014). Body image and depressive symptoms in patients with head and neck cancer: An important relationship. *Supportive Care in Cancer, 22*(11), 3053–3060. doi:10.1007/s00520-014-2312-2

Taylor, C. (2015). Body image concerns after colorectal cancer surgery. *British Journal of Nursing, 24*, S8–S14.

54 RISK FOR IMBALANCED BODY TEMPERATURE

DEFINITION

Vulnerable to failure to maintain body temperature within normal parameter, which may compromise health

RISK FACTORS

- Acute brain injury
- Alteration in metabolic rate
- Condition affecting temperature regulation
- Decreased sweat response
- Dehydration
- Extremes of age
- Extremes of environmental temperature
- Extremes of weight
- Inactivity
- Inappropriate clothing for environmental temperature
- Increase in oxygen demand
- Increased body surface area to weight ratio
- Inefficient nonshivering thermogenesis
- Insufficient supply of subcutaneous fat
- Pharmaceutical agent
- Sedation
- Sepsis
- Vigorous activity

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Fluid and electrolytes
- Neurocognition
- Nutrition
- Respiratory function

EXPECTED OUTCOMES

- The patient will maintain body temperature of 98.6° F to 99.5° F (37° C to 37.5° C).
- The patient will maintain weight within 5% of baseline.
- The patient will maintain balanced intake and output within normal limits for age.
- The patient will have a urine-specific gravity between 1.010 and 1.015.
- The patient will express understanding of factors that cause hypothermia and hyperthermia.

SUGGESTED NOC OUTCOMES

Hydration; Risk Control; Risk Detection; Thermoregulation

INTERVENTIONS AND RATIONALES

Determine: Assess temperature every 4 hours. Use a temperature-taking method appropriate for age and size. *Prolonged elevation of temperature above 104° F (40° C) may produce dehydration and harmful central nervous system effects.*

Weigh patient every morning and record results. *A decrease in weight may indicate dehydration.*

Assess the patient's knowledge and lifestyle before teaching about hypothermia and hyperthermia *to gear the teaching plan to the patient's needs.*

Perform: Maintain adequate fluid intake by offering small amounts of flavored fluids at frequent intervals; record intake and output every shift. *Fever increases fluid requirements by increasing the metabolic rate.* Provide high-calorie liquids, such as colas, fruit juices, and flavored water sweetened with corn syrup, *to help prevent dehydration.*

Administer antipyretics, as ordered, and monitor effectiveness. *Antipyretics act on the hypothalamus to regulate body temperature.*

Check and record urine-specific gravity with each voiding. *Urine-specific gravity increases with dehydration. Adequate urine output and urine-specific gravity between 1.010 and 1.015 indicate sufficient hydration.*

Give a tepid sponge bath for increased temperature *to increase vaporization from skin and decrease body temperature.*

Inform: Teach patient to dress in lightweight clothing when experiencing elevated body temperature *to allow perspiration to evaporate, thereby releasing body heat.*

Instruct the patient on the signs and symptoms of imbalanced body temperature:

- *Hypothermia:* Shallow respirations; slow, weak pulse; decreased body temperature; low blood pressure; and pallor
- *Hyperthermia*: Shivering, shaking chill; feeling hot; extreme thirst; elevated body temperature; and high blood pressure.

Listing the signs and symptoms helps the patient learn and identify warning signals of imbalanced body temperature. Large black type is easier for the older patient to read.

Explain to the patient or family member why the patient needs warm clothing in cool climates, even indoors. Suggest socks, nonslip house shoes, and leg warmers *to provide warmth to vulnerable lower extremities, where vascular changes may cause decreased temperature sensation.*

Instruct the patient or family member to label home thermostats with large numbers and to use black or bright contrasting colors to indicate appropriate temperature settings. *Easy-to-read labels will help the patient maintain room temperature.*

Teach the patient or family members about the dangers of too much direct sunlight on warm days *to prevent overheating in an older patient with faulty thermoreceptors.*

Attend: Encourage the patient to remain active when in a cool environment *to keep warm and maintain normal metabolism.*

Manage: Suggest that a friend, family member, or volunteer from a local community organization visit the patient daily *to help ensure the patient's safety.*

SUGGESTED NIC INTERVENTIONS

Fever Treatment; Environmental Management; Temperature Regulation; Vital Signs Monitoring

REFERENCES

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DEFINITION

Low production of maternal breast milk

DEFINING CHARACTERISTICS

Infant

- Constipation
- Frequent crying
- Frequently seeks to suckle at breast
- Prolonged breast-feeding time
- Voids small amounts of concentrated urine
- Weight gain is <500 g in a month

Mother

- Absence of milk production with nipple stimulation
- Delay in milk production
- Expresses breast milk less than prescribed volume

RELATED FACTORS

Infant

- Ineffective latching on to breast
- Ineffective sucking reflex
- Insufficient opportunity for suckling at the breast
- Insufficient suckling time at breast
- Rejection of breast

Mother

- Alcohol consumption
- Insufficient fluid volume
- Malnutrition
- Pregnancy
- Smoking
- Treatment regimen

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Comfort
- Growth and development
- Nutritional
- Elimination
- Sleep/rest
- Coping
- Role relationships

EXPECTED OUTCOMES

- The patient will produce sufficient milk to satisfy the growth needs of the neonate.

- The patient will perceive that she is producing sufficient milk for her baby.
- Mother and baby will achieve successful and sustained breast-feeding sessions.
- The patient will be free of emotions related to low self-esteem, poor body image, and guilt.

SUGGESTED NOC OUTCOMES

Knowledge: Infant Care; Newborn Adaptation; Breastfeeding Establishment: Infant; Breastfeeding Establishment: Maternal; Nutritional Status: Nutrient Intake; Parent–Infant Attachment; Self-Esteem

INTERVENTIONS AND RATIONALES

Determine: Assess if neonate is able to latch properly to the nipple to suckle. *Ensuring the baby has latched to the nipple instead of the areola aids in milk expression.*

Evaluate whether there is adequate milk removal from each breast at each session. *Milk production is stimulated and increases by suckling and milk removal.*

Do a physical examination of the breast every shift; check nipples for inversion and for pore openings, *as anatomic conditions will limit the ability of the milk to flow to the newborn.* Examine breasts for engorgement, inflammation, infection, or pain. *These conditions cause discomfort and limit the tolerance/ability of the mother to breastfeed.*

Assess exhaustion level and the rest and sleep patterns of mother. *Exhaustion and inability to rejuvenate depresses milk production.*

Assess neonate's mouth to determine normal anatomy of tongue and palate; assess neonate's mouth for *Candida* infection. *Anatomic imperfections and thrush infection affect the neonate's ability to suckle.*

Assess neonate's nose for patency to allow for breathing during suckling. *Neonates are nose breathers and must have patent nares in order to suckle.*

Monitor neonate diaper for urine output (number per day, concentration of urine). *Urine output amount and color are indicators of hydration.* Check fluid-electrolyte status of neonate (urine characteristics and amount; stool output). *These measures guide the health care provider in determining hydration status of the neonate.*

Perform: Position mother/baby properly for baby to latch to nipple and suckle. *The couplet may need direction in assuming the best position of comfort for suckling.*

Provide adequate nourishment and fluid intake to the mother (>150 mL/kg/day). *This is the minimum amount of fluid intake to sustain the mother and provide extra fluid for milk production.*

Provide quiet uninterrupted time for breast-feeding. *Distractions and interruptions interfere with milk production, milk ejection, and the neonate's focus on suckling.*

Inform: Instruct the mother about the following:

- Milk production may take a week before a sufficient amount is produced. Understanding expectations improves confidence and reduces anxiety.
- Suckle the newborn at least 8 times a day to stimulate milk production; goal is 8 to 12 times daily. Understanding expectations improves confidence and reduces anxiety.
- Express milk or pump breasts regularly if newborn is unable to suckle. The breasts must be stimulated frequently to stimulate milk production.
- Provide mother and family unit nutritional instructions for best foods and fluids for intake to support breast milk production. Adequate and proper nutrition will aid the mother in recovery from labor and delivery and provide important nutrients to the neonate.
- Teach mother techniques to keep neonate awake during the feeding sessions. The neonate often needs stimulation to remain awake at breast to suckle sufficient milk.

Attend: Encourage mother to talk about emotions including frustration and disappointment. *Allowing others to assist the mother through emotional barriers may assist in creating peaceful emotions that aid in milk production and milk let-down.* Listen carefully to mother's concerns for clues to emotions and coping with disappointment and guilt, which are early signs of depression and stress. *Early intervention allows emotional healing and allows the mother to focus on the neonate and breast-feeding.*

Manage: Check with health care provider about substances and medications that can suppress milk production (i.e., caffeine, tobacco–nicotine, pseudoephedrine, diuretics, contraceptive pills). *To improve and sustain milk production, avoidance of substances that depress or limit milk production is important.*

Use a multidisciplinary team approach to support mother for breast milk production—registered nurse, lactation specialist, certified nurse midwife, pediatrician, registered dietitian, social worker. *A team approach brings expertise to address the needs of the mother and promotes health and well-being for the family unit.*

SUGGESTED NIC INTERVENTIONS

Breastfeeding Assistance; Active Listening; Newborn Care; Parent Education: Infant; Teaching: Infant Nutrition; Lactation Counseling; Sleep Enhancement

REFERENCES

Briere, C., Lucas, R., McGrath, J. M., Lussier, M., & Brownell, E. (2015). Establishing breastfeeding with the late preterm infant in the NICU. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 44*(1), 102–113. doi:10.1111/1552-6909.12536

Munblit, D., Boyle, R. J., & Warner, J. O. (2015). Factors affecting breast milk composition and potential consequences for development of the allergic phenotype. *Clinical and Experimental Allergy, 45*(3), 583–601. doi:10.1111/cea.12381

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DEFINITION

Difficulty providing milk to an infant or young child directly from the breasts, which my compromise nutritional status of the infant/child

DEFINING CHARACTERISTICS

- Inadequate infant stooling
- Infant arching at breast
- Infant crying at the breast
- Infant crying within the first hour after breast-feeding
- Infant fussing within 1 hour of breast-feeding
- Infant inability to latch on to maternal breast correctly
- Infant resisting latching on to breast
- Infant unresponsive to other comfort measures
- Insufficient emptying of each breast per feeding
- Insufficient infant weight gain
- Insufficient signs of oxytocin release
- Perceived inadequate milk supply
- Sore nipples persisting beyond first week
- Sustained infant weight loss
- Unsustained suckling at the breast

RELATED FACTORS

- Delayed lactogenesis II
- Inadequate milk supply
- Insufficient family support
- Insufficient opportunity for suckling at the breast
- Insufficient parental knowledge regarding breast-feeding techniques
- Insufficient parental knowledge regarding importance of breast-feeding
- Interrupted breast-feeding
- Maternal ambivalence
- Maternal anxiety
- Maternal breast anomaly
- Maternal fatigue
- Maternal obesity
- Maternal pain
- Oropharyngeal defect
- Pacifier use
- Poor infant sucking reflex
- Prematurity
- Previous breast surgery
- Previous history of breast-feeding failure
- Short maternity leave
- Supplemental feedings with artificial nipple

62 INEFFECTIVE BREASTFEEDING

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Communication
- Roles and relationships
- Values and beliefs

EXPECTED OUTCOMES

- The mother will express physical and psychological comfort in breast-feeding practice and techniques.
- The mother will show decreased anxiety and apprehension.
- The mother will state at least one resource for breast-feeding support.
- The infant will feed successfully on both breasts and appear satisfied for at least 2 hours after feeding.
- The infant will grow and thrive.

SUGGESTED NOC OUTCOMES

Breastfeeding Establishment: Maternal and Infant; Breastfeeding Assistance; Emotional Support; Lactation Counseling; Nutritional Management; Parent Education; Support Group

INTERVENTIONS AND RATIONALES

Determine: Assess factors that influence mother's decision to breastfeed. *Assessment information will be used to develop interventions.*

Monitor condition of breasts and nipples to identify problems that might interfere with feeding *to pinpoint problem areas.*

Assess readiness of mother to breastfeed and ability of infant to feed.

Monitor mother's breast-feeding technique. *Improper technique, which impedes feeding, will cause the mother to experience anxiety.*

Perform: Position mother in Fowler's position *to enhance mother's relaxation during feeding.* Place infant in proper position for optimal feeding *to produce proper sucking motion.*

Inform: Teach mother and selected caregiver the techniques for encouraging let-down, *including* warm shower, breast massage, physically caring for the neonate, and holding the neonate close to the breasts. *These measures reduce anxiety and promote the let-down reflex.*

Teach mother techniques (e.g., lying on her side, positioning the infant correctly, holding the nipple with C position, talking to and cuddling the infant) *that will help the infant latch on to the breast.*

Instruct mother to remove infant from the breast to be burped midway during the feeding *to allow for expulsion of air that is swallowed.*

Attend: Ask frequently during hospitalization whether the mother has questions while she is attempting to breastfeed. *This will give her the confidence she needs to continue when she gets home.*

Provide mother and infant with a quiet, private, comfortable environment in which to breastfeed. *Decreasing stressors will help to promote successful breast-feeding experience.*

Encourage expression of fears and anxieties between the mother and the infant *to reduce anxiety and increase the mother's sense of control over the process.*

Manage: Offer written information, a reading list, or a referral to a breastfeeding support group to allow for review of information after discharge:

Refer to home health nurse *for a follow-up visit in the home.*

Refer to a nutritionist *for information on good nutrition and fluid management.*

SUGGESTED NIC INTERVENTIONS

Breastfeeding Assistance; Emotional Support; Lactation Counseling; Infant; Parent Education; Support Group

REFERENCES

The Association of Women's Health, Obstetric, and Neonatal Nurses. (2015). Breastfeeding. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 44, 145–150.

Cordero, L., Thung, S., Landon, M. B., & Nankervis, C. A. (2014). Breast-feeding initiation in women with pregestational diabetes mellitus. *Clinical Pediatrics, 53*(1), 18–25. doi:10.1177/0009922813496455

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Ozlüses, E., & Celebioglu, A. (2014). Educating fathers to improve breastfeeding rates and paternal-infant attachment. *Indian Pediatrics, 51*(8), 654–657.

64 INTERRUPTED BREASTFEEDING

DEFINITION

Break in the continuity of providing milk to an infant or young child directly from the breasts, which may compromise breast-feeding success and/or nutritional status of the infant/child

DEFINING CHARACTERISTICS

- Nonexclusive breast-feeding

RELATED FACTORS

- Contraindications to breast-feeding (e.g., pharmaceutical agents)
- Hospitalized child
- Infant illness
- Maternal employment
- Maternal illness
- Maternal–infant separation
- Need to abruptly wean infant
- Prematurity

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Communication
- Knowledge
- Values and beliefs

EXPECTED OUTCOMES

- The mother will express her understanding of factors that necessitate interruption in breast-feeding.
- The mother will express comfort with her decision about whether to resume breast-feeding.
- The mother will express and store breast milk appropriately.
- The mother will resume breast-feeding when the interfering factor ceases.
- The mother will have adequate milk supply when breast-feeding resumes.
- The mother will obtain relief from discomfort associated with engorgement.
- The mother will ensure that infant's nutritional needs are met.

SUGGESTED NOC OUTCOMES

Breastfeeding Maintenance; Knowledge: Breastfeeding; Motivation; Parent–Infant Attachment; Parenting Performance; Role Performance

INTERVENTIONS AND RATIONALES

Determine: Assess mother's understanding for interrupting breast-feeding *to evaluate need for further instruction.*

Assess mother's desire to resume breast-feeding when reasons for interruption are no longer a factor. *The mother may not wish to continue breast-feeding.*

Assess mother's emotional reactions to having to interrupt breast-feeding. *Emotional feelings may affect resumption after interruption.*

Perform: Review 'mother's daily routine to advise her how to incorporate breast-feeding into her schedule. Mother must have a plan to carry on usual routine and still make sure the baby is fed on schedule.

Instruct mother on methods for expressing and storing breast milk. Demonstrate the use of a breast pump utilizing the following guidelines:

- Initiate pumping 24 to 48 hours after delivery.
- Pump a minimum of five times a day.
- Pump a minimum of 100 minutes a day.
- Pump long enough to soften breasts each time regardless of duration.

Instruct mother on ways to prevent breast engorgement *to prevent discomfort that may keep infant from sucking effectively*. Teach the mother about the use of nipple shield (if appropriate). *The shield is designed to alter flat or inverted nipples.*

Attend: Provide emotional support and encouragement *to help improve patient's confidence and motivation to resume breast-feeding when possible.*

Reassure mother that infant's nutritional needs will be met through other methods *to allay her anxiety.*

If mother must pump for a prolonged period, encourage her to use a piston-style electric pump. *Using an electric pump rather than a hand pump produces milk with a higher fat content.*

Involve patient in planning and decision making. *Having the ability to participate will encourage greater compliance with the plan to resume breast-feeding.*

If mother chooses not to resume breast-feeding, advise her to wear a supportive bra, apply ice, and take a mild analgesic *to alleviate discomfort associated with engorgement.*

Manage: Refer to a lactation support group *for continued assistance in resuming breast-feeding after an interruption.*

Provide appropriate educational home assessment. If possible, have a home health nurse visit the mother and infant *to assess progress.*

SUGGESTED NIC INTERVENTIONS

Attachment Promotion; Bottle Feeding; Emotional Support; Infant; Lactation Counseling; Parent Education; Teaching: Individual

REFERENCES

The Association of Women's Health, Obstetric, and Neonatal Nurses. (2015). Breastfeeding. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *44*, 145–150.

Jenkins, J. M., & Foster, E. M. (2014). The effects of breastfeeding exclusivity on early childhood outcomes. *American Journal of Public Health, 104*(Suppl 1), S128–S135. doi:10.2105/AJPH.2013.301713

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Tang, L., Lee, A. H., & Binns, C. W. (2015). Predictors of early introduction of complementary feeding: longitudinal study. *Pediatrics International, 57*(1), 126–130. doi:10.1111/ped.12421

66 INEFFECTIVE BREATHING PATTERN

DEFINITION

Inspiration and/or expiration that does not provide adequate ventilation

DEFINING CHARACTERISTICS

- Abnormal breathing pattern (e.g., rate, rhythm, depth)
- Altered chest excursion
- Bradypnea
- Decrease in expiratory pressure
- Decrease in inspiratory pressure
- Decrease in minute ventilation
- Decrease in vital capacity
- Dyspnea
- Increase in anterior–posterior chest diameter
- Nasal flaring
- Orthopnea
- Prolonged expiration phase
- Pursed-lip breathing
- Tachypnea
- Use of accessory muscles to breathe
- Use of three-point position

RELATED FACTORS

- Anxiety
- Body position that inhibits lung expansion
- Bony deformity
- Chest wall deformity
- Fatigue
- Hyperventilation
- Hypoventilation syndrome
- Musculoskeletal impairment
- Neurologic immaturity
- Neurologic impairment (e.g., positive EEG, head trauma, seizure disorders)
- Neuromuscular impairment
- Obesity
- Pain
- Respiratory muscle fatigue
- Spinal cord injury

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Cardiac function
- Neurologic and mental status
- Respiratory function

EXPECTED OUTCOMES

- The patient will maintain respiratory rate within 5 breaths/minute of baseline.
- The patient will regain arterial blood gases to baseline.
- The patient will express feelings of comfort when breathing.
- The patient will demonstrate diaphragmatic pursed-lipped breathing.
- The patient will achieve maximal lung expansion with adequate ventilation.
- The patient will maintain heart rate, rhythm, and blood pressure within expected range during periods of activity.
- The patient will demonstrate skill in conserving energy while carrying out activities of daily living (ADLs).

SUGGESTED NOC OUTCOMES

Mechanical Ventilation Response: Adult; Respiratory Status: Airway Patency; Respiratory Status: Gas Exchange; Respiratory Status: Ventilation; Vital Signs

INTERVENTIONS AND RATIONALES

Determine: Monitor and record respiratory rate and depth at least every 4 hours *to detect early stages of respiratory failure*. Auscultate breath sounds at least every 4 hours *to detect decreased or adventitious breath sounds*. Report changes.

Perform: Administer oxygen, as ordered, *to maintain an acceptable level of oxygen at the tissue level.*

Suction airway as needed *to maintain patent airways*.

Assist patient to Fowler's position, *which will promote expansion of lungs and provide comfort*. Support upper extremities with pillows, providing a table and covering it with a pillow to lean on.

Turn and reposition patient at least every 2 hours. Establish a turning schedule for the dependent patient. Post schedule at bedside and monitor frequency. *Turning and repositioning prevent skin breakdown and improve lung expansion and prevent atelectasis.*

Assist patient with ADLs as needed *to conserve energy and avoid overexertion.*

Encourage active exercise: Provide a trapeze or other assistive device whenever possible. *Such devices simplify moving and turning for many patients and allow them to strengthen some upper body muscles.*

Inform: Teach patient the following measures *to promote participation in maintaining health status and improve ventilation*: pursed-lip breathing, abdominal breathing, and relaxation techniques (deep breathing, meditation, guided imagery); taking prescribed medications (ensuring accuracy and frequency and monitoring side effects); and scheduling of activities to allow for rest periods.

Teach caregivers to assist patient with ADLs in a way that maximizes patient's potential. *This enables caregivers to participate in patient's care and encourages them to support patient's independence.*

Attend: Provide emotional support and encouragement *to improve patient's self-concept and motivate patient to perform ADLs.*

Involve patient in planning and decision making. *Having the ability to participate will encourage greater compliance with the plan for activity.*

Have patient perform self-care activities. Begin slowly and increase daily, as tolerated. *Performing self-care activities will assist patient to regain independence and enhance self-esteem.*

Schedule activities to allow for periods of rest.

Manage: Refer to case manager/social worker *to ensure that a home assessment has been done and that whatever modifications were needed to accommodate the patient's level of mobility have been made. Making adjustments in the home will allow the patient a greater degree of independence in performing ADLs, allowing better conservation of energy.*

Refer patient for evaluation of exercise potential and development of individualized exercise program. *Gradual increase in exercise will promote conditioning and ease breathing.*

SUGGESTED NIC INTERVENTIONS

Airway Management; Anxiety Reduction; Oxygen Therapy; Progressive Muscle Relaxation; Respiratory Monitoring; Ventilation Assistance

REFERENCES

Bradley, H., & Esformes, J. (2014). Breathing pattern disorders and functional movement. *International Journal of Sports Physical Therapy, 9*(1), 28–39.

Jones, M., Troup, F., Nugus, J., Roughton, M., Hodson, M., Rayner, C., . . . Pryor, J. (2015). Does manual therapy provide additional benefit to breathing retraining in the management of dysfunctional breathing? A randomised controlled trial. *Disability & Rehabilitation, 37*(9), 763–770. doi:10.3109/09638288.2014.941020

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DEFINITION

Inadequate blood pumped by the heart to meet the metabolic demands of the body

DEFINING CHARACTERISTICS

- *Altered Heart Rate/Rhythm:* Bradycardia, ECG change (e.g., arrhythmia, conduction abnormality, ischemia), heart palpitations, tachycardia
- *Altered Preload:* Decreased central venous pressure (CVP), decrease in pulmonary artery wedge pressure (PAWP), edema, fatigue, heart murmur, increase in CVP, increase in PAWP, jugular vein distension, weight gain
- *Altered Afterload:* Abnormal skin color (e.g., pale, dusky, cyanosis), alteration in blood pressure, clammy skin, decrease in peripheral pulses, decrease in pulmonary vascular resistance (PVR), decrease in systemic vascular resistance (SVR), dyspnea, increase in PVR, increase in SVR, oliguria, prolonged capillary refill
- *Altered Contractility:* Adventitious breath sounds, coughing, decreased cardiac index, decrease in ejection fraction, decrease in left ventricular stroke work index (LVSWI), decrease in stroke volume index (SVI), orthopnea, paroxysmal nocturnal dyspnea, presence of S3 heart sound, presence of S4 heart sound
- *Behavioral/Emotional:* Anxiety, restlessness

RELATED FACTORS

- Alteration in heart rate
- Alteration in heart rhythm
- Altered afterload
- Altered contractility
- Altered preload
- Altered stroke volume

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Respiratory function
- Activity/exercise
- Fluid and electrolytes

EXPECTED OUTCOMES

- The patient will maintain pulse within predetermined limits.
- The patient will maintain blood pressure within predetermined limits.
- The patient will exhibit no arrhythmias.
- The patient will maintain warm and dry skin.
- The patient will exhibit no pedal edema.
- The patient will maintain acceptable cardiac output.
- The patient will verbalize understanding of reportable signs and symptoms.

- The patient will understand diet, medication regimen, and prescribed activity level.

SUGGESTED NOC OUTCOMES

Cardiac Pump Effectiveness; Circulation Status; Tissue Perfusion: Peripheral; Vital Signs

INTERVENTIONS AND RATIONALES

Determine: Monitor patient at least every 4 hours for irregularities in heart rate, rhythm, dyspnea, fatigue, crackles in lungs, jugular venous distension, or chest pain. *Any or all of these may indicate impending cardiac failure or other complications. Report changes immediately.*

Perform: Administer oxygen, as ordered, *to increase supply to myocardium.*

Turn and reposition patient at least every 2 hours. Establish a turning schedule for the dependent patient. Post schedule at bedside and monitor frequency. *Turning and repositioning prevent skin breakdown and improve lung expansion and prevent atelectasis.*

Administer antiarrhythmic drugs, as ordered, *to reduce or eliminate rhythm disturbances. Monitor for adverse effects.*

Administer stool softeners, as prescribed, *to reduce straining during bowel movements.*

Measure and record intake and output. *Decreased urinary output without decreased fluid intake may indicate decreased renal perfusion resulting from decreased cardiac output.*

Weigh patient daily before breakfast *to detect fluid retention.*

Perform active or passive range of motion (ROM) exercises to all extremities every 2 to 4 hours. *ROM exercises foster muscle strength and tone, maintain joint mobility, and prevent contractures.*

Inspect legs and feet *for pedal edema.*

Maintain dietary restrictions, as ordered, *to prevent fluid retention, dehydration, and weight gain or loss.*

Gradually increase levels of activity within prescribed limits of cardiac rate *to allow heart to adjust to increased cardiac demands.*

Inform: Educate patient and family about chest pain and other reportable symptoms, prescribed diet, medications (name, dosage, frequency, and therapeutic and adverse effects), prescribed activity level, simple methods of lifting and bending, and stress-reduction techniques. *Education promotes remembering of and compliance with techniques to reduce energy consumption.*

Attend: Provide emotional support and encouragement *to help* improve patient's self-concept.

Involve patient in planning and decision making. *Having the ability to participate will encourage greater compliance with the plan of treatment.*

Have patient perform self-care activities. Begin slowly and increase daily, as tolerated. *Performing self-care activities will assist patient to regain independence and enhance self-esteem.*

Manage: Refer to case manager/social worker *to ensure that a home assessment has been done and that whatever modifications are needed to accommodate the patient's ongoing care have been made*. Refer to cardiac program for exercise when the time is appropriate.

SUGGESTED NIC INTERVENTIONS

Cardiac Precautions; Circulatory Precautions; Fluid Management; Homodynamic Regulation; Vital Signs Monitoring

REFERENCES

Caitlin, B. J., Lewis, K. B., Nichols, N., & Parsons, L. M. (2015). Advance care planning and the role of the cardiovascular nurse. *Canadian Journal of Cardiovascular Nursing, 25*(3), 5–9.

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72 RISK FOR DECREASED CARDIAC OUTPUT

DEFINITION

Vulnerable to inadequate blood pumped by the heart to meet metabolic demands of the body, which may compromise health

RISK FACTORS

- Alteration in heart rate
- Alteration in heart rhythm
- Altered afterload
- Altered contractility
- Altered preload
- Altered stroke volume

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Respiratory function
- Activity/exercise
- Fluid and electrolytes

EXPECTED OUTCOMES

- The patient will have pulse within normal limits.
- The patient will have blood pressure within normal limits.
- The patient will exhibit no arrhythmias.
- The patient will have warm and dry skin.
- The patient will exhibit no pedal edema.
- The patient will show no signs of dizziness or syncope.
- The patient will experience few or no dyspneic episodes.
- The patient will experience no chest pain.
- The patient will express sense of physical comfort after activity.
- The patient will maintain adequate cardiac output.
- The patient will perform stress-reduction techniques.
- The patient will verbalize understanding of reportable signs and symptoms.
- The patient will verbalize understanding of diet, medication, and activity level on cardiac health.

SUGGESTED NOC OUTCOMES

Cardiac Pump Effectiveness; Circulation Status; Tissue Perfusion: Peripheral; Vital Signs

INTERVENTIONS AND RATIONALES

Determine: Monitor patient for irregularities in heart rate, rhythm, dyspnea, fatigue, crackles in lungs, jugular venous distension, or chest pain. *Any or all of these may indicate impending cardiac failure or other complications. Report changes immediately.*

Perform: Turn and reposition patient at least every 2 hours. Establish a turning schedule for the dependent patient. Post schedule at bedside and monitor frequency. *Turning and repositioning prevent skin breakdown and improve lung expansion and prevent atelectasis.*

Administer antiarrhythmic drugs, as ordered, *to reduce or eliminate rhythm disturbances. Monitor for adverse effects.*

Administer stool softeners, as prescribed, *to reduce straining during bowel movements.*

Measure and record intake and output. *Decreased urinary output without decreased fluid intake may indicate decreased renal perfusion resulting from decreased cardiac output.*

Weigh patient daily before breakfast *to detect fluid retention.*

Perform active or passive range of motion (ROM) exercises to all extremities every 2 to 4 hours. *ROM exercises foster muscle strength and tone, maintain joint mobility, and prevent contractures.*

Inspect legs and feet *for pedal edema.*

Maintain dietary restrictions, as ordered, *to prevent fluid retention, dehydration, and weight gain or loss.*

Gradually increase levels of activity within prescribed limits of cardiac rate *to allow heart to adjust to increased cardiac demands.*

Inform: Educate patient and family about chest pain and other reportable symptoms, prescribed diet, medications (name, dosage, frequency, and therapeutic and adverse effects), prescribed activity level, simple methods of lifting and bending, and stress-reduction techniques. *Education promotes remembering of and compliance with techniques to reduce energy consumption.*

Attend: Provide emotional support and encouragement *to help* improve patient's self-concept.

Involve patient in planning and decision making. *Having the ability to participate will encourage greater compliance with the plan of treatment.*

Have patient perform self-care activities. Begin slowly and increase daily, as tolerated. *Performing self-care activities will assist patient to regain independence and enhance self-esteem.*

Manage: Refer to case manager/social worker *to ensure that a home assessment has been done and that whatever modifications are needed to accommodate the patient's ongoing care have been made.* Refer to cardiac program for exercise when the time is appropriate.

SUGGESTED NIC INTERVENTIONS

Cardiac Precautions; Circulatory Precautions; Fluid Management; Hemodynamic Regulation; Vital Signs Monitoring

REFERENCES

Caitlin, B. J., Lewis, K. B., Nichols, N., & Parsons, L. M. (2015). Advance care planning and the role of the cardiovascular nurse. *Canadian Journal of Cardiovascular Nursing, 25*(3), 5–9.

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RISK FOR IMPAIRED CARDIOVASCULAR FUNCTION

DEFINITION

Vulnerable to internal or external causes that can damage one or more vital organs and the circulatory system itself

RISK FACTORS

- Age ≥65 years
- Diabetes mellitus
- Dyslipidemia
- Family history of cardiovascular disease
- History of cardiovascular disease
- Hypertension
- Insufficient knowledge of modifiable risk factors
- Obesity
- Pharmaceutical agent
- Sedentary lifestyle
- Smoking

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Respiratory function
- Activity/exercise
- Fluid and electrolytes

EXPECTED OUTCOMES

- The patient will have no damage to cardiovascular system or one or more other major organs.
- The patient will have improved myocardial contractility/systemic perfusion.

SUGGESTED NOC OUTCOMES

Cardiac Pump Effectiveness; Circulation Status; Tissue Perfusion: Peripheral; Vital Signs

INTERVENTIONS AND RATIONALES

Determine: Monitor patient for irregularities in heart rate, rhythm, dyspnea, fatigue, crackles in lungs, jugular venous distension, or chest pain. *Any or all of these may indicate impending cardiac failure or other complications. Report changes immediately.*

Perform: Administer diuretics as ordered. *When used in conjunction with low-sodium diet and restriction of fluids, can lead to clinical improvement.*

Administer vasodilators as ordered. *Can increase cardiac output.*

Administer antiarrhythmic drugs, as ordered, *to reduce or eliminate rhythm disturbances. Monitor for adverse effects.*

Administer stool softeners, as prescribed, *to reduce straining during bowel movements.*

Measure and record intake and output. *Decreased urinary output without decreased fluid intake may indicate decreased renal perfusion resulting from decreased cardiac output.*

Weigh patient daily before breakfast *to detect fluid retention.*

Inspect legs and feet *for pedal edema.*

Elevate legs. *Decreases venous stasis.*

Maintain dietary restrictions, as ordered, *to prevent fluid retention, dehydration, and weight gain or loss.*

Inform: Educate about testing such as cardiac stress test, echocardiography, CT, MRI, cardiac catheterization, etc. *Testing may be needed to determine possible damage to one or more vital organs.*

Educate importance of rest periods during activity. *Adequate rest is needed to improve efficiency of cardiac contractility and oxygen consumption.*

Educate on lifestyle changes such as low-salt diet, no smoking, exercise, etc. *Education will decrease risk.*

Attend: Provide emotional support and encouragement *to help* improve patient's self-concept.

Involve patient in planning and decision making. *Having the ability to participate will encourage greater compliance with the plan of treatment.*

Have patient perform self-care activities. Begin slowly and increase daily, as tolerated. *Performing self-care activities will assist patient to regain independence and enhance self-esteem.*

Manage: Refer to case manager/social worker *to ensure that a home assessment has been done and that whatever modifications are needed to accommodate the patient's ongoing care have been made.*

SUGGESTED NIC INTERVENTIONS

Cardiac Precautions; Circulatory Precautions; Fluid Management; Hemodynamic Regulation; Vital Signs Monitoring

REFERENCES

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DEFINITION

Pregnancy and childbirth process and care of the newborn that does not match the environmental context, norms, and expectations

DEFINING CHARACTERISTICS

- *During Pregnancy:* Inadequate prenatal care, inadequate prenatal lifestyle (e.g., elimination, exercise nutrition, personal hygiene, sleep), inadequate preparation of newborn care items, inadequate preparation of the home environment, ineffective management of unpleasant symptoms in pregnancy, insufficient access of support system, insufficient respect for unborn baby, unrealistic birth plan
- *During Labor and Delivery:* Decrease in proactivity during labor and delivery, inadequate lifestyle for stage of labor (e.g., elimination, exercise, nutrition, personal hygiene, sleep), inappropriate response to onset of labor, insufficient access of support system, insufficient attachment behavior
- *After Birth:* Inadequate baby care techniques, inadequate postpartum lifestyle (e.g., elimination, exercise, nutrition, personal hygiene, sleep), inappropriate baby feeding techniques, inappropriate breast care, insufficient access of support system, insufficient attachment behavior, unsafe environment for an infant

RELATED FACTORS

- Domestic violence
- Inconsistent prenatal health visits
- Insufficient knowledge of childbearing process
- Inadequate maternal nutrition
- Insufficient parental role model
- Insufficient prenatal care
- Insufficient support system
- Low maternal confidence
- Maternal powerlessness
- Maternal psychological distress
- Substance abuse
- Unplanned pregnancy
- Unrealistic birth plan
- Unsafe environment
- Unwanted pregnancy

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Comfort
- Growth and development
- Nutrition

- Values/beliefs
- Fluids and electrolytes
- Physical regulation
- Respiratory function
- Tissue integrity
- Behavior
- Coping
- Emotional
- Knowledge
- Roles and relationships

EXPECTED OUTCOMES

- The mother and family unit will demonstrate a willingness to improve her lifestyle and adhere to medical recommendations for optimal prenatal health.
- The mother and family unit will seek and convey confidence in knowledge about pregnancy, the labor and the delivery processes, and newborn care.
- The mother and family unit will cooperate and follow the care directives of the health care team during labor and delivery and the postpartum period.
- The mother and family unit will demonstrate coping and emotional strength to adapt to emergent situations during the prenatal, intrapartal, postpartal, and newborn care periods.
- The mother and family unit will exhibit maternal interest, attachment, and bonding with the newborn.
- The mother and family unit will perform skills for self-care and newborn care including breast-feeding skills.
- The mother and family unit will seek to meet positive self-care needs and to meet the newborn's physical, social, nutritional, and safety needs.

SUGGESTED NOC OUTCOMES

Fetal Status: Antepartum; Fetal Status: Intrapartum; Newborn Adaptation; Breastfeeding Establishment: Infant; Breastfeeding Establishment: Maternal; Parent-Infant Attachment; Role Performance; Prenatal Health Behavior; Knowledge: Breastfeeding; Knowledge: Infant Care; Knowledge: Labor and Delivery; Maternal Status: Antepartum; Maternal Status: Intrapartum; Maternal Status: Postpartum

INTERVENTIONS AND RATIONALES

Determine: Assess baseline knowledge of prenatal self-care, labor and delivery process, and newborn care *to identify and resolve knowledge deficits.*

Assess physical and psychological states of the mother during pregnancy *in order to treat medical conditions and develop a patient-centered plan to address needs and deficits.*

Monitor physiologic vital signs and parameters at each phase of childbearing frequently *as these aid the clinicians in determining courses of action in response to evolving pathophysiologic needs.*

Monitor the emotional baseline of mother/family unit *to identify strengths needed to cope with unknown rapidly changing conditions.*

Perform: Anticipate needs and provide opportunities for mother to reach out for assistance and knowledge for her self-care and expectations of labor and delivery and newborn care. *Mother's engagement in the processes demonstrates interest and initiates autonomy.*

Provide interventions for emergent conditions according to nursing standards of practice within clinical pathway protocols. *Adherence to evidence-based standards and practice guidelines benefits the mother–neonate–family unit and provides quality, efficient team-based care.*

Inform: Teach mother self-care for common prenatal discomforts *to promote patient comfort and autonomy.*

Teach the mother about the pregnancy process and the labor and delivery. *Understanding expectations improves confidence, reduces anxiety, and aids in creating a trusting relationship.*

Demonstrate comfort techniques that aid in labor management and delivery. *As the individual is free from discomfort, she can be more accepting of instruction and can assist in the labor–delivery processes.*

Include mother in planning for changes in treatment plan during labor and delivery. *This indicates respect and reduces anxiety and fear of the unknown.*

Provide accurate information to mother/family unit during crisis/emergent situations. *This aids in anxiety reduction, trust establishment, and the family unit's ability to cooperate with the treatment team for the safety of mother and fetus/newborn.*

Demonstrate techniques that match the mother's abilities to care for the newborn while newborn is undergoing therapeutic care. *Demonstrates respect and individualization of the plan of care for the mother to meet the physical and emotional needs of the newborn.*

Attend: Provide supportive environment during prenatal, intrapartum, and postpartum periods. *When the mother feels comfortable and cared for, she can focus on self-care, healing, and care of newborn undergoing intensive care management.*

Provide bonding time between newborn and mother/family unit, encourage skin-to-skin cuddling, and encourage breast-feeding at delivery. *These and other actions enhance critical bond development between mother/family unit and newborn.*

Support the mother/family unit in the recovery and healing processes of the mother and the neonate following unplanned, emergent stressful

events. *Allowing the mother/family unit to verbalize and explore feelings and emotions aids in the integration process of healing.*

Manage: Arrange for transportation to provider for clinic visit. *Nonadherence to prenatal and postpartum visits may be related to transportation.*

Provide antenatal and postnatal classes on self-care and care of the newborn by a certified childbirth educator. *Advanced knowledge of the childbearing process promotes empowerment and positive maternal outcomes.*

Coordinate multidisciplinary team: registered nurse, nurse midwife, physician, lactation consultant, registered dietitian, social worker. *These professionals assess and uniquely meet the needs of the mother and newborn when there have been events that interfered with the childbearing processes.*

Assist the family unit to develop the support system/network if management of medical and neonatal conditions warrants extended hospitalization. *Anticipatory guidance in seeking resources and assistance will aid the family to cope and provide autonomy in supporting the family as it supports its members in the hospital.*

SUGGESTED NIC INTERVENTIONS

Role Enhancement; Parent Education: Infant; Teaching: Infant Safety 0-3 Months; Birthing; Infant Care; Family Involvement Promotion; Coping Enhancement; Family Integration Promotion

REFERENCES

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DEFINITION

Vulnerable to not matching environmental context, norms, and expectations of pregnancy, childbirth process, and the care of the newborn

RISK FACTORS

- Domestic violence
- Inconsistent prenatal health visits
- Insufficient cognitive readiness for parenting
- Insufficient knowledge of childbearing process
- Inadequate maternal nutrition
- Insufficient parental role model
- Insufficient prenatal care
- Insufficient support system
- Low maternal confidence
- Maternal powerlessness
- Maternal psychological distress
- Substance abuse
- Unplanned pregnancy
- Unrealistic birth plan
- Unwanted pregnancy

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Comfort
- Nutrition
- Self-care
- Coping
- Reproduction
- Behavior
- Knowledge
- Roles/relationships
- Risk management

EXPECTED OUTCOMES

- The patient will demonstrate a willingness to improve her lifestyle for optimal prenatal health.
- The patient will seek and convey confidence in knowledge about pregnancy, the labor and the delivery processes, and newborn care.
- The patient will cooperate and follow the care directives of the health care team during labor and delivery and the postpartum period.
- The patient will exhibit maternal interest, attachment, and bonding with the newborn.
- The patient will perform skills for self-care and newborn care.

- The patient will seek to meet positive self-care needs and to meet the newborn's physical, social, nutritional, and safety needs.

SUGGESTED NOC OUTCOMES

Fetal Status: Antepartum; Fetal Status: Intrapartum; Newborn Adaptation; Breastfeeding Establishment: Infant; Breastfeeding Establishment: Maternal; Parent-Infant Attachment; Role Performance; Prenatal Health Behavior; Knowledge: Breastfeeding; Knowledge: Infant Care; Knowledge: Labor and Delivery; Maternal Status: Antepartum; Maternal Status: Intrapartum; Maternal Status: Postpartum

INTERVENTIONS AND RATIONALES

Determine: Assess baseline knowledge of prenatal self-care, labor and delivery process, and newborn care *to identify and resolve knowledge deficits.*

Assess physical and psychological states of the mother during pregnancy *in order to treat medical conditions and develop plan to address deficits.*

Analyze cultural beliefs contributing to mother's behavior, *since understanding by the health care team can aid in determining a plan of approach and treatment that is patient centered.*

Perform: Convey a nonjudgmental attitude *to allow a trusting relationship to develop.*

Anticipate needs and provide opportunities for mother to reach out for assistance and knowledge for her self-care and expectations of labor and delivery and newborn care. *Mother's engagement in the processes demonstrates interest and initiates autonomy.*

Monitor intrapartal parameters according to accepted standard of practice *to maintain physiologic needs and respond to evolving pathophysiologic needs.*

Implement treatment plan prenatally or intrapartum to alleviate medical conditions *to enhance the physiologic condition of the mother.*

Inform: Teach mother self-care for common prenatal discomforts *to promote patient autonomy.*

Teach the mother about the pregnancy process and the labor and delivery. *Understanding expectations improves confidence, reduces anxiety, and aids in creating a trusting relationship.*

Demonstrate comfort techniques that aid in labor management and delivery. *As the individual is free from discomfort, she can be more accepting of instruction and can assist in the labor–delivery processes.*

Include mother in planning for changes in treatment plan during labor and delivery. *This indicates respect and reduces anxiety and fear of the unknown.*

Demonstrate techniques that match the mother's abilities to care for the newborn. *Demonstrates respect and individualization of the plan of care for the mother.*

Attend: Provide supportive environment during prenatal, intrapartum, and postpartum periods. *When the mother feels comfortable and cared for, she can focus on self-care and care of newborn.*

Provide bonding time between newborn and mother, encourage skin-to-skin cuddling, and encourage breast-feeding at delivery. *These and other actions enhance critical bond development between mother and newborn.*

Provide antenatal and postnatal classes on self-care and care of the newborn by a certified childbirth educator. *Advanced knowledge of the childbearing process promotes empowerment and positive maternal outcomes.*

Manage: Arrange for transportation for clinic visit. *Nonadherence to prenatal and postpartum visits may be related to transportation.*

Coordinate multidisciplinary team: registered nurse, nurse midwife, physician, lactation consultant, registered dietitian, social worker. *These professionals assess and uniquely meet the needs of the mother and newborn.*

SUGGESTED NIC INTERVENTIONS

Role Enhancement; Parent Education: Infant; Teaching: Infant Safety; Birthing; Infant Care; Family Involvement Promotion; Coping Enhancement

REFERENCES

Biro, M. A., Yelland, J. S., & Brown, S. J. (2014). Why are young women less likely to breastfeed? Evidence from an Australian population-based survey. *Birth: Issues in Perinatal Care, 41*(3), 245–253. doi:10.1111/birt.12112

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84 IMPAIRED COMFORT

DEFINITION

Perceived lack of ease, relief, and transcendence in physical, psychospiritual, environmental, cultural, and/or social dimensions

DEFINING CHARACTERISTICS

- Alteration in sleep pattern
- Anxiety
- Crying
- Discontent with situation
- Distressing symptoms
- Fear
- Feeling cold
- Feeling hot
- Feeling of discomfort
- Feeling of hunger
- Inability to relax
- Irritability
- Itching
- Moaning
- Restlessness
- Sighing
- Uneasy in situation

RELATED FACTORS

- Illness-related symptoms
- Insufficient environmental control
- Insufficient privacy
- Insufficient resources (e.g., financial, social, knowledge)
- Insufficient situational control
- Noxious environment stimuli
- Treatment regimen

ASSESSMENT FOCUS

- Cardiac
- Muscle tone
- Pain
- Respiratory
- Sleep patterns

EXPECTED OUTCOMES

- The patient will maintain heart rate, rhythm, and respiration rate within expected range during rest and activity.
- The patient will maintain muscle mass and strength.
- The patient will report pain using pain scale.
- The patient will report periods of restful sleep.

SUGGESTED NOC OUTCOMES

Comfort Status; Coping; Knowledge Health Promotion; Pain Control; Comfort Status: Environment, Physical, Sociocultural, and Psychospiritual

INTERVENTIONS AND RATIONALES

Determine: Monitor pain level using scale 1 to 10. *Using a scale will allow evaluation of the effectiveness of pain-relieving measures.*

Assess vital signs during times of discomfort, including blood pressure, heart rate and rhythm, and respirations. *Use the patient's baseline vital signs to evaluate response to pain and response to pain-relieving measures.*

Assess sleeping patterns in response to discomfort. *Interruption of sleep is common in patients experiencing discomfort.*

Perform: Provide a quiet and relaxing atmosphere. Encourage active exercise *to increase feeling of well-being.* Provide pain medications, as ordered; analyze response *to evaluate effectiveness of pain-relieving measures.*

Inform: Teach relaxation exercises and techniques *to promote reduced pain levels, sleep, and anxiety.* Teach medication administration and schedule to facilitate pain relief. Teach massage therapy to caregiver *to promote comfort.*

Attend: Provide support and encouragement during periods of discomfort. Include patient in plan of action *to promote self-care.*

Manage: Refer to pain management clinic if pain cannot be controlled through relaxation and exercise. Refer to physical therapist to accommodate patient's level of physical activity. Refer to massage therapist to promote relaxation. *All health care professionals contribute to the overall goal of maintaining comfort.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Aromatherapy; Calming Technique; Massage; Environmental Management: Comfort Coping Enhancement

REFERENCES

Krinsky, R., Murillo, I., & Johnson, J. (2014). A practical application of Katharine Kolcaba's comfort theory to cardiac patients. *Applied Nursing Research, 27*(2), 147–150. doi:10.1016/j.apnr.2014.02.004

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86 ACUTE CONFUSION

DEFINITION

Abrupt onset of reversible disturbances of consciousness, attention, cognition, and perception that develop over a short period of time

DEFINING CHARACTERISTICS

- Agitation
- Alteration in cognitive functioning
- Alteration in level of consciousness
- Alteration in psychomotor functioning
- Hallucinations
- Inability to initiate goal-directed behavior
- Inability to initiate purposeful behavior
- Insufficient follow-through with goal-directed behavior
- Insufficient follow-through with purposeful behavior
- Misperception
- Restlessness

RELATED FACTORS

- Age ≥60 years
- Alteration in sleep–wake cycle
- Delirium
- Dementia
- Substance abuse

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Neurocognition
- Nutrition
- Respiratory function
- Risk management
- Sleep/rest

EXPECTED OUTCOMES

- The patient/family will experience no injury.
- The patient/family will maintain a stable neurologic status.
- The patient/family will start to participate in activities of daily living (ADLs).
- The patient/family will report feeling increasingly calm and improved ability to cope with confused state.
- The patient/family will express an understanding of the importance of informing other health care providers about episodes of acute confusion.

SUGGESTED NOC OUTCOMES

Cognition; Cognitive Orientation; Information Processing; Distorted Thought Self-Control

INTERVENTIONS AND RATIONALES

Determine: Assess patient's LOC and changes in behavior *to provide baseline for comparison with ongoing assessment findings.* Monitor neurologic status on a regular basis *to detect any improvement or decline in patient's neurologic function.*

Perform: Limit noise and environmental stimulation *to prevent additional confusion.*

Use appropriate safety measures *to protect patient from injury.* Avoid physical restraints to control agitating patient.

Address patient by name and tell the patient your name *to foster awareness of self and environment.* Also, frequently mention time, place, and date; have a clock and a calendar in sight and refer to these aids.

Give patient short, simple explanations each time you perform a procedure or task *to decrease confusion.* Speak slowly and clearly and allow time to respond *to reduce frustration.*

Schedule nursing care to include quiet times *to help avoid sensory overload.* Plan patient's routine and be consistent *to foster task completion and reduce confusion.*

Ask family members to bring labeled family photos and articles *to create a more secure environment for patient.* Keep patient's possessions in the same place. *A consistent, stable environment reduces confusion and frustration and aids completion of ADLs.*

Inform: Review home measures to use and report if patient begins to exhibit signs of confusion. Tell caregiver to provide short explanations of activities and orient the patient frequently; speak slowly and clearly and allow patient time to respond; and provide patient with a consistent routine. *Teaching empowers patient and family members to take greater responsibility for the health care needs.*

Attend: Have a staff member stay at patient's bedside, if necessary, *to protect the patient from harm.*

Enlist the aid of family member *to help calm patient.* Patiently encourage patient to perform ADLs, dividing tasks into small, critical units.

Be patient and specific in providing instructions. Allow time for patient to perform each task. *These measures enhance the patient's self-esteem as well as help prevent complications related to inactivity.*

Encourage family members to share stories and discuss familiar people and events with patient *to promote a sense of continuity and create a sense of security and comfort.* Support family members' attempts to interact with patient *to provide positive reinforcement.* Allow time before and after visits for family members to express feelings. *Listening to family members in an open and nonjudgmental manner promotes coping and may help you assess and monitor patient's condition.* Reassure patient

and family that confusion is temporary *to help relieve anxiety*. Always include patient in discussions.

Manage: Confer with physician about diagnostic test results, patient's progress in behavior, and patient's LOC. *A collaborative approach to treatment helps ensure high-quality care and continuity of care.*

SUGGESTED NIC INTERVENTIONS

Cognitive Stimulation; Delirium Management; Hallucination Management; Orientation; Cognitive Restructuring; Delusion Management

REFERENCES

Brooks, P., Spillane, J. J., Dick, K., & Stuart-Shor, E. (2014). Developing a strategy to identify and treat older patients with postoperative delirium. *AORN Journal, 99*(2), 256–276. doi:10.1016/j.aorn.2013.12.009

Hea-Jeong, H., & Yeonghee, S. (2014). Effects of nursing intervention program on reducing acute confusion in hospitalized older adults. *Korean Journal of Adult Nursing, 26*(1), 89–97. doi:10.7475/kjan.2014.26.1.89

Ng, J., Pan, C. X., Geube, A., Tan, C., Kawai, F., & Chorost, M. (2015). Your postop patient is confused and agitated--Next steps? *Journal of Family Practice, 64*(6), 361–366.

DEFINITION

Vulnerable to reversible disturbances of consciousness, attention, cognition, and perception that develop over a short period of time, which may compromise health

RISK FACTORS

- Age ≥60 years
- Alteration in cognitive functioning
- Alteration in sleep–wake cycle
- Dehydration
- Dementia
- History of cerebral vascular accident
- Impaired metabolic functioning (e.g., azotemia, decreased hemoglobin, electrolyte imbalance, increase in blood urea nitrogen/creatinine)
- Impaired mobility
- Inappropriate use of restraints
- Infection
- Male gender
- Malnutrition
- Pain
- Pharmaceutical agent
- Sensory deprivation
- Substance abuse
- Urinary retention

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Neurocognition
- Nutrition
- Respiratory function
- Risk management
- Sleep/rest

EXPECTED OUTCOMES

- The patient will remain free from injury.
- The patient will have a stable neurologic status.
- The patient will obtain adequate amounts of sleep.
- The patient will maintain optimal hydration and nutrition.
- The patient will begin to participate in activities of daily living (ADLs).
- The patient will report feeling increasingly calm.
- Family members will report an improved ability to cope with the patient's confused state.
- Family members will state the causes of acute confusion.

- Family members will express the necessity for informing health care providers about acute confusion.

SUGGESTED NOC OUTCOMES

Cognitive Orientation; Information Processing; Memory; Personal Safety Behavior

INTERVENTION AND RATIONALES

Determine: Assess patient's level of consciousness (LOC) and changes in behavior *to provide baseline for comparison with ongoing assessment findings.*

Monitor neurologic status on a regular basis *to detect improvement or decline in the patient's neurologic function.*

Perform: Use appropriate safety measures *to protect patient from injury.* Avoid physical restraints *to prevent agitating patient.*

Address patient by name and tell the patient your name; mention time, place, and date frequently throughout day; and have a large clock and a calendar close by and refer to those aids *to foster awareness of self and environment.*

Give patient short, simple explanations each time you perform a procedure or task *to decrease confusion.* Speak slowly and clearly and allow patient ample time to respond *to reduce patient's frustration and promote task completion.*

Schedule nursing care to provide quiet times for patient *to help avoid sensory overload.* Follow consistent patient routine *to aid task completion and reduce confusion.*

Keep patient's possessions in the same place. *A consistent, stable environment reduces confusion and frustration and aids completion of ADLs.* Ask family to bring labeled family photos and other favorite articles *to create a more secure environment for patient.*

Encourage patient to perform ADLs, dividing tasks into small, critical units. Be patient and specific in providing instructions. Allow time for patient to perform each task. *These measures enhance the patient's self-esteem as well as help prevent complications related to inactivity.*

Inform: Discuss episodes of acute confusion with patient and family members *to make sure they understand the cause of confusion.*

Review measures family members can take at home to help patient if patient begins to exhibit signs of confusion and to report future episodes. Tell them to give patient short explanations of activities; remind the patient of time, place, and date frequently; speak slowly and clearly and allow patient ample time to respond; and provide patient with a consistent routine. *Teaching empowers patient and family to take greater responsibility for patient's health care needs.*

Attend: Have a staff member stay at patient's bedside, if necessary, *to protect patient from harm.* Enlist family member *to help calm patient.*

Encourage family to share stories and discuss familiar people and events with patient to *promote a sense of continuity, security, and comfort.* Manage: Confer with physician about diagnostic test results, patient's progress in behavior, and patient's LOC. *A collaborative approach to treatment helps ensure high-quality care and continuity of care.*

SUGGESTED NIC INTERVENTIONS

Behavior Management: Overactivity/Inattention; Cognitive Stimulation; Delirium Management; Hallucination Management; Reality Orientation

REFERENCES

Brooks, P., Spillane, J. J., Dick, K., & Stuart-Shor, E. (2014). Developing a strategy to identify and treat older patients with postoperative delirium. *AORN Journal, 99*(2), 256–276. doi:10.1016/j.aorn.2013.12.009

Hea-Jeong, H., & Yeonghee, S. (2014). Effects of nursing intervention program on reducing acute confusion in hospitalized older adults. *Korean Journal of Adult Nursing, 26*(1), 89–97. doi:10.7475/kjan.2014.26.1.89

Ng, J., Pan, C. X., Geube, A., Tan, C., Kawai, F., & Chorost, M. (2015). Your postop patient is confused and agitated—Next steps? *Journal of Family Practice, 64*(6), 361–366.

92 CHRONIC CONFUSION

DEFINITION

Irreversible, longstanding, and/or progressive deterioration of intellect and personality characterized by decreased ability to interpret environmental stimuli and decreased capacity for intellectual thought processes, and manifested by disturbances of memory, orientation, and behavior

DEFINING CHARACTERISTICS

- Alteration in interpretation
- Alteration in long-term memory
- Alteration in personality
- Alteration in response stimuli
- Alteration in short-term memory
- Chronic cognitive impairment
- Impaired social functioning
- Normal level of consciousness
- Organic brain disorder
- Progressive alteration in cognitive functioning

RELATED FACTORS

- Alzheimer's disease
- Brain injury (e.g., cerebrovascular impairment, neurologic illness, trauma, tumor)
- Cerebral vascular accident
- Korsakoff's psychosis
- Multi-infarct dementia

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Neurocognition
- Role/relationships
- Self-care

EXPECTED OUTCOMES

- The patient will remain free of injury caused by confusion.
- The patient will exhibit no signs of depression.
- The patient will maintain weight.
- The patient will have an environment structured for maximum functioning.
- The patient will participate in selected activities to fullest extent possible.
- The patient will receive adequate emotional support.
- Family members will discuss strategies to provide care and help patient cope.
- Family members will maintain safety of patient's home environment.
- Family members will receive information on the options available for long-term care.
- Family members will assist patient to prepare for relocation to long-term care facility.

SUGGESTED NOC OUTCOMES

Client Satisfaction: Safety; Cognition; Cognitive Orientation; Distorted Thought Self-Control

INTERVENTIONS AND RATIONALES

Determine: Assess patient's cognitive abilities and changes in behavior *to provide baseline data.*

Weigh patient and include instructions for regular weighing as part of care plan *to monitor patient's nutritional status.*

Perform: Take steps to provide a stable physical environment and consistent daily routine for patient. *Stability and consistency enhance functioning.*

Inform: Teach family members or caregiver strategies to help patient cope with patient's condition: Place an identification bracelet on patient *to promote safety;* touch patient *to convey acceptance;* avoid unfamiliar situations when possible *to help ensure consistent environment;* provide structured rest periods *to prevent fatigue and reduce stress;* refrain from asking questions patient can't answer *to avoid frustration;* provide finger foods if patient won't sit and eat *to ensure adequate nutrition;* select activities based on patient's interests and abilities and praise patient for participating in activities *to enhance sense of self-worth;* use television and radio carefully *to avoid sensory overload;* limit choices patient has to make *to provide structure and avoid confusion;* label familiar photos *to provide a sense of security;* use symbols, rather than written signs, to identify patient's room, bathroom, and other facilities *to help patient identify surroundings;* place patient's name in large block letters on clothing and other belongings *to help the patient recognize belongings and prevent them from becoming lost.*

Attend: Encourage family members to watch mental status assessments *to provide a more accurate view of patient's abilities.*

Evaluate patient's ability to perform self-care activities, including ability to function alone and drive a car. *Safety is a primary concern.*

Ask family members about their ability to provide care for patient *to assess the need for assistance.*

Project an attentive, nonjudgmental attitude when listening to them *to help ensure that you receive accurate information.*

Manage: Assist family members in contacting appropriate community services. If necessary, act as an advocate for patients within health care system *to help secure services needed for ongoing care.*

Provide family members with information concerning long-term health care facilities. If patient is to be moved to a long-term care facility, explain the decision to patient in as simple and gentle terms as possible *to facilitate comprehension.*

Allow patient to express feelings regarding the move *to facilitate grieving over loss of independence*. Provide psychological support to patient and family members *to alleviate stress they may experience during relocation.*

Communicate all aspects of discharge plan to staff members at patient's new residence. *Documenting a discharge plan and communicating it to caregivers help ensure continuity of care.* Interventions should ensure patient's dignity and rights.

SUGGESTED NIC INTERVENTIONS

Cognitive Stimulation; Dementia Management; Family Involvement Promotion; Reality Orientation; Delusion Management

REFERENCES

Griffiths, A., Knight, A., Harwood, R., & Gladman, J. R. (2014). Preparation to care for confused older patients in general hospitals: A study of UK health professionals. *Age & Ageing, 43*(4), 521–527. doi:10.1093/ageing/aft171

Kinnunen-Luovi, K., Saarnio, R., & Isola, A. (2014). Safety incidents involving confused and forgetful older patients in a specialised care setting – analysis of the safety incidents reported to the HaiPro reporting system. *Journal of Clinical Nursing, 23*(17/18), 2442–2450. doi:10.1111/jocn.12364

Sampaio, F. C., & Sequeira, C. (2015). Nurses' knowledge and practices in cases of acute and chronic confusion: A questionnaire survey. *Perspectives in Psychiatric Care, 51*(2), 98–105. doi:10.1111/ppc.12069

DEFINITION

Decrease in normal frequency of defecation accompanied by difficult or incomplete passage of stool and/or passage of excessively hard, dry stool

DEFINING CHARACTERISTICS

- Abdominal pain
- Abdominal tenderness with palpable muscle resistance
- Abdominal tenderness without palpable muscle resistance
- Anorexia
- Atypical presentations in older adults (e.g., changes in mental status, urinary incontinence, unexplained falls, elevated body temperature)
- Borborygmi
- Bright red blood with stool
- Change in bowel pattern
- Decrease in stool frequency
- Decrease in stool volume
- Distended abdomen
- Fatigue
- Hard, formed stool
- Headache
- Hyperactive bowel sounds
- Hypoactive bowel sounds
- Inability to defecate
- Increase in intra-abdominal pressure
- indigestion
- Liquid stool
- Pain with defecation
- Palpable abdominal mass
- Palpable rectal mass
- Percussed abdominal dullness
- Rectal fullness
- Rectal pressure
- Severe flatus
- Soft, paste-like stool in rectum
- Straining with defecation
- Vomiting

RELATED FACTORS

- *Functional:* Abdominal muscle weakness; average daily physical activity is less than recommended for gender and age; habitually ignores urge to defecate; inadequate toileting habits; irregular defecation habits; recent environmental change
- *Mechanical:* Electrolyte imbalance, hemorrhoids, Hirschsprung's disease, neurologic impairment (e.g., positive EEG, head trauma, seizure

disorders), obesity, postsurgical bowel obstruction, pregnancy, prostate enlargement, rectal abscess, rectal anal fissure, rectal anal stricture, rectal prolapse, rectal ulcer, rectocele, tumor
- *Pharmacological:* Laxative abuse, pharmaceutical agent
- *Physiological:* Decrease in gastrointestinal motility, dehydration, eating habit change (e.g., foods, eating times), inadequate dentition, inadequate oral hygiene, insufficient dietary habits, insufficient fiber intake, insufficient fluid intake
- *Psychological:* Confusion, depression, emotional disturbance

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)
- Elimination
- Nutrition
- Pharmacologic function
- Tissue integrity

EXPECTED OUTCOMES

- The patient will participate in development of bowel program.
- The patient will report urge to defecate, as appropriate.
- The patient will increase fluid and fiber intake.
- The patient will report easy and complete evacuation of stools.
- The patient will have elimination pattern within normal limits.
- The patient will adopt personal habits that maintain normal elimination.

SUGGESTED NOC OUTCOMES

Bowel Continence; Bowel Elimination; Hydration; Nutritional Status: Food & Fluid Intake

INTERVENTIONS AND RATIONALES

Determine: Monitor frequency and characteristics of patient's stool daily. *Careful monitoring forms the basis of an effective treatment plan.*

Monitor and record patient's fluid intake and output. *Inadequate fluid intake contributes to dry feces and constipation.*

Perform: Provide privacy for elimination *to promote physiologic functioning.*

Plan and implement an individualized bowel regimen *to establish a regular elimination schedule* and exercise routine *to promote abdominal and pelvic muscle tone.*

Inform: Emphasize importance of responding to urge to defecate. *A timely response to the urge to defecate is necessary to maintain normal physiologic functioning.*

Teach patient to locate public restrooms and to wear easily removable clothing on outings *to promote normal bowel functioning.* Teach patient to massage abdomen once per day and how to locate and gently massage along the transverse and descending colon. *In the older patient, the neural centers in the lower intestinal wall may be impaired, making it*

more difficult for the body to evacuate feces. Massage may help stimulate peristalsis and the urge to defecate.

Teach patient sensible use of laxatives and enemas *to avoid laxative dependency. Overuse of laxatives and enemas may cause fluid and electrolyte loss and damage to intestinal mucosa.*

Attend: Encourage patient to use a bedside commode or walk to toilet facilities to encourage *normal position for evacuation.* Encourage intake of high-fiber foods *to supply bulk for normal elimination and improve muscle tone.* Unless contraindicated, encourage fluid intake of 6 to 8 glasses (1,420 to 1,900 mL) daily *to maintain normal metabolic processes.*

Manage: Help patient understand diet modification plan along with dietitian, if appropriate, *to encourage compliance with prescribed diet*

SUGGESTED NIC INTERVENTIONS

Bowel Management; Bowel Training; Bowel Incontinence Care; Constipation/Impaction Management; Exercise Promotion; Fluid Management; Nutrition Management

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98 RISK FOR CONSTIPATION

DEFINITION

Vulnerable to a decrease in normal frequency of defecation accompanied by difficult or incomplete passage of stool, which may compromise health

RISK FACTORS

- *Functional:* Abdominal muscle weakness; average daily physical activity is less than recommended for gender and age; habitually ignores urge to defecate; inadequate toileting habits; irregular defecation habits; recent environmental change
- *Mechanical:* Electrolyte imbalance, hemorrhoids, Hirschsprung's disease, Neurologic impairment (e.g., positive EEG, head trauma, seizure disorders), obesity, pregnancy, prostate enlargement, rectal abscess, rectal anal fissure, rectal prolapse, rectal ulcer, rectocele, tumor
- *Pharmacological:* Iron salts, laxative abuse, pharmaceutical agent
- *Physiological:* Decrease in gastrointestinal motility, dehydration, eating habit change (e.g., foods, eating times), inadequate dentition, inadequate oral hygiene, insufficient dietary habits, insufficient fiber intake, insufficient fluid intake
- *Psychological:* Confusion, depression, emotional disturbance

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/rest
- Behavior
- Elimination
- Fluid and electrolytes
- Nutrition
- Risk management

EXPECTED OUTCOMES

- The patient will experience no signs or symptoms of constipation.
- The patient will maintain bowel movement every ___ day(s).
- The patient will consume a high-fiber or high-bulk diet, unless contraindicated.
- The patient will maintain fluid intake of ___ mL daily (specify).
- The patient will express understanding of the relationship between constipation and dietary intake, bulk, and activity.
- The patient will express understanding of preventive measures, such as eating fruit and whole grain breads and cereals and engaging in mild activity, if appropriate.

SUGGESTED NOC OUTCOMES

Bowel Continence; Bowel Elimination; Self-Care: Toileting

INTERVENTIONS AND RATIONALES

Determine: Assess bowel sounds and check patient for abdominal distension. Monitor and record frequency and characteristics of stools *to develop an effective treatment plan for preventing constipation and fecal impaction.*

Record intake and output accurately *to ensure accurate fluid replacement therapy.*

Perform: Initiate bowel program. Place patient on a bedpan or commode at specific times daily, as close to usual evacuation time (if known) as possible, *to aid adaptation to routine physiologic function.*

Administer a laxative, an enema, or suppositories, as prescribed, *to promote elimination of solids and gases from GI tract.* Monitor effectiveness.

Inform: Teach patient to gently massage along the transverse and descending colon *to stimulate the bowel's spastic reflex and aid in stools passage.*

Instruct patient, family member, or caregiver on the relationship between diet, activity and exercise, and fluid intake and constipation *to discourage departure from prescribed diet and assist in promoting elimination.*

Review care plan with patient, family member, or caregiver, emphasizing the relationship between the risk factors for constipation and preventive measures *to foster understanding.*

Attend: Encourage fluid intake of 2.5 L daily, unless contraindicated, *to promote fluid replacement therapy and hydration.*

Manage: Consult with a dietitian about how to increase fiber and bulk in patient's diet to the maximum amount prescribed by the physician *to improve intestinal muscle tone and promote comfortable elimination.*

Include a program of mild exercise in your care plan *to promote muscle tone and circulation.*

SUGGESTED NIC INTERVENTIONS

Bowel Training; Bowel Incontinence Care; Bowel Management; Constipation/Impaction Management; Exercise Promotion; Fluid Management; Fluid Monitoring; Nutrition Management

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100 CHRONIC FUNCTIONAL CONSTIPATION

DEFINITION

Infrequent or difficult evacuation of feces, which has been present for at least 3 of the prior 12 months

DEFINING CHARACTERISTICS

- Abdominal distension
- Adult: Presence of two or more of the following symptoms of Rome III classification system:
  - Lumpy or hard stools in ≥25% of defecations
  - Straining during ≥25% of defecations
  - Sensation of incomplete evacuation for ≥25% of defecations
  - Sensation of anorectal obstruction/blockage for ≥25% of defecations
  - Manual maneuvers to facilitate ≥25% of defecations (digital manipulation, pelvic floor support)
  - ≤3 evacuations/week
- Child ≤4 years: Presence of ≥2 criteria on Roman III Pediatric classification system for ≥1 month:
  - ≤2 defecations per week
  - ≥1 episode of fecal incontinence per week
  - Stool retentive posturing
  - Painful or hard bowel movements
  - Presence of large fecal mass in the rectum
  - Large diameter stools that may obstruct the toilet
- Child ≥4 years: Presence of ≥2 criteria on Roman III Pediatric classification system for ≥2 months:
  - ≤2 defecations per week
  - ≥1 episode of fecal incontinence per week
  - Stool retentive posturing
  - Painful or hard bowel movements
  - Presence of large fecal mass in the rectum
  - Large diameter stools that may obstruct the toilet
- Fecal impaction
- Fecal incontinence (in children)
- Leakage of stool with digital stimulation
- Pain with defecation
- Palpable abdominal mass
- Positive fecal occult blood test
- Prolonged straining
- Type 1 or 2 on Bristol Stool Chart

RELATED FACTORS

- Amyloidosis
- Anal fissure

- Anal stricture
- Autonomic neuropathy
- Cerebral intestinal pseudo-obstruction
- Chronic renal insufficiency
- Colorectal cancer
- Dehydration
- Dementia
- Depression
- Dermatomyositis
- Diabetes mellitus
- Diet disproportionally high in protein and fat
- Extra intestinal mass
- Failure to thrive
- Habitually ignores urge to defecate
- Hemorrhoids
- Hirschsprung's disease
- Hypercalcemia
- Hypothyroidism
- Impaired mobility
- Inflammatory bowel disease
- Insufficient dietary intake
- Ischemic stenosis
- Low caloric intake
- Low-fiber diet
- Multiple sclerosis
- Myotonic dystrophy
- Panhypopituitarism
- Paraplegia
- Parkinson's disease
- Pelvic floor dysfunction
- Perineal damage
- Pharmaceutical agent
- Polypharmacy
- Porphyria
- Postinflammatory stenosis
- Pregnancy
- Proctitis
- Scleroderma
- Sedentary lifestyle
- Slow colon transit time
- Spinal cord injury
- Surgical stenosis

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Coping
- Behavior
- Emotional
- Elimination
- Fluid and electrolytes
- Nutrition

EXPECTED OUTCOMES

- The patient will maintain a normal bowel pattern.
- The patient will maintain fluid balance.
- The patient will display normal bowel sounds.
- The patient will express adequate pain relief.
- The patient will identify measures to maintain normal bowel pattern.
- The patient will demonstrate willingness to adhere to treatment measures.
- The patient will state understanding of factors causing constipation.
- The patient will get regular exercise.
- The patient will describe changes in personal habits to maintain normal elimination pattern.
- The patient will state intent to use appropriate resources to help resolve emotional or psychological problems.

SUGGESTED NOC OUTCOMES

Adherence Behavior; Bowel Elimination; Comfort Level; Health Beliefs; Hydration; Knowledge: Health Behavior; Nutritional Status: Food & Fluid Intake; Symptom Control

INTERVENTIONS AND RATIONALES

Determine: Assess patient's dietary habits and encourage modification to include adequate fluids, fresh fruits and vegetables, and whole grain cereals and breads, which *supply necessary bulk for normal elimination.*

Perform: If not contraindicated, increase patient's fluid intake to about 3 L daily *to increase functional capacity of bowel elimination.*

Establish and implement an individualized bowel elimination regimen based on the patient's needs. *Knowledge of normal body functions will improve patient's understanding of problem.*

A footstool may be necessary for patients whose feet do not touch the floor to facilitate a relaxed posture during defecation. *This ensures the best posture to aid in defecation.*

Inform: Explain normal bowel elimination habits *so patient can better understand normal and abnormal body functions.*

Instruct patient to avoid straining during elimination *to avoid tissue damage, bleeding, and pain.*

Instruct patient that abdominal massage may help relieve discomfort and promote defecation *because it triggers bowel's spastic reflex.*

Inform patient not to expect a bowel movement every day or even every other day *to avoid the use of poor health practices to stimulate elimination.*

Attend: Encourage daily physical activity *to strengthen muscles and promote circulation.*

Encourage patient to evacuate at regular times *to aid adaptation and routine physiologic function.*

Urge patient to avoid taking laxatives, if possible, or to gradually decrease their use *to avoid further trauma to intestinal mucosa.* Reassure patient that normal bowel function is possible without laxatives, enemas, or suppositories *to give patient the necessary confidence for compliance.*

Manage: Give information about self-help groups, as appropriate, *to provide additional resources for patient and family.*

SUGGESTED NIC INTERVENTIONS

Bowel Management; Bowel Training; Constipation/Impaction Management; Counseling; Exercise Promotion; Fluid Management; Health Education; Nutrition Management; Nutrition Management

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Gijsbers, C., Kneepkens, C., Vergouwe, Y., & Büller, H. (2014). Occult constipation: Faecal retention as a cause of recurrent abdominal pain in children. *European Journal of Pediatrics*, *173*(6), 781–785. doi:10.1007/s00431-013-2257-3

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104 RISK FOR CHRONIC FUNCTIONAL CONSTIPATION

DEFINITION

Vulnerable to infrequent or difficult evacuation of feces, which has been present nearly 3 of the prior 12 months, which may compromise health

RISK FACTORS

- Aluminum-containing antacids
- Antiepileptics
- Antihypertensives
- Antiparkinsonian agents (anticholinergic or dopaminergic)
- Calcium channel antagonists
- Chronic intestinal pseudo-obstruction
- Decreased food intake
- Dehydration
- Depression
- Diet proportionally high in protein and fat
- Diuretics
- Failure to thrive
- Habitual ignoring of urge to defecate
- Impaired mobility
- Low-fiber diet
- Insufficient fluid intake
- Inactive lifestyle
- Iron preparations
- Low caloric intake
- Nonsteroidal anti-inflammatories (NSAIDs)
- Opioids
- Polypharmacy
- Slow colon transit time
- Tricyclic antidepressants

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Coping
- Behavior
- Emotional
- Elimination
- Fluid and electrolytes
- Nutrition

EXPECTED OUTCOMES

- The patient will maintain a normal bowel pattern.
- The patient will maintain fluid balance.
- The patient will display normal bowel sounds.

- The patient will identify measures to maintain normal bowel pattern.
- The patient will state understanding of factors causing constipation.
- The patient will get regular exercise.
- The patient will maintain personal habits to foster normal elimination pattern.

SUGGESTED NOC OUTCOMES

Adherence Behavior; Bowel Elimination; Comfort Level; Health Beliefs; Hydration; Knowledge: Health Behavior; Nutritional Status: Food & Fluid Intake; Symptom Control

INTERVENTIONS AND RATIONALES

Determine: Assess patient's dietary habits and encourage modification to include adequate fluids, fresh fruits and vegetables, and whole grain cereals and breads, which *supply necessary bulk for normal elimination.*
Perform: If not contraindicated, increase patient's fluid intake to about 3 L daily *to increase functional capacity of bowel elimination.*

Establish and implement an individualized bowel elimination regimen based on the patient's needs. *Knowledge of normal body functions will improve patient's understanding of problem.*

A footstool may be necessary for patients whose feet do not touch the floor to facilitate a relaxed posture during defecation. *This ensures the best posture to aid in defecation.*
Inform: Instruct patient to avoid straining during elimination *to avoid tissue damage, bleeding, and pain.*

Instruct patient that abdominal massage may help relieve discomfort and promote defecation *because it triggers bowel's spastic reflex.*

Inform patient not to expect a bowel movement every day or even every other day *to avoid the use of poor health practices to stimulate elimination.*
Attend: Encourage daily physical activity *to strengthen muscles and promote circulation.*
Encourage patient to evacuate at regular times *to aid adaptation and routine physiologic function.*

Urge patient to avoid taking laxatives, if possible, or to gradually decrease their use *to avoid further trauma to intestinal mucosa.* Reassure patient that normal bowel function is possible without laxatives, enemas, or suppositories *to give patient the necessary confidence for compliance.*
Manage: Give information about self-help groups, as appropriate, *to provide additional resources for patient and family.*

SUGGESTED NIC INTERVENTIONS

Bowel Management; Bowel Training; Constipation/Impaction Management; Counseling; Exercise Promotion; Fluid Management; Health Education; Nutrition Management; Nutrition Management

REFERENCES

Gijsbers, C., Kneepkens, C., Vergouwe, Y., & Büller, H. (2014). Occult constipation: Faecal retention as a cause of recurrent abdominal pain in children. *European Journal of Pediatrics*, *173*(6), 781–785. doi:10.1007/s00431-013-2257-3

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DEFINITION

Self-diagnosis of constipation combined with abuse of laxatives, enemas, and/or suppositories to ensure a daily bowel movement

DEFINING CHARACTERISTICS

- Enema abuse
- Expects daily bowel movement
- Expects daily bowel movement at same time every day
- Laxative abuse
- Suppository abuse

RELATED FACTORS

- Cultural health beliefs
- Family health beliefs
- Impaired thought process

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Coping
- Behavior
- Emotional
- Elimination
- Fluid and electrolytes
- Nutrition

EXPECTED OUTCOMES

- The patient will decrease use of laxatives, enemas, or suppositories.
- The patient will state understanding of normal bowel function.
- The patient will discuss feelings about elimination pattern.
- The patient will have a return-to-normal elimination pattern.
- The patient will experience bowel movement every ___ day(s) without laxatives, enemas, or suppositories.
- The patient will state understanding of factors causing constipation.
- The patient will get regular exercise.
- The patient will describe changes in personal habits to maintain normal elimination pattern.
- The patient will state intent to use appropriate resources to help resolve emotional or psychological problems.

SUGGESTED NOC OUTCOMES

Adherence Behavior; Bowel Continence; Bowel Elimination; Health Beliefs; Health Beliefs: Perceived Threat; Knowledge: Health Behavior

INTERVENTIONS AND RATIONALES

Determine: Assess patient's dietary habits and encourage modification to include adequate fluids, fresh fruits and vegetables, and whole grain cereals and breads, which *supply necessary bulk for normal elimination.*

Perform: If not contraindicated, increase patient's fluid intake to about 3 L daily *to increase functional capacity of bowel elimination.*

Establish and implement an individualized bowel elimination regimen based on the patient's needs. *Knowledge of normal body functions will improve patient's understanding of problem.*

Inform: Explain normal bowel elimination habits *so patient can better understand normal and abnormal body functions.*

Instruct patient to avoid straining during elimination *to avoid tissue damage, bleeding, and pain.*

Instruct patient that abdominal massage may help relieve discomfort and promote defecation *because it triggers bowel's spastic reflex.*

Inform patient not to expect a bowel movement every day or even every other day *to avoid the use of poor health practices to stimulate elimination.*

Attend: Encourage patient to engage in daily exercise, such as brisk walking, *to strengthen muscle tone and stimulate circulation.*

Encourage patient to evacuate at regular times *to aid adaptation and routine physiologic function.*

Urge patient to avoid taking laxatives, if possible, or to gradually decrease their use *to avoid further trauma to intestinal mucosa.* Reassure patient that normal bowel function is possible without laxatives, enemas, or suppositories *to give patient the necessary confidence for compliance.*

Manage: Give information about self-help groups, as appropriate, *to provide additional resources for patient and family.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Bowel Training; Bowel Incontinence Care; Bowel Management; Counseling; Health Education; Nutrition Management

REFERENCES

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DEFINITION

Exposure to environmental contaminants in doses sufficient to cause adverse health effects

DEFINING CHARACTERISTICS

- *Pesticides:* Dermatologic effects of pesticide exposure, gastrointestinal effects of pesticide exposure, neurologic effects of pesticide exposure, pulmonary effects of pesticide exposure, renal effects of pesticide exposure
- *Chemicals:* Dermatologic effects of chemical exposure, gastrointestinal effects of chemical exposure, immunologic effects of chemical exposure, neurologic effects of chemical exposure, pulmonary effects of chemical exposure, renal effects of chemical exposure
- *Biologicals:* Dermatologic effects of exposure to biologicals, gastrointestinal effects of biologic exposure, neurologic effects of biologic exposure, pulmonary effects of biologic exposure, renal effects of biologic exposure
- *Pollution:* Neurologic effects of pollution exposure, pulmonary effects of pollution exposure
- *Waste:* Dermatologic effects of waste exposure, gastrointestinal effects of waste exposure, hepatic effects of waste exposure, pulmonary effects of waste exposure
- *Radiation:* Exposure to radioactive material, genetic effects of radiation exposure, immunologic effects of radiation exposure, neurologic effects of radiation exposure, oncologic effect of radiation

RELATED FACTORS

- *External:* Carpeted flooring, chemical contamination of food, chemical contamination of water, economically disadvantaged, exposure to areas with high contaminant level, exposure to bioterrorism, exposure to disaster (natural or man-made), exposure to radiation, flaking, peeling surface in presence of young children (e.g., paint, plaster), household hygiene practices, inadequate breakdown of contaminant, inadequate municipal services (e.g., trash removal, sewage treatment facilities), inadequate protective clothing, inappropriate use of protective clothing, ingestion of contaminated material (e.g., radioactive, food, water), personal hygiene practices, playing where environmental contaminants are used, unprotected exposure to chemical (e.g., arsenic), use of environmental contaminant in the home, use of noxious material in insufficiently ventilated area (e.g., lacquer, paint), use of noxious material without effective protection (e.g., lacquer, paint)
- *Internal:* Age (e.g., children <5 years, older adults), concomitant exposure, developmental characteristics of children, female gender, gestational age during exposure, inadequate nutrition, preexisting disease, pregnancy, previous exposure to contaminant, smoking

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Populations
- Risk management

EXPECTED OUTCOMES

- The patient/community will have minimized health effects associated with contamination.
- The patient/community will utilize health surveillance data system to monitor for contamination incidents.
- The patient/community will utilize disaster plan to evacuate and triage affected members.
- The patient/community will minimize exposure to contaminants.

SUGGESTED NOC OUTCOMES

Community Disaster Readiness; Community Disaster Response; Community Health Status; Health Beliefs: Perceived Threat; Knowledge: Health Resources, Risk Control

INTERVENTIONS AND RATIONALES

Determine: Triage, stabilize, transport, and treat affected community members. *Accurate triage and early treatment provide the best chance of survival to affected persons.*

Monitor individuals for therapeutic effects, side effects, and compliance with postexposure drug therapy. Drug therapy may extend over a long period of time and will require monitoring for compliance as well as therapeutic and side effects.

Perform: Help individuals cope with contamination incident; use groups that have survived terrorist attacks as useful resource for victims *to aid in support; those with experience can share reactions and useful coping mechanisms.*

Help individuals deal with feelings of fear, vulnerability, and grief *to minimize risk of traumatic stress.*

Decontaminate persons, clothing, and equipment using approved procedure. Victims may first require decontamination before entering health facility *to receive care in order to prevent the spread of contamination.*

Use appropriate isolation precautions, including universal, airborne, droplet, and contact isolation. *Proper use of isolation precautions prevents cross-contamination.*

Inform: Provide accurate information on risks involved, preventive measures, and use of antibiotics and vaccines *to enhance the use of protective measures.*

Attend: *Encourage individuals to talk to others about their fears.* Interventions aimed at supporting an individual's coping can help the person deal

with feelings of fear, helplessness, and loss of *control that are normal reactions in a crisis situation.*

Manage: Collaborate with other agencies (local health department, emergency medical services, state and federal agencies). *Communication and collaboration among agencies increase ability to handle crises efficiently and correctly.*

SUGGESTED NIC INTERVENTIONS

Bioterrorism Preparedness; Crisis Intervention; Environmental Management: Community; Infection Control; Health Education; Triage; Communicable Disease Management; Surveillance

REFERENCES

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112 RISK FOR CONTAMINATION

DEFINITION

Vulnerable to exposure to environmental contaminants, which may compromise health

RISK FACTORS

External

- Carpeted flooring
- Chemical contamination of food
- Chemical contamination of water
- Economically disadvantaged
- Exposure to areas with high contaminant level
- Exposure to atmospheric pollutants
- Exposure to bioterrorism
- Exposure to disaster (natural or man-made)
- Exposure to radiation
- Flaking, peeling surface in presence of young children (e.g., paint, plaster)
- Inadequate breakdown of contaminant
- Inadequate household hygieve practices
- Inadequate municipal services (e.g., trash removal, sewage treatment facilities)
- Inadequate personal hygiene practices
- Inadequate protective clothing
- Inappropriate use of protective clothing
- Playing where environmental contaminants are used
- Unprotected exposure to chemical (e.g., chromium, lead)
- Use of environmental contaminant in the home
- Use of noxious material in insufficiently ventilated area (e.g., lacquer, paint)
- Use of noxious material without effective protection (e.g., lacquer, paint)

Internal

- Concomitant exposure
- Developmental characteristics of children
- Extremes of age
- Female gender
- Gestational age during exposure
- Inadequate nutrition
- Preexisting disease
- Pregnancy
- Previous exposure to contaminant
- Smoking

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Populations
- Risk management

EXPECTED OUTCOMES

- The patient/community will remain free from adverse effects of contamination.
- The patient/community will utilize health surveillance data system to monitor for contamination incidents.
- The patient/community will participate in mass casualty and disaster readiness drills.
- The patient/community will remain free from contamination-related health effects.
- The patient/community will have minimal exposure to contaminants.

SUGGESTED NOC OUTCOMES

Community Disaster Readiness; Community Disaster Response; Community Health Status; Health Beliefs: Perceived Threat; Knowledge: Health Behavior; Knowledge: Health Resources; Risk Control

INTERVENTIONS AND RATIONALES

Determine: Monitor individuals for therapeutic effects, side effects, and compliance with postexposure drug therapy. *Drug therapy may extend over a long period of time and will require monitoring for compliance as well as therapeutic and side effects.*

Perform: Conduct surveillance for environmental contamination; notify agencies authorized to protect the environment of contaminants in the area. *Early surveillance and detection are critical components of preparation.*

Assist individuals in relocating to safer environment *to decrease their risk of contamination.*

Modify environment to minimize risk. *Modification of the environment will decrease the risk of actual contamination.*

Implement decontamination of persons, clothing, and equipment by using approved procedure. Victims may first require decontamination before entering health facility *to receive care in order to prevent the spread of contamination.*

Use appropriate isolation precautions: universal, airborne, droplet, and contact isolation. *Proper use of isolation precautions prevents cross-contamination by contaminating agent.*

Inform: Provide accurate information on risks involved, preventive measures, and use of antibiotics and *vaccines to reduce anxiety and increase compliance.*

Attend: Assist community members with feelings of fear and vulnerability. *Interventions aimed at supporting an individual's coping help the person deal with feelings of fear, helplessness, and loss of control that are normal reactions in a crisis situation.*

Manage: In conjunction with other health care providers, schedule mass casualty and disaster readiness drills. *Practice in handling contamination occurrences will decrease the risk of exposure during actual contamination events.*

SUGGESTED NIC INTERVENTIONS

Bioterrorism Preparedness; Communicable Disease Management; Community; Community Disaster Preparedness; Environmental Management: Community Environmental Management: Safety; Environmental Risk Protection; Health Education; Health Policy Monitoring; Health Screening; Immunization/Vaccination Management; Risk Identification; Surveillance: Safety

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DEFINITION

Repeated projection of falsely positive self-evaluation based on a self-protective pattern that defends against underlying perceived threats to positive self-regard

DEFINING CHARACTERISTICS

- Alteration to reality testing
- Denial of problems
- Denial of weaknesses
- Difficulty establishing relationships
- Difficulty maintaining relationship(s)
- Grandiosity
- Hostile laughter
- Hypersensitivity to a discourtesy
- Hypersensitivity to criticism
- Insufficient follow-through with treatment
- Insufficient participation in treatment
- Projection of blame
- Projection of responsibility
- Rationalization of failures
- Reality distortion
- Ridicule of others
- Superior attitude toward others

RELATED FACTORS

- Conflict between self-perception and value system
- Fear of failure
- Fear of humiliation
- Fear of repercussion
- Insufficient confidence in others
- Insufficient resilience
- Insufficient self-confidence
- Insufficient support system
- Uncertainty
- Unrealistic self-expectations

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Emotional
- Communication
- Coping
- Knowledge
- Roles/relationships
- Self-perception

EXPECTED OUTCOMES

- The patient will state the reason for hospitalization.
- The patient will verbally describe self-perception, body image, success, and failures.
- The patient will engage in decision making about care.
- The patient will express a responsible attitude toward own behavior.
- The patient will demonstrate follow-through in decisions related to health care.
- The patient will interact with others in a socially acceptable manner.

SUGGESTED NOC OUTCOMES

Acceptance: Health Status; Coping; Self-Esteem; Social Interaction Skills; Self-Direction of Care

INTERVENTIONS AND RATIONALES

Determine: Assess patient's understanding of current illness, relationships with family and friends, self-esteem, self-perception, support systems, spiritual support. *Specific assessment information will assist in developing an accurate plan of care for the individual.*

Perform: Assist patient to compile a list of things that patient likes and dislikes about present situation. *Performing this exercise can help the patient identify aspects of self and identify changes patient would like to make with specific variables.*

Have patient perform as many self-care activities as possible, and make treatment-related decisions *to encourage a sense of autonomy and promote compliance.*

Provide a structured daily routine. *Structure may help provide an alternative to self-absorption.*

Inform: Teach patient relaxation techniques such as guided imagery, deep breathing, meditation, aromatherapy, and progressive muscle relaxation. *Purposeful relaxation efforts help reduce anxiety.*

Teach patient strategies for positive thinking. Work specifically to identify negative thoughts and rephrase them in a positive way. *Making the patient conscious of negative thoughts will help reinforce the need to think about things and people in a more positive way.*

Attend: Arrange for interaction between the patient and family or friends and observe the interaction patterns. *This allows the nurse to provide feedback about the effectiveness of communication.*

Allow time for patient to talk about frustration. *Speaking to a sensitive listener may help to reduce some frustration and may lead to new ideas about how to help the patient resolve issues.*

Provide positive feedback to patient when the patient assumes responsibility for his or her own behavior *in order to reinforce positive coping behaviors.*

Manage: Encourage the patient to meet with someone who is coping successfully with a similar problem. *This may assist the patient to work toward a positive outcome.*

Encourage the patient to consider participating in a support group. *Participation in such a group may help the patient cope more effectively, as well as establish new relationships.*

Refer to case manager/social worker to ensure that follow-up is provided.

SUGGESTED NIC INTERVENTIONS

Calming Techniques; Coping Enhancement; Emotional Support; Self-Awareness Enhancement; Self-Responsibility Facilitation; Self-Modification Assistance

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118 INEFFECTIVE COPING

DEFINITION

Inability to form a valid appraisal of the stressors, inadequate choices of practiced responses, and/or inability to use available resources

DEFINING CHARACTERISTICS

- Alteration in concentration
- Alteration in sleep pattern
- Change in communication pattern
- Destructive behavior toward others
- Destructive behavior toward self
- Difficulty organizing information
- Fatigue
- Frequent illness
- Inability to ask for help
- Inability to attend to information
- Inability to deal with a situation
- Inability to meet basic needs
- Inability to meet role expectation
- Ineffective coping strategies
- Insufficient access of social support
- Insufficient goal-directed behavior
- Insufficient problem resolution
- Insufficient problem-solving skills
- Risk-taking behavior
- Substance abuse

RELATED FACTORS

- Gender differences in coping strategies
- High degree of threat
- Inability to conserve adaptive energies
- Inaccurate threat appraisal
- Inadequate confidence in ability to deal with a situation
- Inadequate opportunity to prepare for stressor
- Inadequate resources
- Ineffective tension-release strategies
- Insufficient sense of control
- Insufficient social support
- Maturational crisis
- Situational crisis
- Uncertainty

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication
- Coping

EXPECTED OUTCOMES

- The patient will verbalize increased ability to cope.
- The patient will expand support network to meet social and emotional needs.
- The patient will locate and use appropriate resources for help in problem-solving.
- The patient will report increased ability to meet demands of daily living.
- The patient will make changes to environment to ensure enhanced coping or move into long-term care facility, as needed.

SUGGESTED NOC OUTCOMES

Coping; Decision Making; Impulse Self-Control; Information Processing; Social Interaction Skills; Social Support

INTERVENTIONS AND RATIONALES

Determine: Monitor physiologic responses to increased activity level, including respirations, heart rate and rhythm, and blood pressure. *Vital signs are likely to change as the patient deals with the frustration from poor coping strategies.* Assess understanding of the current health problem and desire *to participate in treatment.*

Perform: Listen to the patient. Respond in a matter-of-fact, nonjudgmental manner. *Judgmental responses will impede the development of a trusting relationship.* Practice guided imagery and deep breathing with the patient *to help the patient relax.*

Inform: Provide patient with information about relaxation techniques. *These techniques take practice. Information will help the patient understand the benefit.*

Teach patient about the disease process and explain treatments *to allay fear and allow the patient to regain sense of control.*

Teach positive coping strategies and have patient role-play them and give praise for successful modeling. *This will help to reinforce coping behaviors.*

Attend: Assist patient to develop short- and long-term goals *to encourage better coping and a roadmap to measure progress.* Provide emotional support and encouragement *to help improve patient's negative self-concept and motivate the patient to perform activities of daily living.* Involve patient in planning and decision making. *Having the ability to participate will encourage greater compliance with treatment plan.* Encourage patient to engage in social activities with people of all age groups. *Participation once a week will help relieve the patient's sense of isolation.*

Manage: Refer patient for professional psychological counseling. *Formal counseling helps ease the nurse's frustration, increases objectivity, and fosters collaborative approach to patient's care.*

Before discharge, refer patient to case manager who can help patient become involved in informal community programs, such as volunteering, fostering grandparents, or participating in religious groups, *to provide peer and social contact and decrease the patient's loneliness and isolation.* Refer patient to a support group. *In the context of a group, the patient may develop a more positive view in the present situation.*

SUGGESTED NIC INTERVENTIONS

Coping Enhancement; Decision-Making Support; Emotional Support; Environmental Management; Impulse Control Training; Support System Enhancement

REFERENCES

Jacobs, N. L., Dehue, F., Völlink, T., & Lechner, L. (2014). Determinants of adolescents' ineffective and improved coping with cyberbullying: A Delphi study. *Journal of Adolescence, 37*(4), 373–385. doi:10.1016/j.adolescence.2014.02.011

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DEFINITION

A pattern of community activities for adaptation and problem-solving that is unsatisfactory for meeting the demands or needs of the community

DEFINING CHARACTERISTICS

- Community does not meet expectation of its members
- Deficient community participation
- Elevated community illness rate
- Excessive community conflict
- Excessive stress
- High incidence of community problems (e.g., homicides, vandalism, terrorism, robbery, abuse, unemployment, poverty, militancy, mental illness)
- Perceived community powerlessness
- Perceived community vulnerability

RELATED FACTORS

- Exposure to disaster (natural or man-made)
- History of disaster (e.g., natural, man-made)
- Inadequate resources for problem-solving
- Insufficient community resources (e.g., respite, recreation, social support)
- Nonexistent community systems

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Communication
- Coping
- Health care system
- Risk management
- Values and beliefs

EXPECTED OUTCOMES

- Community members will express awareness of seriousness of high school adolescent pregnancy rate in their community.
- Community members will express need for plan to reduce prevalence of teen pregnancy.
- Community members will develop and implement plan to reduce teen pregnancy.
- Community members will evaluate success of plan in meeting goals and objectives and will continue to revise it, as necessary.
- Community members will report reduction in rate of teen pregnancy.

SUGGESTED NOC OUTCOMES

Community Competence; Community Health Status

INTERVENTIONS AND RATIONALES

Determine: Assess the following: community demographics, number of teen pregnancies in the community in the past 2 years, attitudes toward teen

mothers and their infants, availability of programs in the schools that help teen mothers continue their education, teens' knowledge about sex and sexuality, religious attitudes in the community toward sex and sexuality, influence of religious groups on educators. *Assessment information will be useful in establishing appropriate interventions.*

Perform: Collect statistical data from schools *to analyze teen pregnancy rates as a basis for evaluating a pregnancy prevention program.* Plan a teen pregnancy program that can be used in schools. Include information on risks, problems, and complications of teen pregnancy. Contact local corporations *for financial assistance in supporting educational programs.*

Establish clubs for adolescent girls in the community. *These can be used as a method for educating as well as helping girls establish healthy relationships.*

Establish therapeutic relationships with pregnant adolescents to *build support during this difficult period.*

Inform: Provide education on birth-control measures (including abstinence from sex) and have this information available at school.

Encourage an information campaign *to educate adolescents, parents, and community members about problems related to teen pregnancy.*

Teach parents to observe behavioral cues from child. For example, the child may become fussy when ready for a nap or may pull his or her ear if he or she has an earache *to indicate that he or she has pain.* Explain the range of options for responding to these cues in positive ways. *Parents may be unfamiliar with cues from child behavior.*

Teach parents to give physical care when the need exists. *The parents may need instruction on the importance and proper way of providing care.* Teach relaxation techniques that can be done by the parents such as guided imagery, progressive muscle relaxation, and meditation. *These measures restore psychological and physical equilibrium by decreasing autonomic response to anxiety.*

Encourage local youth groups and religious and social organizations to feature guest speakers on pregnancy prevention at their meetings. *Speakers with expertise in the area of teen pregnancy are better able to provide information that may help teens make better choices in sexual behavior.*

Attend: Encourage community members to establish school-based clinics that allow teens' access to reproductive-system models, pregnancy tests, and nonprescription birth-control measures *to support teens who choose to protect themselves from unwanted pregnancy.*

Manage: Develop a referral list for teens that includes resources such as hospitals with human sexuality courses, charities that provide prenatal care and childbirth services, women's clinics, and Planned Parenthood *to compensate for restricted access to information in the schools.*

SUGGESTED NIC INTERVENTIONS

Community Health Development; Health Education; Health Screening; Program Development; Health Policy Monitoring

REFERENCES

Craig, S. L., Betancourt, I., & Muskat, B. (2015). Thinking big, supporting families and enabling coping: The value of social work in patient and family centered health care. *Social Work in Health Care*, *54*(5), 422–443. doi:10.1080/00981389.2015.1017074

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124 COMPROMISED FAMILY COPING

DEFINITION

An usually supportive primary person (family member, significant other, or close friend) provides insufficient, ineffective, or compromised support, comfort, assistance, or encouragement that may be needed by the client to manage or master adaptive tasks related to his or her health challenge

DEFINING CHARACTERISTICS

- Assistive behaviors by support person produce unsatisfactory results
- Client complaint about support person's response to health problem
- Client concern about support person's response to health problem
- Limitation in communication between support person and client
- Protective behavior by support person incongruent with client's abilities
- Protective behavior by support person incongruent with client's need for autonomy
- Support person reports inadequate understanding that interferes with effective behaviors
- Support person reports insufficient knowledge that interferes with effective behaviors
- Support person reports preoccupation with own reaction to client's need
- Support person withdraws from client

RELATED FACTORS

- Coexisting situations affecting the support person
- Developmental crisis experienced by support person
- Exhaustion of support person's capacity
- Family disorganization
- Family role change
- Insufficient information available to support person
- Insufficient reciprocal support
- Insufficient support given by client to support person
- Insufficient understanding of information by support person
- Misinformation obtained by support person
- Misunderstanding of information by support person
- Preoccupation by support person with concern outside of family
- Prolonged disease that exhausts capacity of support person
- Situational crisis faced by support person

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication
- Coping
- Emotional status

EXPECTED OUTCOMES

- The family members will assume responsibility for roles and activities formerly held by the patient.
- The family members will express feelings about assuming responsibility of care for family member.
- The patient and family members will identify and make use of appropriate community services.
- The patient and family members will express satisfaction with improved ability to cope with current crisis.

SUGGESTED NOC OUTCOMES

Caregiver Emotional Health; Caregiver-Patient Relationship; Caregiver Stressors; Family Coping; Family Normalization; Family Functioning

INTERVENTIONS AND RATIONALES

Determine: Identify the primary caregiver in family, and assess roles of other family members. Determine usual coping mechanisms employed by this patient and family. Describe patterns of communication used in problem-solving. Identify what support systems exist for the family and patient outside the family. Identify strengths and weakness in the family's communication patterns. *Assessment data will assist with establishment of interventions.*

Perform: Direct development of short- and long-term goals by the patient and family members. *Initially, the family members will need help from the caregiver until they understand more about the process of planning.*

Identify appropriate community services for the family *to assist with* coping.

Inform: Educate patient and family members about the process of aging *to assist patient and family to understand how changes in the patient have affected the family.*

Teach family members ways of maximizing the use of coping strategies that seem to have worked for them in the past. Teach new coping strategies and have family members role model them. *Practice will help the family practice the behaviors in real situations.*

Attend: Avoid becoming involved in a power struggle between patient and family members. *The patient may no longer be able to fill ordinary roles, and the sudden shift in roles may lead to a power struggle.*

Encourage family members to express feelings about caring for an older family member. Be nonjudgmental when listening to the family; discuss the issues associated with caring for an older person. *If the nurse is judgmental, the family members may not be comfortable discussing their problem.*

Provide emotional support for primary caregiver. Some families may hesitate to accept outside help. Other families may be unwilling to make

even small sacrifices to care for an older family member. If family members have not been supportive or caring for the elder member before, they are unlikely to change.

Manage: Refer to community agencies (e.g., adult day care, respite care, and geriatric outreach services) *that can assist the family in caring for the elder.* Communicate to the hospice nurse where the patient is at present in coping with the terminal illness.

Refer to case manager or social service *to assist with ongoing coordination of the patient's needs after hospitalization.*

Refer to a member of the clergy or a spiritual counselor when deemed appropriate. *Patients will often be more inclined to talk to a spiritual counselor.*

SUGGESTED NIC INTERVENTIONS

Support System Enhancement; Coping Enhancement; Family Involvement Promotion; Respite Care; Family Support

REFERENCES

del-Pino-Casado, R., Pérez-Cruz, M., & Frías-Osuna, A. (2014). Coping, subjective burden and anxiety among family caregivers of older dependents. *Journal of Clinical Nursing, 23*(23/24), 3335–3344. doi:10.1111/jocn.12561

Santos de Araújo Dantas, M., Amador Silva, D., Ataíde Melo de Pinho, T., Barros Torquato, I. M., Dantas de Assis, W., & dos Santos, S. R. (2015). Family coping strategies for leukemia diagnosis: Social and religious aspects. *Journal of Nursing UFPE/Revista De Enfermagem UFPE, 9*(1), 137–142. doi:10.5205/reuol.6817-60679-1-ED.0901201519

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DEFINITION

Behavior of primary person (family member, significant other, or close friend) that disables his or her capabilities and the client's capacities to effectively address tasks essential to either person's adaptation to the health challenge

DEFINING CHARACTERISTICS

- Abandonment
- Adopts illness symptoms of client
- Aggression
- Agitation
- Client dependence
- Depression
- Desertion
- Disregard for client's needs
- Distortion of reality about client's health problem
- Family behaviors detrimental to well-being
- Hostility
- Impaired ability to structure a meaningful life
- Impaired individualism
- Intolerance
- Neglect of basic needs of client
- Neglect of relationship with family member
- Neglect of treatment regimen
- Performing routines without regard for client's needs
- Prolonged hyperfocus on client
- Psychosomatic symptoms
- Rejection

RELATED FACTORS

- Ambivalent family relationships
- Chronically unexpressed feelings by support person
- Differing coping styles between support person and client
- Differing coping styles between support persons
- Inconsistent management of family's resistance to treatment

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Communication
- Coping
- Knowledge
- Values and beliefs

EXPECTED OUTCOMES

To the extent possible, family members will participate in aspects of patient's care without evidence of increased conflict.

- The patient will express confidence in ability to make decisions despite pressure from family members.
- The patient will contact appropriate sources of support outside the family.
- The patient will take steps to ensure that care needs are met despite family's shortcomings.
- The patient will express greater understanding of emotional limitations of family members.

SUGGESTED NOC OUTCOMES

Caregiver Emotional Health; Caregiver-Patient Relationship; Caregiving Endurance Potential; Family Coping; Family Support During Treatment

INTERVENTIONS AND RATIONALES

Determine: Assess effects of patient's disease on ability of family to cope *to identify strengths and weaknesses in patient's patterns of coping.*

Describe role relationships in the family. Evaluate changes that occur in family relationships during the course of the patient's hospitalization. *This information will be helpful in making a plan.*

Have patient identify support systems outside the family *to encourage responsibility for knowing what support systems are helpful.*

Perform: Engage family in assisting with physical aspects of patient care. *Family members should have an opportunity to overcome dysfunctional behavior.*

Develop short- and long-term goals with both patient and family. *Problems associated with coping may will require long-term planning to resolve.*

Inform: Teach patient strategies to discuss, *to confront in a positive way that will help cope with the present situation.* Role-play coping strategies with the patient *to reinforce new adaptive behaviors.*

Educate family members about resources in the community *that can assist them with the patient after hospitalization.*

Teach *patient decision-making skills and assist* the patient to practice with simple decisions. *Beginning with simple decisions will begin helping the patient lay out options before deciding.*

Attend: Maintain objectivity when dealing with family conflicts. Do not become embroiled in the dynamics of a dysfunctional family *to maintain objectivity and effectiveness.*

Focus on being a patient advocate. Reaffirm patient's right to make decisions without interference from family members. Encourage patient to seek help that family cannot provide by participating in support group.

Help patient select a support group that best meets personal needs. Participation in a support group may improve the patient's ability to cope as well as provide meaningful relationships.

Listen attentively to patient's expression of pain over unresolved conflicts with family members. The patient may have to grieve over the fact that the patient does not have an "ideal" family, capable of meeting the emotional needs of the patient. *Therapeutic listening helps patients to understand them and their family better and to understand how conflicts from the past affect their behavior.*

Manage: Refer patient to a home health agency, homemaker service, meals-on-wheels, or other appropriate community services for assistance and follow-up. *Use of various community services may help make up the family's shortcomings in coping.*

SUGGESTED NIC INTERVENTIONS

Anger Control Assistance; Caregiver Support; Family Involvement Promotion; Family Mobilization; Family Support; Family Integrity Promotion; Case Management

REFERENCES

Alpert, J. M., & Womble, F. E. (2015). Coping as a caregiver for an elderly family member. *Health Communication, 30*(7), 714–721. doi:10.1080/10410236.2013.879560

Dardas, L. A., & Ahmad, M. M. (2015). Coping strategies as mediators and moderators between stress and quality of life among parents of children with autistic disorder. *Stress & Health: Journal of the International Society for the Investigation of Stress, 31*(1), 5–12. doi:10.1002/smi.2513

The impact of childhood hearing loss on the family: Mothers' and fathers' stress and coping resources. (2016). *Journal of Deaf Studies & Deaf Education, 21*(1), 23–33. doi:10.1093/deafed/env038

130 DEATH ANXIETY

DEFINITION

Vague uneasy feeling of discomfort or dread generated by perceptions of a real or imagined threat to one's existence

DEFINING CHARACTERISTICS

- Concern about strain on the caregiver
- Deep sadness
- Fear of developing terminal illness
- Fear of loss of mental abilities when dying
- Fear of pain related to dying
- Fear of premature death
- Fear of prolonged dying process
- Fear of suffering related to dying
- Fear of the dying process
- Negative thoughts related to death and dying
- Powerlessness
- Worried about the impact of one's death on significant other

RELATED FACTORS

- Anticipation of adverse consequences of anesthesia
- Anticipation of impact of death on others
- Anticipation of pain
- Anticipation of suffering
- Confronting the reality of terminal disease
- Discussions on the topic of death
- Experiencing dying process
- Near-death experience
- Nonacceptance of own mortality
- Observations related to death
- Perceived imminence of death
- Uncertainty about encountering a higher power
- Uncertainty about life after death
- Uncertainty about the existence of a higher power
- Uncertainty of prognosis

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication
- Emotional status

EXPECTED OUTCOMES

- The patient will identify time alone and time needed with others.
- The patient will communicate important thoughts and feelings to family members.

- The patient will obtain the level of spiritual support desired.
- The patient will use available support systems.
- The patient will perform self-care activities to tolerance level.
- The patient will express feelings of comfort and peacefulness.

SUGGESTED NOC OUTCOMES

Acceptance: Health Status; Anxiety Level; Depression Level; Dignified Life Closure; Fear Self-Control; Hope

INTERVENTIONS AND RATIONALES

Determine: Assess how much support the patient desires. *Patients may want a higher degree of independence in dealing with death than the caregiver wants to allow.*

Assess patient's spiritual needs. *Often as death approaches, individuals begin thinking more about the needs of the spirit.*

Determine which comfort measures the family believes will enhance feelings of well-being. *Dying patients have the right to decide how much physical, emotional, and spiritual care they wish to have.*

Perform: Administer medication to relieve pain, and provide comfort as required. Medicating at an appropriate level does much to relieve pain and often *helps the dying person maintain greater feeling of self-control.*

Turn and reposition patient at least every 2 hours. Establish a turning schedule for the dependent patient. Post schedule at bedside and monitor frequency. *Turning and repositioning may prevent skin breakdown, improve lung expansion, and prevent atelectasis.*

Provide simple physical gestures of support such as holding hands with the patient and encouraging family members to do the same. *Patient may want to experience less touching when the patient begins to let go.*

Provide comfort measures, including bath, massage, regulation of environmental temperature, and mouth care *according to patient's preferences. These measures promote relaxation and feelings of well-being.*

Inform: Teach family members ways of discerning unobtrusively what the patient's desires for comfort and peace are at this time *because some patients prefer not to be bothered unless they specifically request comfort measures. Being sensitive to patient needs promotes individualized care.*

Teach caregivers to assist patient with self-care activities in a way that maximizes patient's rights to choose. *This enables caregivers to participate in patient's care while supporting patient's independence.*

Attend: Help family identify, discuss, and resolve issues related to patient's dying. Provide emotional support and encouragement to help. Clear communication promotes family integrity.

Demonstrate to patient willingness to discuss the spiritual aspects of death and dying *to foster an open discussion.* Keep conversation focused on patients' spiritual values and the role they play coping with dying.

Meeting the patient's spiritual needs conveys respect for the importance of all aspects of care.

If patient is confused, provide reassurance by telling who is in the room. *This information may help to reduce anxiety.*

Manage: Refer to hospice for end-of-life care if this has not already been done. Communicate to the hospice nurse where the patient is at present in coping with the terminal illness. Continuity of care is crucial during times of stress.

Refer to a member of the clergy or a spiritual counselor, according to the patient's preference, *to show respect for the patient's beliefs and provide spiritual care.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Anticipatory Guidance; Family Involvement Promotion; Pain Management; Spiritual Support; Touch

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Strang, P. (2014). What is extreme death anxiety and what are its consequences? *Journal of Palliative Care, 30*(4), 321–326.

DEFINITION

Uncertainty about course of action to be taken when choice among competing actions involves risk, loss, or challenge to values and beliefs

DEFINING CHARACTERISTICS

- Delay in decision making
- Distress while attempting a decision
- Physical sign of distress (e.g., increase in heart rate, restlessness)
- Physical sign of tension
- Questioning of moral principle while attempting a decision
- Questioning of moral rule while attempting a decision
- Questioning of moral values while attempting a decision
- Questioning of personal beliefs while attempting a decision
- Questioning of personal values while attempting a decision
- Recognizes undesired consequences of actions being considered
- Self-focused
- Uncertainty about choices
- Vacillating among choices

RELATED FACTORS

- Divergent sources of information
- Interference with decision making
- Lack of experience with decision making
- Lack of relevant information
- Moral obligations require actions
- Moral obligations require no action
- Unclear personal beliefs or values

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Communication
- Roles and relationships
- Values and beliefs

EXPECTED OUTCOMES

- The patient will state feelings about the current situation.
- The patient will discuss benefits and drawbacks of treatment options.
- The patient will make minor decisions related to daily activities.
- The patient will accept assistance from family, friends, clergy, and other support persons.
- The patient will report feeling comfortable about ability to make an appropriate, rational choice.

SUGGESTED NOC OUTCOMES

Decision Making; Information Processing; Participation in Health Care Decisions

INTERVENTIONS AND RATIONALES

Determine: Assess major challenges patient will face in making decisions about care, as well as factors that influence patient's present decision-making skills. *This information will be useful in establishing appropriate interventions.*

Perform: Arrange patient's environment *to promote relaxation and comfort while the patient is trying to gain control of decision making.*

Assist with self-care activities while patient needs help *to ensure that activities of daily living are met.*

Offer massage *to reduce tension and assist patient to relax.*

Help patient make decisions about daily activities *to enhance the feelings of control.*

Help patient identify available options and possible consequences *to assist with rational, logical decision making.*

Inform: Teach techniques for progressive muscle relaxation *to decrease physical and psychological signs of tension.*

Attend: Encourage visits with family, friends, and clergy; provide privacy during visits *to foster emotional support.*

Encourage patient to express concerns about frustrations in making decisions. Take the time to assist the patient *to explore or sort out aspects of decision making that cause the patient difficulty.*

Manage: Offer written information, a reading list, or a referral to a support group *to ensure that patient will have reference material when it is needed.*

Refer to home health nurse *for a follow-up visit in the home.*

Refer to a nutritionist *for information on good nutrition and fluid management.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Assertiveness Training; Decision-Making Support; Learning Facilitation; Mutual Goal-Setting

REFERENCES

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DEFINITION

Conscious or unconscious attempt to disavow the knowledge or meaning of an event to reduce anxiety and/or fear, leading to the detriment of health

DEFINING CHARACTERISTICS

- Delay in seeking health care
- Denies fear of death
- Denies fear of invalidism
- Displaces fear of impact of the condition
- Displaces source of symptoms
- Does not admit impact of disease on life
- Does not perceive relevance of danger
- Does not perceive relevance of symptoms
- Inappropriate affect
- Minimizes symptoms
- Refusal of health care
- Use of dismissive gestures when speaking of distressing event
- Use of dismissive comments when speaking of distressing event
- Use of treatment not advised by health care professional

RELATED FACTORS

- Anxiety
- Excessive stress
- Fear of death
- Fear of losing autonomy
- Fear of separation
- Ineffective coping strategies
- Insufficient emotional support
- Insufficient sense of control
- Perceived inadequacy in dealing with strong emotions
- Threat of unpleasant reality

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication
- Coping
- Values and beliefs

EXPECTED OUTCOMES

- The patient will describe knowledge and perception of present health problem.
- The patient will describe life pattern and report any changes.
- The patient will express knowledge of stages of grieving.
- The patient will demonstrate behavior associated with the grief process.

- The patient will indicate, either verbally or through behavior, an increased awareness of reality.

SUGGESTED NOC OUTCOMES

Acceptance: Health Status; Anxiety Level; Coping; Fear Self-Control; Health Beliefs: Perceived Threat; Symptom Control

INTERVENTIONS AND RATIONALES

Determine: Assess patient's understanding and perception of present health state, including awareness of diagnosis, and perception of relevance on life pattern and description of symptoms.

Evaluate coping status and mental status, including mood, affect, memory, and judgment. *Assessment of these factors will help identify appropriate interventions.*

Perform: Schedule a specific amount of uninterrupted non-care-related time each day with the patient *to allow patient to express feelings and concerns.*

Assist patient with activities of living, as needed, *to conserve energy and avoid overexertion.* Assist with grooming (e.g., shaving for men, hair and makeup for women). Offer massage *to enhance comfort and promote relaxation.*

Encourage active exercise (e.g., provide a trapeze or other assistive device, if needed). *Exercise will promote positive attitude.*

Inform: Discuss stages of anticipatory *grieving to increase understanding of what is happening and increase patient's ability to cope.*

Teach patient about diagnosis and treatment as the patient demonstrates readiness to learn. Provide brochures and simple written materials *to help with the learning process.*

Attend: Provide emotional support and encouragement *to help improve patient's self-concept and motivate the patient to be more involved in planning care.*

Involve patient in planning and decision making. *Having the ability to participate will encourage greater compliance with the plan for treatment.*

Have patient perform self-care activities. Begin slowly and increase daily, as tolerated. *Performing self-care activities will assist patient to regain independence and enhance self-esteem.*

Schedule treatments apart from visiting *to allow for periods of rest.*

Maintain frequent discussions with physicians and staff *to be certain what patient has been told by other care providers.*

Manage: Refer to case manager/social worker *for follow-up care.*

Refer to clergy person *for spiritual care* if patient expresses interest.

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction, Behavior Modification; Calming; Counseling; Decision-Making Support; Truth Telling

REFERENCES

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Williams, A. R., Olfson, M., & Galanter, M. (2015). Assessing and improving clinical insight among patients 'in denial'. *JAMA Psychiatry, 72*(4), 303–304. doi:10.1001/jamapsychiatry.2014.2684

DEFINITION

Disruption in tooth development/eruption patterns or structural integrity of individual teeth

DEFINING CHARACTERISTICS

- Abraded teeth
- Absence of teeth
- Dental caries
- Enamel discoloration
- Erosion of enamel
- Excessive oral calculus
- Excessive oral plaque
- Facial asymmetry
- Halitosis
- Incomplete tooth eruption for age
- Loose tooth
- Malocclusion
- Premature loss of primary teeth
- Root caries
- Tooth fracture
- Tooth misalignment
- Toothache

RELATED FACTORS

- Barrier to self-care
- Bruxism
- Chronic vomiting
- Difficulty accessing dental care
- Economically disadvantaged
- Excessive intake of fluoride
- Excessive use of abrasive oral cleaning agents
- Genetic predisposition
- Habitual use of staining substance (e.g., coffee, red wine, tea, tobacco)
- Insufficient dietary habits
- Insufficient knowledge of dental health
- Insufficient oral hygiene
- Malnutrition
- Oral temperature sensitivity
- Pharmaceutical agent

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Knowledge
- Nutrition
- Roles/responsibilities
- Values and beliefs

EXPECTED OUTCOMES

- The individual will brush teeth with minimal supervision.
- The individual will demonstrate good brushing technique.
- The individual will not show evidence of dental caries, periodontal disease, or malocclusion.
- The individual will reduce quantity of cariogenic foods in diet.
- The individual will show evidence of good daily oral hygiene.

SUGGESTED NOC OUTCOMES

Oral Hygiene; Self-Care: Oral Hygiene

INTERVENTIONS AND RATIONALES

Determine: Assess dental history, primary and secondary tooth development, frequency of visits to dentist, frequency of brushing, condition of the teeth, nutritional status, medications, socioeconomic status. *Assessment of these factors will help to identify appropriate interventions.*

Perform: Provide tooth brush, toothpaste, and dental floss *to ensure that supplies are available.*

Schedule times for brushing and have patient begin keeping a record. *Keeping a record will promote compliance.*

Inform: Teach child principles of good oral hygiene by using teaching methods appropriate to the child's age group *to foster compliance.*

Teach the child and parents or caregiver about the relationship between diet and dental health. Show the child pictures that promote good dental health and pictures of foods that lead to dental decay. If the child can read, teach the child to read labels; teach the child to avoid products with excessive sucrose. *Sucrose is a simple sugar that promotes dental decay.*

Demonstrate good brushing technique. Stress the importance of having teeth feel clean rather than the need to follow a specific procedure *to reinforce good dental hygiene habits.*

Attend: Encourage parents to create a pleasant mealtime environment with nutritious foods made to look appealing to a child *so that the child will learn to recognize nutritious foods.*

Give positive reinforcement for good choices. Be supportive to the parents as they try to help the child modify diet to include more nutritional foods. *It is not easy to teach children to make right food choices, and parents benefit from encouragement to keep reinforcing good healthy choices.*

Encourage ample fluid intake to keep gums well hydrated. *Adequate fluids promote healthy gums.*

Manage: Refer to dentist *for assessment of dental health.*

Schedule a follow-up appointment with parents *to ensure they have taken child to the dentist.*

Where it is indicated, refer to a nutritionist *for help in modifying diet.*

SUGGESTED NIC INTERVENTIONS

Oral Health Maintenance; Oral Health Promotion; Teaching: Individual

REFERENCES

Chi, D., McManus, B., & Carle, A. (2014). Caregiver burden and preventive dental care use for US children with special health care needs: A stratified analysis based on functional limitation. *Maternal & Child Health Journal*, *18*(4), 882–890.

Friedman, J. W., & Mathu-Muju, K. R. (2014). Dental therapists: Improving access to oral health care for underserved children. *American Journal of Public Health*, *104*(6), 1005–1009. doi:10.2105/AJPH.2014.301895

Masterson, E. E., & Sabbah, W. (2015). Maternal allostatic load, caretaking behaviors, and child dental caries experience: A cross-sectional evaluation of linked mother--child data from the third national health and nutrition examination survey. *American Journal of Public Health*, *105*(11), 2306–2311. doi:10.2105/AJPH.2015.302729.

DEFINITION

Vulnerable to delay of 25% or more in one or more of the areas of social or self-regulatory behavior, or in cognitive, language, gross, or fine motor skills, which may compromise health.

RISK FACTORS

- *Prenatal:* Economically disadvantaged, endocrine disorder, functional illiteracy, genetic disorder, infection, inadequate nutrition, insufficient prenatal care, late-term prenatal care, maternal age ≤15 years, maternal age ≥35 years, substance abuse, unplanned pregnancy, unwanted pregnancy
- *Individual:* Behavior disorder (e.g., attention deficit, oppositional defiant), brain injury (e.g., abuse, accident, hemorrhage, shaken baby syndrome), chronic illness, congenital disorder, failure to thrive, genetic disorder, hearing impairment, history of adoption, inadequate nutrition, involvement with the foster care system, lead poisoning, natural disaster, positive drug screen, prematurity, recurrent otitis media, seizure disorder, substance abuse, technology dependence (e.g., ventilator, augmentative communication), treatment regimen, visual impairment
- *Environment:* Economically disadvantaged, exposure to violence, learning disability, mental health issue (e.g., depression, psychosis, personality disorder, substance abuse), presence of abuse (e.g., physical, psychological, sexual)
- *Caregiver:* Learning disability, mental health issue (e.g., depression, psychosis, personality disorder, substance abuse), presence of abuse (e.g., physical, psychological, sexual)

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Communication
- Emotional
- Roles/relationship
- Values/beliefs

EXPECTED OUTCOMES

- The child will continue to grow and gain weight in accordance with growth chart of age and sex.
- The child will consume _____ calories and _____ mL of fluids representing _____ servings (specify for each food group).
- The child will participate in activities and be provided with a supervised, unconfined environment that includes age-appropriate toys and fosters interaction with child's development.
- The parents will express understanding of measures to reduce child's risk for delayed development.

- The parents will identify risk factors that may interfere with child's development.

SUGGESTED NOC OUTCOMES

Family Functioning; Growth; Parenting Performance; Risk Control; Child Development: 1 Month through Adolescence; Decision Making; Knowledge: Parenting

INTERVENTION AND RATIONALES

Determine: Assess family's developmental stage, family roles, family rules, socioeconomic status, family health history, history of substance abuse, history of sexual abuse of spouse or children, problem-solving and decision-making skills, religious affiliation, ethnicity. *Assessment information will aid in developing a workable plan of care.*

Perform: Weigh and measure child. Review growth chart *to establish current height and weight values.*

Establish a meal program *to meet the child's nutritional needs.*

Create an environment in which family members can express themselves openly and honestly. Establish rules for communication during meetings with the family. *Having rules allows everyone to participate and keep the discussion on the designated topic.*

Inform: Teach parents about nutritional requirements needed for child of specific weight and age. Discuss various meal choices available to the child. *Providing instruction in writing simplifies the parents' role in selecting healthy foods.*

Educate parents about child's need for quality interaction with family members and others. Inform parents about age-appropriate activities and toys as well as potential playmates for a child of specific age. Emphasize importance of providing an unconfined, supervised environment in which the child can *play to foster play that encourages the child to move freely.*

Educate parents about risk factors that may lead to delayed development, such as lack of supportive interactions or age-appropriate activities. *The ability to recognize risk factors will promote getting help for the parents and child sooner.*

Teach coping skills to parents *to enable them to deal effectively with the child's needs.*

Attend: Encourage parents to listen to the child and communicate in a loving, supportive way *in order to allow the child to maintain a positive attitude.*

Encourage parents to identify preventive measures they may initiate at home to ensure continuity of care. *Consistency in providing care will help the child understand that the plan carries over to all aspects of the child's life.*

Manage: Provide parents with a copy of child's teaching plan. *This helps to reinforce what the child is learning.*

Refer to case manager/social worker *to ensure that a home assessment is done.*

Refer to nutritionist *for follow-up with food issues.*

SUGGESTED NIC INTERVENTIONS

Family Process Maintenance; Coping Enhancement; Family Integrity Promotion; Normalization Promotion; Risk Identification; Developmental Enhancement

REFERENCES

Attaway, J., Stone, C. L., Sendor, C., & Rosario, E. R. (2015). Effect of amplification on speech and language in children with aural atresia. *American Journal of Audiology*, *24*(3), 354–359. doi:10.1044/2015_AJA-15-0021

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Tiesler, C., & Heinrich, J. (2014). Prenatal nicotine exposure and child behavioural problems. *European Child & Adolescent Psychiatry*, *23*(10), 913–929. doi:10.1007/s00787-014-0615-y

Van der Linde, B. W., van Netten, J. J., Otten, B., Postema, K., Geuze, R. H., & Schoemaker, M. M. (2015). Activities of daily living in children with developmental coordination disorder: Performance, learning, and participation. *Physical Therapy*, *95*(11), 1496–1506. doi:10.2522/ptj.20140211

DEFINITION

Passage of loose, unformed stools

DEFINING CHARACTERISTICS

- Abdominal pain
- Bowel urgency
- Cramping
- Hyperactive bowel sounds
- Loose liquid stools >3 in 24 hours

RELATED FACTORS

- *Psychological*: Gastrointestinal inflammation, gastrointestinal irritation, infection, malabsorption, parasite
- *Physiological*: Anxiety, increase in stress level
- *Situational*: Enteral feedings, exposure to contaminant, exposure to toxin, laxative abuse, substance abuse, travel, treatment regimen

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Emotional
- Elimination
- Fluid and electrolytes
- Nutrition

EXPECTED OUTCOMES

- The patient will have less or no diarrheal episodes.
- The patient will resume usual bowel pattern.
- The patient will maintain weight and fluid and electrolyte balance.
- The patient will keep skin clean and free from irritation or ulcerations.
- The patient will explain causative factors and preventive measures.
- The patient will discuss relationship of stress and anxiety to episodes of diarrhea.
- The patient will state plans to use stress-reduction techniques (specify).
- The patient will demonstrate ability to use at least one stress-reduction technique.

SUGGESTED NOC OUTCOMES

Bowel Continence; Hydration; Symptom Control; Bowel Elimination

INTERVENTIONS AND RATIONALES

Determine: Monitor and record frequency and characteristics of stools *to monitor treatment effectiveness.*

Identify stressors and help the patient solve problems *to provide more realistic approach to care.*

Monitor perianal skin for irritation and ulceration; treat according to established protocol *to promote comfort, skin integrity, and freedom from infection.*

Perform: Administer antidiarrheal medications, as ordered, *to improve body function, promote comfort, and balance body fluids, salts, and acid–base levels.* Monitor and report effectiveness of medication.

Provide replacement fluids and electrolytes, as prescribed. Maintain accurate records *to ensure balanced fluid intake and output.*

Inform: Teach patient to use relaxation techniques *to reduce muscle tension and nervousness;* recognize and reduce intake of diarrhea-producing foods or substances (such as dairy products and fruit) to reduce residual waste matter and decrease intestinal irritation.

Instruct patient to record diarrheal episodes and report them to staff to *promote comfort and maintain effective patient–staff communication.*

Attend: Encourage patient to ventilate stresses and anxiety; *release of pent-up emotions can temporarily relieve emotional distress.*

Encourage and assist patient to practice relaxation techniques *to reduce tension and promote self-knowledge and growth.*

Spend at least 10 minutes with patient twice daily to discuss stress-reducing techniques; *this can help patient pinpoint specific fears.*

Manage: Consult with dietitian *to determine foods that may be related to diarrheal episodes.*

SUGGESTED NIC INTERVENTIONS

Diarrhea Management; Nutrition Management; Skin Surveillance; Anxiety Reduction

REFERENCES

Keefe, D. M., Elting, L. S., Nguyen, H. T., Grunberg, S. M., Aprile, G., Bonaventura, A., . . . Sonis, S. T. (2014). Risk and outcomes of chemotherapy-induced diarrhea (CID) among patients with colorectal cancer receiving multi-cycle chemotherapy. *Cancer Chemotherapy & Pharmacology, 74*(4), 675–680. doi:10.1007/s00280-014-2526-5

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Peart, J., & Richardson, A. (2015). Developing a critical care bowel management assessment tool to manage fecal incontinence. *Nursing in Critical Care, 20*(1), 34–40. doi:10.1111/nicc.12101

146 RISK FOR DISUSE SYNDROME

DEFINITION

Vulnerable to deterioration of body systems as the result of prescribed or unavoidable musculoskeletal inactivity, which may compromise health

RISK FACTORS

- Alteration in level of consciousness
- Mechanical immobility
- Pain
- Paralysis
- Prescribed immobility

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Cardiac function
- Coping
- Elimination; nutrition
- Fluid and electrolytes
- Neurocognition
- Respiratory function
- Risk management
- Tissue integrity

EXPECTED OUTCOMES

- The patient will have no evidence of altered mental, sensory, or motor ability.
- The patient will have no evidence of thrombus formation or venous stasis.
- The patient will have no evidence of decreased chest movement, cough stimulus, depth of ventilation, pooling of secretions, or signs of infection.
- The patient will maintain normal bowel elimination patterns.
- The patient will maintain adequate dietary intake, hydration, and weight.
- The patient will have no evidence of urine retention, infection, or renal calculi.
- The patient will maintain muscle strength and tone and joint range of motion (ROM).
- The patient will have no evidence of contractures or skin breakdown.
- The patient will maintain normal neurologic, cardiovascular, respiratory, gastrointestinal, nutritional, genitourinary, musculoskeletal, and integumentary functioning during period of inactivity.

SUGGESTED NOC OUTCOMES

Coordinated Movement; Endurance; Immobility Consequences: Physiological; Immobility Consequences: Psycho-Cognitive; Mobility; Risk Control; Comfort Status

INTERVENTIONS AND RATIONALES

Determine: Inspect skin every shift and follow facility policy for prevention of pressure ulcers *to prevent or mitigate skin breakdown.*

Administer anticoagulant therapy, if ordered; monitor for signs and symptoms of bleeding. *Anticoagulant therapy may cause hemorrhage.*

Monitor vital signs every 4 hours: Monitor breath sounds and respiratory rate, rhythm, and depth *to rule out respiratory complications.* Monitor arterial blood gas levels or pulse oximetry *to assess oxygenation, ventilation, and metabolic status.*

Monitor urine characteristics and patient's subjective complaints typical of urinary tract of infections (UTIs), such as burning, frequency, and urgency. Obtain urine cultures, as ordered. *These measures aid early detection of UTI.*

Identify functional level *to provide baseline for future assessment,* and encourage appropriate participation in care *to prevent complications of immobility and increase patient's feelings of self-esteem.*

Perform: Avoid positions that put prolonged pressure on body parts and compress blood vessels; reposition patient at least every 2 hours within prescribed limits. *These measures enhance circulation and help prevent tissue or skin breakdown.*

Use pressure-reducing or pressure-equalizing equipment, as indicated or ordered (flotation pad, air pressure mattress, sheepskin pads, or special bed). *This helps prevent skin breakdown by relieving pressure.*

Apply antiembolism stockings; remove for 1 hour every 8 hours. *Stockings promote venous return to heart, prevent venous stasis, and decrease or prevent swelling of lower extremities.*

Suction airway, as needed and ordered, *to clear airway and stimulate cough reflex.* Note secretion characteristics.

Provide small, frequent meals of favorite foods *to increase dietary intake.* Increase fiber content *to enhance bowel elimination.* Increase protein and vitamin C *to promote wound healing*; limit calcium *to reduce risk of renal and bladder calculi.*

Perform active or passive ROM exercises at least once per shift. Teach and monitor appropriate isotonic and isometric exercises. *These measures prevent joint contractures, muscle atrophy, and other complications of prolonged inactivity.*

Provide or help with daily hygiene; keep skin dry and lubricated *to prevent cracking and possible infection.*

Inform: Teach and monitor deep breathing, coughing, and use of incentive spirometer to *help clear airways, expand lungs, and prevent respiratory complications.* Maintain regimen every 2 hours.

Instruct patient to avoid straining during bowel movements, *which may be hazardous to patients with cardiovascular disorders and increased*

intracranial pressure. Teach to administer stool softeners, suppositories, or laxatives, as ordered, and monitor effectiveness.

Attend: Encourage fluid intake of 2.5 to 3.5 L daily, unless contraindicated, *to maintain urine output and aid bowel elimination.* Encourage patient and family to verbalize frustrations *to help patient and family cope with treatment.*

SUGGESTED NIC INTERVENTIONS

Activity Therapy; Body Mechanics Promotion; Cognitive Stimulation; Energy Management; Exercise Promotion; Exercise Therapy: Ambulation and Joint Mobility; Fluid Management; Nutrition Management

REFERENCES

Fernandes, T., Mendes, E., Preto, L., & Novo, A. (2015). Experience of a mobilization and active exercise program on the range of motion of bedridden patients with disuse syndrome. *Journal of Rehabilitation Medicine, 47*(8), 791–792.

Powers, S. (2014). Can antioxidants protect against disuse muscle atrophy? *Sports Medicine, 44*, 155–165. doi:10.1007/s40279-014-0255-x

Shuval, K., Kohl, H. W., 3rd, Bernstein, I., Cheng, D., Pettee Gabriel, K., Barlow, C. E., . . . Dipietro, L. (2014). Sedentary behavior and physical inactivity assessment in primary care: The Rapid Assessment Disuse Index (RADI) study. *British Journal of Sports Medicine, 48*(3), 250–255. doi:10.1136/bjsports-2013-092901

DEFINITION

Decreased stimulation from (or interest or engagement in) recreational or leisure activities

DEFINING CHARACTERISTICS

- Boredom
- Current setting does not allow engagement in activity

RELATED FACTORS

- Insufficient diversional activity
- Extremes of age
- Prolonged hospitalization
- Prolonged institutionalization

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Emotional status
- Neurocognition
- Physical status
- Respiratory function

EXPECTED OUTCOMES

- The patient will express interest in using leisure time meaningfully.
- The patient will express interest and participate in activities that can be provided (e.g., watch selected television program, listen to radio or music daily).
- The patient will report satisfaction with use of leisure time.
- The patient will modify environment to provide maximum stimulation (e.g., hanging posters or cards and moving bed next to a window).

SUGGESTED NOC OUTCOMES

Leisure Participation; Motivation; Social Involvement; Personal Well-Being

INTERVENTIONS AND RATIONALES

Determine: Assess leisure activity preferences. Identify the type of music patient prefers; seek help from family and hospital resources *to provide selected music daily that relieves boredom and stimulates interest.*

Perform: Provide supplies and set time to indulge in hobby. Obtain radio, television, or crochet hook and yarn (if desired). Allow patient to (if TV or radio) select programs. Communicate patient's desires to coworkers (e.g., Turn on television set at _____ [time] to _____ [channel]. Give crochet hook and yarn to patient daily at _____ [time]). *Specifying time for activity indicates its value.* Avoid scheduling activities during leisure time, *which is integral to quality of life.*

Ask volunteers (friends, family, or hospital volunteer) to read newspapers, books, or magazines to patient at specific times. *Personal contact helps alleviate boredom.*

Engage patient in conversation while carrying out routine care. Discuss patient's favorite topics as much as possible. *Conversation conveys caring and recognition of patient's worth.*

Provide talking books or I-Pod if available. *These provide low-effort sources of enjoyment for bedridden patient.*

Obtain an adapter for television to provide captions *for hearing-impaired patient.*

Provide plants for the patient to tend to. *Caring for live plants may stimulate interest.*

Change scenery when possible; for example, take the patient outside in a wheelchair *to help reduce boredom.*

Attend: Encourage discussion of previously enjoyed hobbies, interests, or skills to direct planning of new activities. Suggest performing an activity helpful to others or otherwise productive *to promote interest.*

Encourage patient's family or caregiver to bring personal articles (posters, cards, and pictures) *to help make environment more stimulating (the patient may respond better to objects with personal meaning).*

Manage: Make referral to recreational, occupational, or physical therapist for consultation on adaptive equipment to carry out desired activity; arrange for therapy sessions. *Adaptive equipment allows patient to continue enjoying activities or may stimulate interest in new activities.*

SUGGESTED NIC INTERVENTIONS

Activity Therapy; Animal-Assisted Therapy; Art Therapy; Recreation Therapy

REFERENCES

Camic, P. M., Tischler, V., & Pearman, C. H. (2014). Viewing and making art together: A multi-session art-gallery-based intervention for people with dementia and their carers. *Aging & Mental Health, 18*(2), 161–168. doi:10.1080/13607863.2013.818101

Hsin-Sing, W., Hung-Lan, W., & Hsien-Ju, L. (2014). Applying a creative art activity in care: Report on an experience with a newly admitted resident. *Journal of Nursing, 61*(5), 104–110. doi:10.6224/JN.61.5.104

Physical activity interventions: An essential component in recovery from mental illness. (2015). *British Journal of Sports Medicine, 49*(24), 1544–1545. doi:10.1136/bjsports-2014-094314

DEFINITION

Vulnerable to eye discomfort or damage to the cornea and conjunctiva due to reduced quantity or quality of tears to moisten the eye, which may compromise health

RISK FACTORS

- Aging
- Autoimmune disease (rheumatoid arthritis, diabetes mellitus, thyroid disease)
- Contact lens wearer
- Environmental factor (e.g., air-conditioning, excessive wind, sunlight exposure, air pollution, low humidity)
- Female gender
- History of allergy
- Hormonal change
- Lifestyle choice (e.g., smoking, caffeine use, prolonged reading)
- Mechanical ventilation
- Neurologic lesion with sensory or motor reflex loss (e.g., lagophthalmos, lack of spontaneous blink reflex)
- Ocular surface damage
- Treatment regimen
- Vitamin A deficiency

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Risk management
- Pharmacologic function
- Tissue integrity
- Knowledge

EXPECTED OUTCOMES

- The patient will state personal risk factors for dry eye.
- The patient will take steps to minimize risk factors.
- The patient will understand the need for collaboration with health care team if signs/symptoms occur/persist.

SUGGESTED NOC OUTCOMES

Risk Control; Risk Detection; Tissue Integrity: Skin/Mucous Membranes; Knowledge: Health Behavior

INTERVENTIONS AND RATIONALES

Determine: Identify use of systemic medications that may decrease tear production and lifestyle behaviors that may potentiate dry eye conditions. *Assessment data may influence interventions.* Assess for history of medical conditions *to determine underlying risks for dry eye syndrome.*

Perform: Modify physical environment to increase humidity, minimize excessive air movement, and control dust, *which can decrease tear production.* Administer artificial tears as indicated *to relieve symptoms.* Perform protective measures such as preservative-free artificial tears or polyethylene eye cover for critically ill patients *to prevent eye damage due to dry eye syndrome*

Inform: Teach about simple environmental modifications *to reduce evaporation of tears.* Encourage patient to take frequent breaks from visually demanding activities *to help minimize risk factors.* Suggest diet rich in omega-3 fatty acid or dietary supplement. *Diet low in omega-3 fatty acids can increase risk of dry eye syndrome.* Instruct patient on the use of sunglasses *to limit exposure to light.* Instruct patient to try over-the-counter artificial tears *for temporary relief of dry eye.*

Attend: Encourage adherence to lifestyle modifications, *which will improve quality of life and decrease the risk of eye damage.*

Manage: Refer to eye specialist if symptoms persist *for further evaluation and continued care.* Collaborate with primary care provider regarding possible changes in medications *that may be contributing to dry eye condition.* Encourage annual eye exam *to monitor for any changes.* Offer written treatment guidelines, as needed, *to reinforce learning.*

SUGGESTED NIC INTERVENTIONS

Risk Management; Risk Identification; Behavior Management; Eye Care

REFERENCES

Ezuddin, N., Alawa, K., & Galor, A. (2015). Therapeutic strategies to treat dry eye in an aging population. *Drugs & Aging, 32*(7), 505–513. doi:10.1007/s40266-015-0277-6

Marshall, L. L., & Roach, J. M. (2016). Treatment of dry eye disease. *Consultant Pharmacist, 31*(2), 96–106. doi:10.4140/TCP.n.2016.96

Sun, H., & Kye Ha, K. (2014). Dry eye syndrome and ocular fatigue according to the status of contact lens wearing and management among female university students. *Journal of Korean Academy of Community Health Nursing, 25*(4), 259–269. doi:10.12799/jkachn.2014.25.4.259

RISK FOR PERIPHERAL NEUROVASCULAR DYSFUNCTION

DEFINITION

Vulnerable to disruption in the circulation, sensation, and motion of an extremity, which may compromise health

RISK FACTORS

- Burns
- Fracture
- Immobilization
- Mechanical compression (e.g., tourniquet, cast, brace, dressing, restraint)
- Orthopedic surgery
- Trauma
- Vascular obstruction

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Physical regulation
- Sensation/perception
- Cardiac function
- Comfort

EXPECTED OUTCOMES

- The patient/family will have no evidence of disability related to peripheral neurovascular dysfunction after injury or treatment.
- The patient/family will maintain circulation in extremities.
- The patient/family will feel and move each toe or finger after application of cast, brace, or splint.
- The patient/family will demonstrate correct body-positioning techniques.
- The patient/family will express understanding of risk of altered neurovascular status and need to report symptoms of impaired circulation.
- The patient/family will enroll in smoking-cessation program, as appropriate.
- The patient/family will exhibit no symptoms of neurovascular compromise.

SUGGESTED NOC OUTCOMES

Circulation Status; Neurological Status: Peripheral; Risk Control: Tobacco Use; Risk Detection; Tissue Perfusion: Peripheral; Knowledge: Substance Abuse Control

INTERVENTIONS AND RATIONALES

Determine: Note if patient will undergo surgery or a procedure that increases the risk of peripheral neurovascular dysfunction *to anticipate complications.*

As appropriate, assess circulation before and after application of the cast, brace, or splint *to detect signs of impaired circulation.*

Perform: Immobilize the joints directly above and below the suspected fracture site, leaving room for pulse assessment *to facilitate monitoring of circulatory status.*

Remove the clothing around the suspected fracture site, clean the site, apply sterile dressings to open wounds, and carefully apply a cast, brace, or splint *to avoid further infection and trauma.*

Follow facility guidelines for the application of such devices as tourniquets, restraints, and tape *to ensure adequate circulation in affected extremity.*

If you suspect nerve compression, assess the position of the extremity that has a cast, brace, or splint. *Positioning of the extremity may affect circulation.*

Elevate the limb above heart level after surgery or trauma *to reduce the risk of edema.* If increased intracompartmental pressure is evident, maintain the affected limb at heart level *to reduce pressure.*

If edema appears in the affected extremity, split, bivalve, slit, or cut a window in the cast and padding according to facility protocol *to avoid neurovascular impairment.*

Inject prescribed neurotoxic agents (such as penicillin G, hydrocortisone, tetanus toxoid, and diazepam) away from the affected extremity and major nerves *to avoid injury.*

Avoid flexing the affected extremity. *Flexion may reduce venous circulation, increasing the risk of neurovascular complications.*

Administer and monitor the effectiveness of vasodilators, as ordered, *to control vasospasm.*

Inform: If patient requires a fasciotomy to restore circulation, provide educational material that explains this emergency procedure *to reduce patient anxiety.*

Instruct patient and family members in proper positioning when lying in bed and when sitting and in methods of obtaining pressure relief *to avoid pooling of blood and pressure ulcers.*

If appropriate, discuss the cause of the injury and safety precautions *to avoid further injury.*

Instruct patient and family members in recognizing and reporting symptoms of peripheral neurovascular dysfunction, including numbness, pain, and tingling *to prevent onset of neurovascular damage after discharge.*

Attend: If patient smokes, encourage the patient to enroll in a smoking-cessation program. *Quitting smoking may enhance oxygenation, decreasing the risk of peripheral neurovascular dysfunction.*

Take measures to ease anxiety, *which could lead to vasoconstriction.*

Manage: Refer patient to appropriate community resources related to safety precautions *to achieve optimal safety level.*

SUGGESTED NIC INTERVENTIONS

Circulatory Precautions; Exercise Promotion: Strength Training; Exercise Therapy: Joint Mobility; Peripheral Sensation Management; Positioning: Neurologic; Pressure Ulcer Prevention; Skin Surveillance; Splinting; Smoking Cessation Assistance

REFERENCES

Cam, R., & Korkmaz, F. D. (2014). The effect of long-term care and follow-up on complications in patients with external fixators. *International Journal of Nursing Practice*, *20*(1), 89–96. doi:10.1111/ijn.12126

McKee, J., Wade, C., & McCarron, M. O. (2015). A quality improvement programme with a specialist nurse in a neurovascular clinic. *Journal of Clinical Nursing*, *24*(3/4), 386–392. doi:10.1111/jocn.12609

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156 RISK FOR ELECTROLYTE IMBALANCE

DEFINITION

Vulnerable to changes in serum electrolyte levels, which may compromise health

RISK FACTORS

- Compromised regulatory mechanism
- Diarrhea
- Endocrine regulatory dysfunction (e.g., glucose intolerance, increase in IGF-1, androgen, DHEA, and cortisol)
- Excessive fluid volume
- Insufficient fluid volume
- Renal dysfunction
- Vomiting
- Treatment regimen

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Fluid and electrolytes
- Physical regulation

EXPECTED OUTCOMES

- The patient will maintain electrolyte levels within the normal limits.
- The patient will maintain adequate fluid balance consistent with underlying disease restrictions.
- The patient will identify health situations that increase risk for electrolyte imbalance and verbalize interventions to promote balance.
- The patient will verbalize signs and symptoms that require immediate intervention by health care provider.
- The patient will remain safe from injury associated with electrolyte imbalance.

SUGGESTED NOC OUTCOMES

Electrolyte & Acid–Base Balance, Fluid Balance

INTERVENTIONS AND RATIONALES

Determine: Assess patient's fluid status. *Patients who demonstrate fluid volume alterations are likely to have electrolyte alterations as well.*

Monitor patient for physical signs of electrolyte imbalance. *Many cardiac, neurologic, and musculoskeletal symptoms are indicative of specific electrolyte abnormalities.*

Perform: Collect and evaluate serum electrolyte results, as ordered, *to allow for prompt diagnosis and treatment of any abnormalities.*

Treat underlying medical condition. *Correction of the underlying cause of electrolyte imbalance is the first step in correcting electrolyte imbalance.*

Inform: Educate patient and family regarding risks for electrolyte disturbances associated with their particular medical condition and possible interventions if symptoms occur. *Early identification and intervention may prevent life-threatening complications of electrolyte imbalance.*
Attend: Provide support and encouragement to patient and family in their efforts to participate in the management of the condition. *Positive feedback will increase self-confidence and feeling of partnership in care.*
Manage: Coordinate care with other members of the health care team to provide safe environment. *Electrolyte imbalances can cause poor coordination, weakness, and altered gait.*

SUGGESTED NIC INTERVENTIONS

Electrolyte Management, Electrolyte Monitoring, Fluid–Electrolyte Management; Laboratory Data Interpretation

REFERENCES

Crawford, A. H. (2014). Hyperkalemia: Recognition and management of a critical electrolyte disturbance. *Journal of Infusion Nursing, 37*(3), 167–175. doi:10.1097/NAN.0000000000000036

Keane, M. (2014). Recognizing and managing acute hyponatraemia. *Emergency Nurse, 21*(9), 32–36.

Palmer, B. F., & Clegg, D. J. (2015). Electrolyte and acid–base disturbances in patients with diabetes mellitus. *New England Journal of Medicine, 373*(6), 548–559. doi:10.1056/NEJMra1503102

158 IMPAIRED EMANCIPATED DECISION-MAKING

DEFINITION

A process of choosing a healthcare decision that does not include personal knowledge and/or consideration of social norms, or does not occur in a flexible environment, resulting in decisional dissatisfaction.

DEFINING CHARACTERISTICS

- Delay in enacting chosen health care option
- Distress when listening to other's opinion
- Excessive concern about what others think is the best decision
- Feeling constrained in describing own opinion
- Inability to choose a health care option that best fits current lifestyle
- Inability to describe how option will fit into current lifestyle
- Limited verbalization about health care option in other's presence

RELATED FACTORS

- Decrease in understanding of all available health care options
- Inability to adequately verbalize perceptions about health care options
- Inadequate time to discuss health care options
- Insufficient privacy to openly discuss health care options
- Limited decision-making experience
- Traditional hierarchical family
- Traditional hierarchical health care system

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication
- Coping
- Emotional
- Neurocognition
- Risk management
- Self-care
- Sensation/perception

EXPECTED OUTCOMES

- The patients will demonstrate consideration of how available health care choices fit with their values, beliefs, preferences, and lifestyle.
- The patients will express consideration of their own values, beliefs, and preferences independent of those of others in considering the available health care options.
- The patients will verbalize their opinion freely.
- The patient will make a health care choice.
- The patient will verbalize satisfaction with their health care choice based on the options available to them.

SUGGESTED NOC OUTCOMES

Decision-Making; Information Processing; Participation in Health Care Decisions

INTERVENTIONS AND RATIONALES

Determine: Continually assess for readiness to make a health care choice *to promote timely decision making.*

Perform: Ensure privacy for one-to-one interaction between patient and nurse. *The patient's status in relationships with family/loved ones may inhibit frank discussion in their presence.*

Ensure that communications and information provided are at a level consistent with the patient's cognitive abilities *to ensure understanding.*

Avoid limiting choices based on health care provider's preference, values, or beliefs, and avoid encouraging one choice over another. *The health care team is accountable to the patient to provide appropriate information on all available options and to promote autonomous decision making.*

Validate the patients' experience, and ask permission to discuss their thoughts and feelings about their choices with them. Identify any anxiety or fear related to making a decision. *Fear and anxiety can lead to anger, feeling pressured or overwhelmed, procrastination, and/or excessive seeing of reassurance or opinions from others.*

Inform: Discuss the patient's emotional experience of needing to make a health care choice with them. *The patient may feel anger, fear, anxiety, pressured, or overwhelmed by the need to choose or the choices offered.*

Provide clarifying information about choices, if needed. *Misinterpretations of information may lead to difficulty making a decision.*

Attend: Engage the patient in the therapeutic relationship. Demonstrate an attitude of respect, patience, and acceptance. *Persons who feel cared for, understood, and respected in health care situations are better motivated to collaboratively participate in their care.*

Explore with the patients the meaning of their experience of making a health care decision. Ask them what meanings their current health care situation and having to make a health care decision have for them. *The health care need and necessity to make a health care decision may represent a crisis for the patient. Understanding the patient's experience of this can direct the identification of other necessary assessments and interventions.*

Engage the patient to use a problem-solving framework to identify and to evaluate the possible available choices. Ask the patients to list the advantages and drawbacks to each choice, as well as their personal values, goals, and preferences related to each choice. Encourage the patient to identify personal and social barriers to enacting any of the choices. Then ask the patients to rate the suitability of each choice based on their appraisal of each one. *Use of a problem-solving framework in consideration*

of health care choices encourages the patients to consider health care options from the context of their own experience and to identify their own best choices given their life situation.

Manage: Refer for professional support to address anxious distorted thoughts, if needed. *Counseling maybe required to assist the patient to work through distorted thoughts and determine own best course of action.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Assertiveness Training; Decision-Making Support; Learning Facilitation; Mutual Goal Setting

REFERENCES

Kramer-Roy, D. (2015). Using participatory and creative methods to facilitate emancipatory research with people facing multiple disadvantage: A role for health and care professionals. *Disability and Society, 30*(8), 1207–1224.

Olesen, M. L., Graungaard, A. H. & Husted, G. R. (2015). Deciding treatment for miscarriage-Experiences of women and healthcare professionals. *Scandinavian Journal of Caring Sciences, 29*(2), 386–394.

Welzel, C. & Delhey, J. (2015). Generalizing trust: The benign force of emancipation. *Journal of cross-Cultural Psychology, 46*(7), 875–896.

Wittmann-Price, R. A. & Price, S. W. (2014). Development and revision of the Wittmann-Price emancipated decision-making scale. *Journal or Nursing Measurement, 22*(3), 361–367.

DEFINITION

Vulnerable to a process of choosing a healthcare decision that does not include personal knowledge and/or consideration of social norms, or does not occur in a flexible environment resulting in decisional dissatisfaction

RISK FACTORS

- Inadequate time to discuss health care options
- Insufficient confidence to openly discuss health care options
- Insufficient privacy to openly discuss health care options
- Limited decision-making experience
- Traditional hierarchical family
- Traditional hierarchical health care systems

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication
- Coping
- Emotional
- Neurocognition
- Risk management
- Self-care
- Sensation/perception

EXPECTED OUTCOMES

- The patients will verbalize their opinion freely.
- The patients will verbalize their values, beliefs, and preferences.
- The patients will identify any disparities between their and others values, beliefs, and preferences.
- The patients will have information needs met.
- The patient will make an autonomous health care choice.

SUGGESTED NOC OUTCOMES

Decision-Making; Information Processing; Participation in Health Care Decisions

INTERVENTIONS AND RATIONALES

Determine: Continually assess for readiness to make a health care choice *to promote timely decision making.*

Respectfully inquire as to the patient's cultural background, including gender roles, generational roles, and social expectations. *The patient is the best source of knowledge of the patient's particular culture.*

Perform: Ensure privacy for one-to-one interaction between patient and nurse. *The patient's status in relationships with family/loved ones may inhibit frank discussion in their presence.* If necessary, move the interaction, modify the environment, or remove others to ensure privacy.

Avoid limiting choices based on health care provider's preference, values, or beliefs, and avoid encouraging one choice over another. *The health care team is accountable to the patient to provide appropriate information on all available options and to promote autonomous decision making.*

Ensure that communications and information provided are at a level consistent with the patient's cognitive abilities *to ensure understanding.*

Validate the patient's understanding *to promote self-esteem and confidence in knowledge and strengthen the therapeutic relationship.*

Ask the patients about strategies they have used in the past to make decisions. Validate their past choices in strategies. Reinforce independent strategies *to identify and draw on personal experiences and strengths in decision making.*

Inform: Provide education, as needed, in an accepting, nonjudgmental, supportive manner. Avoid taking a stance of correcting the patients; rather, build on their knowledge and understanding *to build knowledge capacity while preserving self-esteem.*

Attend: Engage the patient in the therapeutic relationship. Demonstrate an attitude of respect, patience, and acceptance. *Persons who feel cared for, understood, and respected in health care situations are better motivated to collaboratively participate in their care.*

Encourage the patients to explore any cultural considerations they are making in their health care decision making and to share what it is like for them to include those considerations *Negative or conflicting emotions, or indecision, may arise in the patients due to incongruence between the values and beliefs of their culture and their personal values, beliefs, and preferences.*

Explore with the patients the meaning of their experience of making a health care decision. Ask them what meanings their current health care situation and having to make a health care decision have for them. *The health care need and necessity to make a health care decision may represent a crisis for the patient. Understanding the patient's experience of this can direct the identification of other necessary assessments and interventions.*

If past experience in decision making is limited, engage the patients to use a problem-solving framework to identify and to evaluate the possible choices available to them. *Use of a problem-solving framework in consideration of health care choices encourages the patients to consider health care options from the context of their own experience and to identify their own best choices given their life situation.*

Manage: Refer for professional support, if needed. *Counseling maybe required to assist the patient to work through distorted thoughts and determine own best course of action.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Assertiveness Training; Decision-Making Support; Learning Facilitation; Mutual Goal Setting

REFERENCES

Kramer-Roy, D. (2015). Using participatory and creative methods to facilitate emancipatory research with people facing multiple disadvantage: A role for health and care professionals. *Disability and Society, 30*(8), 1207–1224.

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164 LABILE EMOTIONAL CONTROL

DEFINITION

Uncontrollable outbursts of exaggerated and involuntary emotional expression

DEFINING CHARACTERISTICS

- Absences of eye contact
- Difficulty in use of facial expressions
- Embarrassment regarding emotional expression
- Excessive crying without feeling sadness
- Excessive laughing without feeling happiness
- Expression of emotion incongruent with triggering factor
- Involuntary crying
- Involuntary laughing
- Tearfulness
- Uncontrollable crying
- Uncontrollable laughing
- Withdrawal from occupational situation
- Withdrawal from social situation

RELATED FACTORS

- Alternation in self-esteem
- Brain injury
- Emotional disturbance
- Fatigue
- Functional impairment
- Insufficient knowledge about symptom control
- Insufficient knowledge of disease
- Insufficient muscle strength
- Mood disorder
- Musculoskeletal impairment
- Pharmaceutical agent
- Physical disability
- Psychiatric disorder
- Social distress
- Stressors
- Substance abuse

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Emotional
- Neurocognition
- Self-care
- Sensation/perception

EXPECTED OUTCOMES

- The patient will identify the personal and social impacts of emotional outbursts, and own goals for managing/limiting outbursts.
- The patient will discuss bodily, cognitive, and situational experiences correlating with periods of emotional outbursts.
- The patient will practice strategies to promote emotional control.
- The patient will express positive self-esteem.

SUGGESTED NOC OUTCOMES

Aggression Control; Anxiety Control; Coping; Impulse Control; Self-Esteem; Self-Mutilation Restraint; Social Interaction Skills

INTERVENTIONS AND RATIONALES

Determine: Assist the patient to identify environmental and situational triggers to physiologic arousal, and engage the patient to create a plan to limit physiologic arousal *to promote self-efficacy in proactive management of emotional outbursts.*

Perform: During the outburst, use a calm tone and communicate in short, direct, specific statements. Expect that the patient may need extra time to process information and that instructions may need to be repeated *as diminished cognitive capacity may impact processing of information.*

When the outburst has ended, ensure that the patient's immediate physiologic needs (i.e., rest, nutrition, hydration, elimination) are addressed prior to engaging in interventions to reduce and prevent future outbursts. *Basic physiologic needs must be met for the patient to be able to engage therapeutically.*

Use nonjudgmental, matter-of-fact language *to promote self-esteem.*

Inform: Do not attempt to teach new skills/information while the patient is in the midst of an intense emotional outburst *as the patient's cognitive capacity may be reduced at this time.*

Teach new skills when the patient is calm. *Emotional outbursts physiologically are time-limited.*

Teach the patient about the social impact of emotional outbursts (as needed). Ask the patient to identify individuals who have been affected by the patient's emotional outbursts. Ask the patient to identify any social impact and/or occupational impact (i.e., work, school) of emotional outbursts *to promote insight and stimulate motivation to engage in strategies to limit outbursts.*

Attend: Engage the patients in discussion of how life would be different if they had better control over their emotional outbursts *to foster motivation and engagement in care.*

Ask the patients to decide at least one reason why they want to better control their emotional expression *to foster motivation and engagement in interventions and to promote self-efficacy.*

Involve the patients in their care. Provide options and solicit feedback on the patients' experience of care. *Partnering with the patient promotes self-efficacy and self-esteem, and strengthens the therapeutic alliance.*

Solicit the patient's thoughts and experience of bodily sensations during care. Reinforce and support use of adaptive coping strategies to limit emotional outbursts. *To help the patient further develop awareness of signs and triggers, and to promote use of strategies to limit/prevent outbursts.*

Assist the patient to identify and practice strategies to manage distressing/exciting situations and strong emotions. Use vicarious learning or role-play exercises to practice plan of response to limit emotional outbursts. *Practice of strategies in a safe and controlled environment develops skills in strategies and builds confidence to apply strategies in triggering situations.*

Manage: Assist the patient with referral to specialized resources in Mindfulness, Dialectical Behavior Therapy, and/or Cognitive Behavioral Therapy, as indicated, in consultation with the interdisciplinary care team. *Mindfulness improves attention and body awareness, and promotes cognitive control and attentional capability in situations of high emotion. Mindfulness, Dialectical Behavior Therapy, and Cognitive Behavior Therapy each have applications for improving cognitive control and emotional dysregulation.*

SUGGESTED NIC INTERVENTIONS

Anger Control Assistance; Anxiety Reduction; Cognitive Restructuring; Coping Enhancement; Impulse Control Training; Support Group

REFERENCES

Grecucci, A., Pappaianni, E., Siugzdaite, R., Theuninck, A., Job, R. (2015). Mindful emotion regulation: Exploring the neurocognitive mechanisms behind mindfulness. *BioMed Research International, 2015*, 67072.

Linehan, M. (2014). *DBT skills training manual* (2nd ed.). New York: Guilford Press.

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DEFINITION

Vulnerable to increased susceptibility to falling, which may cause physical harm and compromise health

RISK FACTORS

- *Adult:* Age ≥65 years, history of falls, living alone, lower limb prosthesis, use of assistive device (e.g., walker, cane, wheelchair)
- *Child:* Absence of stairway gate, absence of window guard, age ≤2 years, inadequate supervision, insufficient automobile restraints, male gender when <1 year of age
- *Cognitive:* Alteration in cognitive functioning
- *Environment:* Cluttered environment, exposure to unsafe weather-related condition (e.g., wet floors, ice), insufficient lighting, insufficient antislip material in bathroom, unfamiliar setting, use of restraints, use of throw rugs
- *Pharmaceutical Agents:* Alcohol consumption, pharmaceutical agent
- *Physiological:* Acute illness, alteration in blood glucose level, anemia, arthritis, condition affecting the foot, decrease in lower extremity strength, diarrhea, difficulty with gait, fairness when extending neck, faintness when turning neck, hearing impairment, impaired balance, impaired mobility, incontinence, neoplasm, neuropathy, orthostatic hypotension, postoperative recovery period, proprioceptive deficit, sleeplessness, urinary urgency, vascular disease, visual impairment

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Cardiac function
- Knowledge
- Neurocognition
- Sensation/perception

EXPECTED OUTCOMES

- Patient and family will identify factors that increase potential for falling.
- Patient and family will assist in identifying and applying safety measures to prevent injury.
- Patient and family will make necessary changes in the physical environment to ensure safety for the patient.
- Patient and family will develop long-term strategies to promote safety and prevent falls.
- Patient and family will optimize patient's ability to carry out activities of living within sensor motor limitations.

SUGGESTED NOC OUTCOMES

Balance; Cognition; Risk Control; Knowledge: Fall Prevention; Safe Home Environment; Fall Prevention Behavior, Falls Occurrence

INTERVENTIONS AND RATIONALES

Determine: For adults, assess severity of sensory or motor deficits, environmental hazards and inadequate lighting, medication use, improper use of assistive devices.

For children, assess sensory or motor deficits, recent illnesses, unsteady balance, running at speeds beyond capability, and inadequate supervision. *Assessment factors will help identify appropriate interventions.*

Perform: For older adults, make necessary changes in environment (i.e., remove throw rugs). Orient patient to environment. Post a notice that the patient is at risk for falling. Place side rails up and bed position down when the patient is in bed. Place personal items within the patient's reach. *These measures prevent injury to patient.*

For children, make necessary changes in environment (i.e., apply window guards), keep toys and other objects from lying around on the floor, use a gate when necessary to keep the child in a confined area, provide adequate supervision *to prevent injury to the patient.*

Inform: Provide family with a list of all the things they need to do to prevent the patient from falling. Go over each item and explain the reason for each cautionary measure. *Written instructions will reinforce the need for prevention.*

Teach patient with an unstable gait how to use assistive devices properly. *Improper use of assistive devices can put the patient at greater risk of falling.*

Teach patient and family about the use of safe lighting. Advise patients to wear sunglasses to reduce glare. *Proper lighting is always considered as a preventive measure.*

Teach patients about medications that have been prescribed for them. *Overmedication in older adults is one of the major risk factors in falls. Understanding on the part of the patient and family can reduce the incidence of falls in the home.*

Attend: Ask frequently during hospitalization whether patient and family have questions about the modifications needed to prevent falls. Listen carefully to statement or ideas the patient and/or family may present about potential for falls in their individual home settings. *Greater awareness on the part of both patient and family can markedly reduce the risk of falls.*

Encourage adult patient to express feelings about the fear of falling. *Being able to express the fear will raise the nurse's awareness of what the patient considers problem areas.*

Manage: Arrange for social service/case manager to make a home visit *to help prepare the family for the patient's return to a safe environment.*

Refer patient and family to community resources *that may offer assistance to the patient when needed.*

Refer to home health nurse *for a follow-up visit in the home.*

SUGGESTED NIC INTERVENTIONS

Environmental Management: Safety; Exercise Therapy: Balance; Fall Prevention; Medication Management; Teaching

REFERENCES

Godlock, G. (2016). Implementation of an evidence-based patient safety team to prevent falls in inpatient medical units. *MEDSURG Nursing*, *25*(1), 17–23.

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Tomita, M. R., Saharan, S., Rajendran, S., Nochajski, S. M., & Schweitzer, J. A. (2014). Psychometrics of the home safety self-Assessment tool (HSSAT) to prevent falls in community-dwelling older adults. *American Journal of Occupational Therapy*, *68*(6), 711–718. doi:10.5014/ajot.2014.010801

DEFINITION

Psychosocial, spiritual, and physiological functions of the family unit are chronically disorganized, which leads to conflict, denial of problems, resistance to change, ineffective problem solving, and a series of self-perpetuating crises

DEFINING CHARACTERISTICS

- *Behavioral:* Agitation, alteration in concentration, blaming, broken promises, chaos, complicated grieving, conflict avoidance, contradictory communication pattern, controlling communication pattern, criticizing, decrease in physical comfort, denial of problems, dependency, difficulty having fun, difficulty with intimate relationship, difficulty with life-cycle transition, disturbances in academic performance in children, enabling substance use pattern, escalating conflict, failure to accomplish developmental tasks transitions, Harsh self-judgment, immaturity, inability to accept a wide range of feelings, inability to accept help, inability to adapt to change, inability to deal constructively with traumatic experiences, inability to express a wide range of feelings, inability to meet emotional needs of its members, inability to meet the security needs of its members, inability to meet spiritual needs of its members, inability to receive help appropriately, inappropriate anger expression, insufficient knowledge about substance abuse, insufficient problem-solving skills, lying, manipulation, nicotine addiction, orientation favors tension relief rather than goals, paradoxical communication pattern, power struggles, rationalization, refusal to get help, seeking of affirmation, seeking of approval, self-blame, social isolation, special occasions centered on substance use, stress-related physical illnesses, substance abuse, unreliable behavior, verbal abuse of children, verbal abuse of parent, verbal abuse of partner
- *Feelings:* Abandonment, anger, anxiety, confuses love and pity, confusion, depression, dissatisfaction, embarrassment, emotional isolation, emotionally controlled by others, failure, fear, feeling different from others, feeling misunderstood, feeling unloved, guilt, hopelessness, hostility, hurt, insecurity, lingering resentment, loneliness, loss, loss of identity, low self-esteem, mistrust, moodiness, powerlessness, rejection, repressed emotions, shame, surgical procedure, taking responsibility for substance abuser's behavior, tension, unhappiness, vulnerability, worthlessness
- *Roles and Relationships:* Change in role function, chronic family problems, closed communication system, conflict between partners, deterioration in family relationships, diminished ability of family members to relate to each other for mutual growth and maturation, disrupted family rituals,

disrupted family roles, disturbance in family dynamics, economically disadvantaged, family denial, inconsistent parenting, ineffective communication with partner, insufficient cohesiveness, insufficient family respect for autonomy of its members, insufficient family respect for individuality of its members, insufficient relationship skills, intimacy dysfunction, neglect of obligation to family member, pattern of rejection, perceived insufficient parental support, triangulating family

RELATED FACTORS

- Addictive personality
- Biologic factors
- Family history of resistance to treatment
- Family history of substance abuse
- Genetic predisposition to substance abuse
- Ineffective coping strategies
- Insufficient problem-solving skills
- Substance abuse

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Emotional
- Coping
- Values and beliefs
- Communication
- Knowledge
- Self-perception

EXPECTED OUTCOMES

- Family members will acknowledge there is a problem with alcoholism within the family.
- Family members will sign contracts stating they will not engage in abusive behavior.
- Family members will communicate their needs, using "I" statements.
- Family members will discuss problems in an open, safe environment.
- Family members will acknowledge their strengths and progress in resolving problems.
- Family members will state plans to continue to seek counseling and attend appropriate support group meetings.

SUGGESTED NOC OUTCOMES

Family Coping; Family Functioning; Family Normalization; Role Performance; Substance Addiction Consequences; Risk Control: Alcohol Abuse and Drug Use

INTERVENTIONS AND RATIONALES

Determine: Assess drinking pattern, use of other substances, patterns of withdrawal, ability of alcoholic member to function in occupational and familial roles, ability of family members to function in their roles, family health history, affiliation with a religious group and religious practices. *Assessment factors will assist in identifying appropriate interventions.*

Perform: Create an environment in which family members feel free to express themselves honestly about the present situation *to decrease their anxiety and help family members develop confidence in their ability to resolve problems.*

Inform alcoholic family member that he will have to acknowledge his alcoholism before progress can be made in rebuilding family relations to *establish abstinence as a basis for treatment.*

Inform: Teach family members to communicate their needs assertively. Have them practice using "I" statements to express feelings *to help them get in touch with their feelings.*

Inform patient and family about the symptoms and effects of addictive behaviors on both the patient and the family *to help them understand the role they play in both the disease and the recovery process.*

Do interactive planning and role-playing with the patient and family to help them gain the skills needed to effect necessary changes in communication patterns in the family. *Role-playing helps create a realistic view of the behaviors that reinforce behaviors in themselves and the patient.*

Attend: Encourage family members to acknowledge that alcoholism is a problem within the family *in order to break through family denial.*

Ask alcoholic family member to sign a contract stating he will abstain from alcohol *to help him take responsibility for his own behavior.*

Help family members evaluate the consequences of abusive and violent behavior. Inform them that any suspected abuse will be reported. Ask family members to sign contracts so they will not continue to abuse one another *to make them take responsibility for their behavior. Being able to identify strengths provides the confidence the family needs to continue working toward a positive outcome for both patient and family.*

Assist family members to identify their strengths and talk about progress they have made in resolving problems associated with alcoholism or living with a family member who has alcoholism.

Provide additional emotional support to the head of the family about altered role and additional responsibility *to build self-esteem.*

Manage: Refer family for continued family therapy *so they can continue the process of restructuring their lives.*

Refer patient and family to AA, Al-Anon, or other appropriate support group *to establish the importance of abstinence.*

SUGGESTED NIC INTERVENTIONS

Coping Enhancement; Family Process Maintenance; Family Support; Substance Use Prevention; Substance Use Treatment

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DEFINITION

Change in family relationships and/or functioning

DEFINING CHARACTERISTICS

- Alteration in availability for affective responsiveness
- Alteration in family conflict resolution
- Alteration in family satisfaction
- Alteration in intimacy
- Alteration in participation for problem-solving
- Change in communication pattern
- Change in somatization
- Change in stress-reduction behavior
- Changes in expressions of conflict with community resources
- Changes in expressions of isolation from community resources
- Changes in participation for decision making
- Changes in available emotional support
- Decrease in mutual support
- Ineffective task completion
- Power alliance change
- Ritual change

RELATED FACTORS

- Alteration in family finances
- Change in family social status
- Changes in interaction with community
- Developmental crisis
- Developmental transition
- Power shift among family members
- Shift in family roles
- Shift in health status of a family member
- Situational crisis
- Situational transition

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Communication
- Coping
- Emotional
- Roles/relationship

EXPECTED OUTCOMES

- Family members will not experience physical, verbal, emotional, or sexual abuse.
- Family members will communicate clearly, honestly, consistently, and directly.

- Family members will establish clearly defined roles and equitable responsibilities.
- Family members will express understanding of rules and expectations.
- Family members will report that the methods of problem-solving and resolving conflicts have improved.
- Family members will report a decrease in the number and intensity of family crises.
- Family members will seek ongoing treatment.

SUGGESTED NOC OUTCOMES

Family Coping; Family Functioning; Family Normalization; Social Interaction Skills; Substance Addiction Consequences

INTERVENTION AND RATIONALES

Determine: Assess family's developmental stage, roles, rules, socioeconomic status, health history, history of substance abuse; history of sexual abuse of spouse or children, problem-solving and decision-making skills, and patterns of communication. *Assessment information will provide development of appropriate interventions.*

Perform: Meet with family members to establish levels of authority and responsibility in the family. *Understanding the family dynamics provides information about the kinds of support the family needs to work with the patient's issues.*

Create an environment in which family members can express themselves openly and honestly *to build trust and self-esteem.*

Establish rules for communication during meetings with the family to *assist family members to take responsibility for their own behavior.*

Inform: Teach family members basic communication skills *to enable them to discuss issues in a positive way.* Have them role-play with one another numerous times *to demonstrate what has been learned.*

Involve the family in exercises *to reduce stress and deal with anger.*

Attend: Hold adults accountable for their alcohol or substance abuse and have them sign a "Use contract" *to decrease denial, increase trust, and promote positive change.*

Involve patient in planning and decision making. *Having the ability to participate will encourage greater compliance with the plan.*

Assist family to set limits on abusive behaviors and have them sign "Abuse contracts" *to foster feelings of safety and trust.*

Manage: Refer to case manager/social worker *to ensure that a home assessment is done.*

Refer to support groups that deal with substance abuse, domestic violence, or sexual abuse depending on the needs of the patient and/or family *to enhance interpersonal skills and strengthen the family unit.*

Provide all appropriate phone numbers so that the family members can initiate whatever follow-up is needed.

SUGGESTED NIC INTERVENTIONS

Coping Enhancement; Family Integrity Promotion; Family Process Maintenance; Family Support; Normalization Promotion; Substance Use Prevention; Substance Use Treatment

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DEFINITION

An overwhelming sustained sense of exhaustion and decreased capacity for physical and mental work at the usual level

DEFINING CHARACTERISTICS

- Alteration in concentration
- Alteration in libido
- Disinterest in surroundings
- Drowsiness
- Guilt about difficulty maintaining responsibilities
- Impaired ability to maintain usual physical activity
- Impaired ability to maintain usual routines
- Increase in physical symptoms
- Increase in rest requirement
- Ineffective role performance
- Insufficient energy
- Introspection
- Lethargy
- Listlessness
- Nonrestorative sleep pattern (i.e., due to caregiver responsibilities, parenting practices, sleep partner)
- Tiredness

RELATED FACTORS

- Anxiety
- Depression
- Environmental barrier (e.g., ambient noise, daylight/darkness exposure, ambient temperature/humidity, unfamiliar setting)
- Increase in physical exertion
- Malnutrition
- Negative life event
- Nonstimulating lifestyle
- Occupational demands (e.g., shift work, high level of activity, stress)
- Physical deconditioning
- Physiologic condition (e.g., anemia, pregnancy, disease)
- Sleep deprivation
- Stressors

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Cardiovascular function
- Coping
- Neurocognition
- Nutrition

- Reproduction
- Respiratory function
- Risk management
- Sleep/rest

EXPECTED OUTCOMES

- The patient will identify and employ measures to prevent or modify fatigue.
- The patient will explain relationship of fatigue to disease process and activity level.
- The patient will verbally express increased energy.
- The patient will articulate plan to resolve fatigue problems.

SUGGESTED NOC OUTCOMES

Fatigue Level; Activity Tolerance; Endurance; Energy Conservation; Nutritional Status: Energy; Psychomotor Energy; Personal Well-Being

INTERVENTIONS AND RATIONALES

Determine: Assess usual patterns of sleep and activity *to establish a baseline.*
Perform: Conserve energy through rest, planning, and setting priorities *to prevent or alleviate fatigue.* Alternate activities with periods of rest. Avoid scheduling two energy-draining procedures on the same day. Encourage activities that can be completed in short periods. *These measures help to avoid overexertion and increase stamina.*

Reduce demands placed on patient (e.g., ask one family member to call at specified times and relay messages to friends and other family members) *to reduce physical and emotional stress.*

Structure environment (e.g., set up daily schedule on the basis of patient needs and desires) *to encourage compliance with treatment regimen.*

Postpone eating when patient is fatigued, *to avoid aggravating condition.* Provide small, frequent feedings *to conserve patient's energy and encourage increased dietary intake.*

Establish a regular sleeping pattern. Getting 8 to 10 hours of sleep nightly helps reduce fatigue.
Inform: Discuss effect of fatigue on daily living and personal goals. Explore with patient relationship between fatigue and disease process *to help increase patient compliance with schedule for activity and rest.*
Attend: Encourage patient to eat foods rich in iron and minerals, unless contraindicated, *to help avoid anemia and demineralization.*
Manage: Encourage patient to explore feelings and emotions with a supportive counselor, clergy, or other professional *to help cope with illness and avoid aggravating fatigue.*

SUGGESTED NIC INTERVENTIONS

Activity Therapy; Coping Enhancement; Energy Management; Exercise Promotion; Sleep Enhancement; Autogenic Training; Progressive Muscle Relaxation

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DEFINITION

Response to perceived threat that is consciously recognized as a danger

DEFINING CHARACTERISTICS

- Apprehensiveness
- Decreased self-assurance
- Excitedness
- Feeling dread
- Feeling of fear
- Feeling of panic
- Feeling of terror
- Feeling of alarm
- Increase in blood pressure
- Increase in tension
- Jitteriness
- Muscle tension
- Nausea
- Pallor
- Pupil dilation
- Vomiting

Cognitive

- Decrease in learning ability
- Decrease in problem-solving ability
- Decrease in productivity
- Identifies object of fear
- Stimulus believed to be a threat

Behaviors

- Attack behaviors
- Avoidance behaviors
- Focus narrowed to the source of fear
- Impulsiveness
- Increase in alertness

Physiological

- Anorexia
- Change in physiologic response (e.g., blood pressure, heart rate, respiratory rate, oxygen saturation, and end-title CO_2)
- Diarrhea
- Dry mouth
- Dyspnea
- Fatigue
- Increase in perspiration
- Increase in respiratory rate

RELATED FACTORS

- Innate releasing mechanism to external stimuli (e.g., neurotransmitters)
- Innate response to stimuli (e.g., sudden noise, height)
- Language barrier
- Learned response
- Phobic stimulus
- Sensory deficit (e.g., visual, hearing)
- Separation from support system
- Unfamiliar setting

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Physical regulation
- Risk management
- Sleep/rest

EXPECTED OUTCOMES

- The patient will identify source of fear.
- The patient will communicate feelings about separation from support systems.
- The patient will communicate feelings of comfort or satisfaction.
- The patient will use situational supports to reduce fear.
- The patient will integrate into daily behavior at least one fear-reducing coping mechanism, such as asking questions about treatment progress or making decisions about care.

SUGGESTED NOC OUTCOMES

Anxiety Control; Comfort Level; Coping; Fear Level; Fear Control; Pain Level

INTERVENTIONS AND RATIONALES

Determine: Ask patient to identify source of fear; assess patient's understanding of situation. *Perceptions may be erroneously based.*

Perform: Help patient maintain daily contact with family: Arrange for telephone calls, help write letters, promptly convey messages to patient from family and vice versa, encourage patient to have pictures of loved ones, provide privacy for visits, take patient to day room or other quiet area. *These measures help patient reestablish and maintain social relationships.*

Involve patient in planning care and setting goals to renew confidence and give a sense of control in a crisis situation. If patient has no visitors, spend an extra 15 minutes each shift in casual conversation; encourage other staff members to stop for brief visits. *These measures help patient cope with separation.*

Administer anti-anxiety medications, as ordered, and monitor effectiveness. *Drug therapy may be needed to manage high anxiety levels or panic disorders.*

Inform: Instruct patient in relaxation techniques such as imagery and progressive muscle relaxation *to reduce symptoms of sympathetic stimulation.*

Answer questions and help patient understand care *to reduce anxiety and correct misconceptions.*

Attend: When feasible and where policies permit, relax visiting restrictions *to reduce patient's sense of isolation.*

Allow a close family member or friend to participate in care *to provide an additional source of support.*

Support family and friends in their efforts to understand patient's fear and to respond accordingly *to help them understand that patient's emotions are appropriate in context of situation.*

Manage: Refer patient to community or professional mental health resources *to provide assistance.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Anxiety Reduction; Cognitive Restructuring; Counseling; Coping Enhancement; Decision-Making Support; Security Enhancement; Presence; Support Group; Relaxation Therapy

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DEFINITION

Impaired ability of an infant to suck or coordinate the suck/swallow response resulting in inadequate oral nutrition for metabolic needs

DEFINING CHARACTERISTICS

- Inability to coordinate sucking, swallowing, and breathing
- Inability to initiate an effective suck
- Inability to sustain an effective suck

RELATED FACTORS

- Neurologic delay
- Neurologic impairment (e.g., positive EEG, head trauma, seizure disorders)
- Oral hypersensitivity
- Oropharyngeal defect
- Prematurity
- Prolonged nil per os (NPO) status

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Fluid and electrolytes
- Growth and development
- Nutrition
- Roles/relationships

EXPECTED OUTCOMES

- The neonate will not lose more than 10% of birth weight within first week of life.
- The neonate will gain 4 to 7 oz (113.5 to 198.5 g) after first week of life.
- The neonate will remain hydrated.
- The neonate will receive adequate supplemental nutrition until able to suckle sufficiently.
- The neonate will establish effective suck-and-swallow reflexes that allow for adequate intake of nutrients.
- The parents will identify factors that interfere with neonate establishing effective feeding pattern.
- The parents will express increased confidence in their ability to perform appropriate feeding techniques.

SUGGESTED NOC OUTCOMES

Breast-Feeding Establishment: Infant; Breast-Feeding Maintenance; Nutritional Status: Food & Fluid Intake; Swallowing Status; Newborn Adaptation; Knowledge: Breastfeeding

INTERVENTIONS AND RATIONALES

Determine: Weigh neonate at the same time each day on the same scale *to detect excessive weight loss early.*

Continuously assess neonate's sucking pattern *to monitor for ineffective patterns.*

Assess parents' knowledge of feeding techniques *to help identify and clear up misconceptions.*

Assess parents' level of anxiety about the neonate's feeding difficulty. *Anxiety may interfere with the parents' ability to learn new techniques.*

Monitor neonate for poor skin turgor, dry mucous membranes, decreased or concentrated urine, and sunken fontanels and eyeballs *to detect possible dehydration and allow for immediate intervention.*

Record the number of stools and amount of urine voided each shift. *An altered bowel elimination pattern may indicate decreased food intake; decreased amounts of concentrated urine may indicate dehydration.*

Assess the need for gavage feeding. *The neonate may temporarily require alternative means of obtaining adequate fluids and calories.*

If neonate requires intravenous nourishment, assess the insertion site, amount infused, and infusion rate every hour *to monitor fluid intake and identify possible complications, such as infiltration and phlebitis.*

Perform: Remain with the parents and neonate during the feeding *to identify problem areas and direct interventions.*

For bottle-feeding, record the amount ingested at each feeding; for breast-feeding, record the number of minutes the neonate nurses at each breast and the amount of any supplement ingested *to monitor for inadequate caloric and fluid intake.*

Provide an alternative nipple, such as a preemie nipple. *A preemie nipple has a larger hole and softer texture, which makes it easier for the neonate to obtain formula.*

For breast-feeding, ensure that the neonate's tongue is properly positioned under the mother's nipple *to promote adequate sucking.*

Alternate oral and gavage feeding *to conserve the neonate's energy.*

Inform: Teach parents to place the neonate in the upright position during feeding *to prevent aspiration.*

Teach parents to unwrap and position a sleepy neonate before feeding *to ensure that the neonate is awake and alert enough to suckle sufficiently.*

Attend: Provide positive reinforcement for the parents' efforts *to improve their feeding technique to decrease anxiety and enhance feelings of success.*

Manage: Assess neonate for neurologic deficits or other pathophysiologic causes of ineffective sucking *to identify the need for referral for more extensive evaluation.*

SUGGESTED NIC INTERVENTIONS

Attachment Promotion; Breastfeeding Assistance; Lactation Counseling; Nonnutritive Sucking; Teaching: Infant Nutrition; Parent Education: Infant

REFERENCES

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DEFINITION

Decreased intravascular, interstitial, and/or intracellular fluid. This refers to dehydration, water loss alone without change in sodium

DEFINING CHARACTERISTICS

- Alteration in mental status
- Alteration in skin turgor
- Decrease in blood pressure
- Decrease in pulse pressure
- Decrease in pulse volume
- Decrease in tongue turgor
- Decrease in urine output
- Decrease in venous filling
- Dry mucous membranes
- Dry skin
- Increase in body temperature
- Increase in heart rate
- Increase in hematocrit
- Increase in urine concentration
- Sudden weight loss
- Thirst
- Weakness

RELATED FACTORS

- Active fluid volume loss
- Compromised regulatory mechanism

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Fluid and electrolytes
- Physical regulation

EXPECTED OUTCOMES

- The patient will maintain stable vital signs.
- The patient will have normal skin color.
- The patient will have electrolyte levels within normal range.
- The patient will maintain an adequate fluid volume.
- The patient will maintain an adequate urine volume.
- The patient will have normal skin turgor and moist mucous membranes.
- The patient will have a urine specific gravity between 1.005 and 1.010.
- The patient will have normal fluid and blood volume.
- The patient will express understanding of factors that caused fluid volume deficit.

SUGGESTED NOC OUTCOMES

Electrolyte & Acid/Base Balance; Fluid Balance; Hydration; Nutritional Status: Food & Fluid Intake

INTERVENTIONS AND RATIONALES

Determine: Monitor and record vital signs every 2 hours or as often as necessary until stable. Then monitor and record vital signs every 4 hours. *Tachycardia, dyspnea, or hypotension may indicate fluid volume deficit or electrolyte imbalance.*

Measure intake and output every 1 to 4 hours. Record and report significant changes. Include urine, stools, vomitus, wound drainage, nasogastric drainage, chest tube drainage, and any other output. *Low urine output and high specific gravity indicate hypovolemia.*

Weigh patient daily at same time to give more accurate and consistent data. *Weight is a good indicator of fluid status.*

Assess skin turgor and oral mucous membranes every 8 hours *to check for dehydration.* Give meticulous mouth care every 4 hours *to avoid dehydrating mucous membranes.*

Test urine specific gravity every 8 hours. *Elevated specific gravity may indicate dehydration.*

Measure abdominal girth every shift *to monitor for ascites and third-space shift. Report changes.*

Perform: Cover patient lightly. Avoid overheating *to prevent vasodilation, blood pooling in extremities, and reduced circulating blood volume.*

Administer fluids, blood or blood products, or plasma expanders *to replace fluids and whole blood loss and facilitate fluid movement into intravascular space.* Monitor and record effectiveness and any adverse effects.

Don't allow patient to sit or stand up quickly as long as circulation is compromised, *to avoid orthostatic hypotension and possible syncope.*

Administer and monitor medications *to prevent further fluid loss.*

Inform: Explain reasons for fluid loss, and teach patient how to monitor fluid volume, for example, by recording daily weight and measuring intake and output. *This encourages patient involvement in personal care.*

SUGGESTED NIC INTERVENTIONS

Acid–Base Management; Acid-Base Monitoring; Electrolyte Monitoring; Fluid Management; Hypovolemia Management; Electrolyte Management; Fluid Monitoring

REFERENCES

Bunn, D., Jimoh, F., Wilsher, S. H., & Hooper, L. (2015). Increasing fluid intake and reducing dehydration risk in older people living in long-term care: A systematic review. *Journal of the American Medical Directors Association, 16*(2), 101–113. doi:10.1016/j.jamda.2014.10.016

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188 RISK FOR DEFICIENT FLUID VOLUME

DEFINITION

Vulnerable to experiencing decreased intravascular, interstitial, and/or intracellular fluid volumes, which may compromise health

RISK FACTORS

- Active fluid volume loss
- Barrier to accessing fluid
- Compromised regulatory mechanism
- Deviations affecting fluid absorption
- Deviations affecting fluid intake
- Excessive fluid loss through normal route
- Extremes of age
- Extremes of weight
- Factors influencing fluid needs
- Fluid loss through abnormal route
- Insufficient knowledge about fluid needs
- Pharmaceutical agent

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Fluid and electrolytes
- Physical regulation

EXPECTED OUTCOMES

- The patient will maintain stable vital signs.
- The patient will have normal skin color.
- The patient will maintain urine output of at least ___ mL/hour.
- The patient will maintain electrolyte values within normal range.
- The patient will maintain intake at _____ mL/24 hour.
- The patient will have an intake equal to or exceeding output.
- The patient will express understanding of need to maintain adequate fluid intake.
- The patient will demonstrate skill in weighing himself or herself accurately and recording weight.
- The patient will measure and record own intake and output.
- The patient will return to normal, appropriate diet.

SUGGESTED NOC OUTCOMES

Electrolyte & Acid–Base Balance; Fluid Balance; Hydration; Nutritional Status: Food & Fluid Intake; Risk Detection; Urinary Elimination

INTERVENTIONS AND RATIONALES

Determine: Monitor and record vital signs every 4 hours. *Fever, tachycardia, dyspnea, or hypotension may indicate hypovolemia.*

Determine patient's fluid preferences *to enhance intake.*

Maintain accurate record of intake and output *to aid estimation of patient's fluid balance*. Measure urine output every hour. Record and report output of less than ____ mL/hr. *Decreased urine output may indicate reduced fluid volume*. Measure and record drainage from all tubes and catheters *to take such losses into account when replacing fluid*.

When copious drainage appears on dressings, weigh dressings every 8 hours and record with other output sources. *Excessive wound drainage causes significant fluid imbalances* (1 kg dressing equals about 1 L of fluid).

Test urine specific gravity each shift. Monitor laboratory values and report abnormal findings to physician. *Increased urine specific gravity may indicate dehydration. Elevated HCT and Hb levels also indicate dehydration.*

Monitor serum electrolyte levels and report abnormalities. *Fluid loss may cause significant electrolyte imbalance.*

Obtain and record patient's weight at same time every day to help ensure accurate data. *Daily weighing helps estimate body fluid status.*

Monitor skin turgor each shift to check for dehydration; report any decrease in turgor. *Poor skin turgor is a sign of dehydration.*

Examine oral mucous membranes each shift. *Dry mucous membranes are a sign of dehydration.*

Perform: Cover wounds to minimize fluid loss and prevent skin excoriation.

Keep oral fluids at bedside within patient's reach and encourage patient to drink. *This gives patient some control over fluid intake and supplements parenteral fluid intake.*

Force oral fluids when possible and indicated *to enhance replacement of lost fluids. (Bowel sounds should be present and patient awake before giving oral fluids.)*

Administer parenteral fluids, as prescribed, to replace fluid losses. Maintain parenteral fluids or blood transfusions at prescribed rate *to prevent further fluid loss or overload.*

Progress patient to appropriate diet, as prescribed, *to help achieve fluid and electrolyte balance.*

Inform: Instruct patient on maintaining appropriate fluid intake, including recording daily weight, measuring intake and output, and recognizing signs of dehydration. *This encourages patient and caregiver participation and enhances patient's sense of control.*

SUGGESTED NIC INTERVENTIONS

Acid–Base Management; Acid–Base Monitoring; Fluid Management; Fluid Monitoring; Hypovolemia Management; Surveillance; Intravenous (IV) Therapy

REFERENCES

Bunn, D., Jimoh, F., Wilsher, S. H., & Hooper, L. (2015). Increasing fluid intake and reducing dehydration risk in older people living in long-term care: A systematic review. *Journal of the American Medical Directors Association, 16*(2), 101–113. doi:10.1016/j.jamda.2014.10.016

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DEFINITION

Increased isotonic fluid retention

DEFINING CHARACTERISTICS

- Adventitious breath sounds
- Alteration in blood pressure
- Alteration in mental status
- Alteration in pulmonary artery pressure (PAP)
- Alteration in respiratory pattern
- Alteration in urine specific gravity
- Anasarca
- Anxiety
- Azotemia
- Decrease in hematocrit
- Decrease in hemoglobin
- Dyspnea
- Edema
- Electrolyte imbalance
- Hepatomegaly
- Increase in central venous pressure (CVP)
- Intake exceeds output
- Jugular vein distension
- Oliguria
- Orthopnea
- Paroxysmal nocturnal dyspnea
- Pleural effusion
- Positive hepatojugular reflex
- Pulmonary congestion
- Restlessness
- Presence of S_3 heart sound
- Weight gain over short period of time

RELATED FACTORS

- Compromised regulatory mechanism
- Excess fluid intake
- Excess sodium intake

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Elimination
- Fluid and electrolytes
- Neurocognition
- Nutrition
- Respiratory function

EXPECTED OUTCOMES

- The patient will state ability to breathe comfortably.
- The patient will maintain fluid intake at ___ mL/day.
- The patient will return to baseline weight.
- The patient will maintain vital signs within normal limits (specify).
- The patient will exhibit urine specific gravity of 1.005 to 1.010.
- The patient will have normal skin turgor.
- The patient will show electrolyte level within normal range (specify).
- The patient will avoid complications of excess fluid.

SUGGESTED NOC OUTCOMES

Electrolyte & Acid/Base Balance; Fluid Balance; Fluid Overload Severity; Kidney Function; Nutritional Status: Food & Fluid Intake

INTERVENTIONS AND RATIONALES

Determine: Monitor and record vital signs at least every 4 hours. *Changes may indicate fluid or electrolyte imbalances.* Measure and record intake and output. *Intake greater than output may indicate fluid retention and possible overload.*

Weigh patient at same time each day *to obtain consistent readings.* Test urine specific gravity every 8 hours and record results. Monitor laboratory values and report significant changes to physician. *High specific gravity indicates fluid retention. Fluid overload may alter electrolyte levels.*

Assess patient daily for edema, including ascites and dependent or sacral edema. *Fluid overload or decreased osmotic pressure may result in edema, especially in dependent areas.*

Perform: Help patient into a position that aids breathing, such as Fowler's or semi-Fowler's, *to increase chest expansion and improve ventilation.*

Administer oxygen, as ordered, *to enhance arterial blood oxygenation.* Restrict fluids to ____ mL/shift. *Excessive fluids will worsen patient's condition.*

Administer diuretics, as ordered, *to promote fluid excretion.* Record effects. Maintain patient on sodium-restricted diet, as ordered, *to reduce excess fluid and prevent reaccumulation.*

Reposition patient every 2 hours, inspect skin for redness with each turn, and institute measures, as needed, *to prevent skin breakdown.*

Apply antiembolism stockings or intermittent pneumatic compression stockings *to increase venous return.* Remove for 1 hour every 8 hours or according to facility policy.

Inform: Educate patient regarding maintenance of daily weight record, daily measuring and recording of intake and output, diuretic therapy, and dietary restrictions, especially sodium. *These measures encourage patient and caregivers to participate more fully.*

Attend: Encourage patient to cough and deep-breathe every 2 to 4 hours *to prevent pulmonary complications*.

SUGGESTED NIC INTERVENTIONS

Acid–Base Management; Acid–Base Monitoring; Electrolyte Management; Fluid Management; Fluid Monitoring; Nutrition Management; Electrolyte Monitoring; Hypervolemia Management

REFERENCES

Azzolin, K., Mussi, C. M., Ruschel, K. B., de Souza, E. N., de Fátima Lucena, A., & Rabelo-Silva, E. R. (2013). Effectiveness of nursing interventions in heart failure patients in home care using NANDA-I, NIC, and NOC. *Applied Nursing Research*, *26*(4), 239–244. doi:10.1016/j.apnr.2013.08.003

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194 RISK FOR IMBALANCED FLUID VOLUME

DEFINITION

Vulnerable to a decrease, increase, or rapid shift from one to the other of intravascular, interstitial, and/or intracellular fluid, which may compromise health. This refers to body fluid loss, gain, or both

RISK FACTORS

- Apheresis
- Ascites
- Burns
- Intestinal obstruction
- Pancreatitis
- Sepsis
- Trauma
- Treatment regimen

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Fluid and electrolytes
- Physical regulation

EXPECTED OUTCOMES

- The patient will remain hemodynamically stable.
- The patient will not experience electrolyte imbalance.
- The patient will maintain adequate urine output.
- The patient will identify risk factors contributing to possible imbalanced fluid volume.

SUGGESTED NOC OUTCOMES

Fluid Balance; Hydration; Vital Signs; Electrolyte & Acid/Base Balance

INTERVENTIONS AND RATIONALES

Determine: Assess for conditions that may contribute to imbalanced fluid volume. *Prompt treatment of the underlying cause may prevent serious complications of fluid imbalance.*

Monitor vital signs and other assessment parameters frequently. *Changes in heart rate and rhythm, blood pressure, and breath sounds may indicate altered fluid status.*

Monitor intake and output *to evaluate need for fluid replacement.*

Perform: Collect and evaluate urine output frequently. Measure urine specific gravity as indicated. Decreased *urine volume and elevated specific gravity indicate hypovolemia.*

Collect and evaluate serum electrolyte levels. *Fluid alterations may affect electrolyte levels.*

Administer intravenous fluids as indicated. *Proactive fluid management may prevent serious imbalances.*

Inform: Educate patient and family regarding fluid restrictions or need for increased fluids, depending on underlying condition. Knowledge *will enhance feeling of participation and sense of control.*

Attend: Provide encouragement and support for cooperation with prescribed treatment regimen. *Positive reinforcement will promote compliance.*

Manage: Coordinate care with other members of health care team *to effectively manage underlying medical condition and prevent any alteration in fluid balance.*

SUGGESTED NIC INTERVENTIONS

Fluid Management; Fluid Monitoring; Intravenous (IV) Therapy; Electrolyte Management; Electrolyte Monitoring

REFERENCES

Elofson, K. A., Eiferman, D. S., Porter, K., & Murphy, C. V. (2015). Impact of late fluid balance on clinical outcomes in the critically ill surgical and trauma population. *Journal of Critical Care, 30*(6), 1338–1343. doi:10.1016/j.jcrc.2015.07.009

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196 FRAIL ELDERLY SYNDROME

DEFINITION

Dynamic state of unstable equilibrium that affects the older individual experiencing deterioration in one or more domain of health (physical, functional, psychological, or social) and leads to increased susceptibility to adverse health effects, in particular disability

DEFINING CHARACTERISTICS

- Activity intolerance
- Bathing self-care deficit
- Decreased cardiac output
- Dressing self-care deficit
- Fatigue
- Feeding self-care deficit
- Hopelessness
- Imbalanced nutrition: Less than body requirements
- Impaired physical mobility
- Impaired walking
- Social isolation
- Toileting self-care deficit

RELATED FACTORS

- Alteration in cognitive functioning
- Chronic illness
- History of falls
- Living alone
- Malnutrition
- Prolonged hospitalization
- Psychiatric disorder
- Sarcopenia
- Sarcopenic obesity
- Sedentary lifestyle

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Cardiac function
- Neurocognition
- Nutrition
- Self-care
- Sensation/perception
- Sleep/rest

EXPECTED OUTCOMES

- The patient will maintain or improve physical function.
- The patient will maintain or improve psychological function.

- The patient will maintain or improve social function.
- The patient will remain independent for as long as possible.
- The patient will remain safe in the chosen living environment.

SUGGESTED NOC OUTCOMES

Physical Aging; Psychosocial Adjustment: Life Change; Client Satisfaction: Functional Assistance

INTERVENTIONS AND RATIONALES

Determine: Conduct head to toe physical assessment. *Gain an overall picture of the patient's health.*

Conduct environmental assessment. *Can identify risks for falls and ability to manage care outside the hospital.*

Assess fall risk *to determine client's safety.*

Assess medications *to determine possible side effects.*

Perform: Provide antidepressants, as ordered. *Delay of treatment may accelerate decline of patient status.*

Provide appetite-stimulating medications, as ordered. *May increase appetite.*

Provide patient with ample time to complete activities of daily living. *Can increase ability to complete activities of daily living.*

Provide supplemental nutritional drinks. *Can provide extra calories and energy intake.*

Inform: Educate on importance of regular exercise. *Can improve mobility, improve gait, decrease incidence of falls, increase muscle strength.*

Attend: Provide socialization opportunities. *Isolation can exacerbate depression.*

Provide stimulating activities. *Keeps cognitive mind engaged.*

Manage: Implement interdisciplinary treatment plan. *Can improve physical and psychological function, improve patient satisfaction, decrease need for hospitalization.*

Provide physical and occupational therapy, as needed. *Can improve functional impairment.*

SUGGESTED NIC INTERVENTIONS

Physical Exercise; Strength Training; Balance Training

REFERENCES

Chen, X., Mao, G., & Leng, S. X. (2014). Frailty syndrome: An overview. *Clinical Interventions in Aging, 9,* 433–441. doi:10.2147/CIA.S45300

Lenardt, M. H., Hammerschmidt Kolb Carneiro, N., Albino, J., & Hautsch Willig, M. (2014). Quality of life of frail elderly users of the primary care. *Acta Paulista de Enfermagem*, *27*(5), 399–404. doi:10.1590/1982-0194201400067

Palace, A. J., & Flood-Sukhdeo, J. (2014). The frailty syndrome. *Today's Geriatric Medicine, 7*(1), 18.

198 RISK FOR FRAIL ELDERLY SYNDROME

DEFINITION

Vulnerable to a dynamic state of unstable equilibrium that affects the older individual experiencing deterioration in one or more domain of health (physical, functional, psychological, or social) and leads to increased susceptibility to adverse health effects, in particular disability

RISK FACTORS

- Activity intolerance
- Age >70 years
- Alteration in cognitive functioning
- Altered clotting process (e.g., Factor VII, D-dimers)
- Anorexia
- Anxiety
- Average daily physical activity is less than recommended for gender and age
- Chronic illness
- Constricted life space
- Decrease in energy
- Decrease in muscle strength
- Decrease in serum 25-hydroxyvitamin D concentration
- Depression
- Economically disadvantaged
- Endocrine regulatory dysfunction (e.g., glucose intolerance, increase in 1GF-1, androgen, DHEA, and cortisol)
- Ethnicity other than Caucasian
- Exhaustion
- Fear of falling
- Female gender
- History of falls
- Immobility
- Impaired balance
- Impaired mobility
- Insufficient social support
- Living alone
- Low educational level
- Malnutrition
- Muscle weakness
- Obesity
- Prolonged hospitalization
- Sadness
- Sarcopenia
- Sarcopenic obesity
- Sedentary lifestyle

- Sensory deficit (e.g., visual, hearing)
- Social isolation
- Social vulnerability (e.g., disempowerment, decreased life control)
- Suppressed inflammatory response (e.g., IL-6, CRP)
- Unintentional loss of 25% of body weight over 1 year
- Unintentional weight loss >10 lb (>4.5 kg) in 1 year
- Walking 15 feet requires >6 seconds (4 m >5 seconds)

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Cardiac function
- Neurocognition
- Nutrition
- Self-care
- Sensation/perception
- Sleep/rest

EXPECTED OUTCOMES

- The patient will remain independent for as long as possible.
- The patient will remain safe in the chosen living environment.
- The patient will not experience deterioration in physical domain.
- The patient will not experience deterioration in functional domain.
- The patient will not experience deterioration in psychological domain.
- The patient will not experience deterioration in social domain.
- The patient will not be susceptible to adverse health effects.

SUGGESTED NOC OUTCOMES

Physical Aging; Psychosocial Adjustment: Life Change; Client Satisfaction: Functional Assistance

INTERVENTIONS AND RATIONALES

Determine: Conduct head to toe physical assessment. *Gain an overall picture of the patient's health.*

Conduct environmental assessment. *Can identify risks for falls and ability to manage care outside the hospital.*

Assess fall risk *to determine client's safety.*

Assess medications *to determine possible side effects.*

Perform: Provide antidepressants, as ordered. *Delay of treatment may accelerate decline of patient status.*

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SUGGESTED NIC INTERVENTIONS

Physical Exercise; Strength Training; Balance Training

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Chen, X., Mao, G., & Leng, S. X. (2014). Frailty syndrome: An overview. *Clinical Interventions in Aging, 9,* 433–441. doi: 10.2147/CIA.S45300

Lenardt, M. H., Hammerschmidt Kolb Carneiro, N., Albino, J., & Hautsch Willig, M. (2014). Quality of life of frail elderly users of the primary care. *Acta Paulista de Enfermagem*, *27*(5), 399–404. doi:10.1590/1982-0194201400067

Palace, A. J., & Flood-Sukhdeo, J. (2014). The frailty syndrome. *Today's Geriatric Medicine, 7*(1), 18.

DEFINITION

Excess or deficit in oxygenation and/or carbon dioxide elimination at the alveolar–capillary membrane

DEFINING CHARACTERISTICS

- Abnormal arterial blood gases
- Abnormal arterial pH
- Abnormal breathing pattern (e.g., rate, rhythm, depth)
- Abnormal skin color (e.g., pale, dusky, cyanosis)
- Confusion
- Cyanosis
- Decrease in carbon dioxide
- Diaphoresis
- Dyspnea
- Headache upon awakening
- Hypercapnia
- Hypoxemia
- Hypoxia
- Irritability
- Nasal flaring
- Restlessness
- Somnolence
- Tachycardia
- Vision disturbance

RELATED FACTORS

- Alveolar–capillary membrane changes
- Ventilation–perfusion imbalance

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Cardiac function
- Neurocognition
- Respiratory function

EXPECTED OUTCOMES

- The patient will maintain respiratory rate within 5 breaths of baseline.
- The patient will carry out activities of living (ADLs) without weakness or fatigue.
- The patient will maintain normal Hb and HCT levels.
- The patient will express feelings of comfort in maintaining air exchange.
- The patient will cough effectively and expectorate sputum.
- The patient will be free from adventitious breath sounds.
- The patient will perform relaxation techniques every 4 hours.
- The patient will use correct bronchial hygiene.

SUGGESTED NOC OUTCOMES

Respiratory Status: Airway Patency; Respiratory Status: Ventilation; Respiratory Statue: Gas Exchange; Vital Signs; Tissue Perfusion: Pulmonary

INTERVENTIONS AND RATIONALES

Determine: Monitor respiratory status, rate and depth of breaths, chest expansion, accessory muscle use, cough and amount and color of sputum, and auscultation of breath sounds every 4 hours *to detect early signs of respiratory failure.*

Monitor vital signs, arterial blood gases, and Hb levels *to detect changes in gas exchange.*

Report signs of fluid overload or dehydration immediately. *This can lead to changes in acid–base balance and affect respiratory status.*

Perform: Elevate head 30 degrees to facilitate lung expansion and prevent atelectasis. Assist with ADLs, as needed, *to decrease tissue oxygen.*

Perform bronchial hygiene, as ordered (e.g., coughing, percussing, postural drainage, and suctioning), *to promote drainage and keep airways clear.* Administer bronchodilators, antibiotics, and steroids, as ordered.

Record intake and output every *8 hours to monitor fluid balance.*

Auscultate lungs every 4 hours and report abnormalities *to detect decreased or adventitious breath sounds.*

Orient patient to the environment, that is, use of call bell, side rails, and bed positioning controls. Place side rails up and bed position down when the patient is in bed. Place personal items within the patient's reach. Assist when the patient is getting out of bed in case of dizziness. *These measures prevent risk of falling.* Move patient slowly *to avoid hypostatic hypotension.* Post a notice where it can be seen that the patient is at risk for falling.

Inform: Teach and demonstrate correct breathing and coughing techniques such as diaphragmatic or abdominal breathing and have patient do return demonstration *to ensure patient understands proper technique and promote effective coughing and deep breathing.*

Teach patient correct way of using inhalers. Remind patient about mouth care after each dose. *Failure to clean the mouth after inhaling can cause candidiasis in the throat.*

Review all medications with patient and family and list side effects for each *to ensure that the patient recognizes side effects and reports them to the physician.*

Encourage relaxation techniques *to reduce oxygen demand.*

Attend: Encourage patient to express feelings. Attentive listening helps build a trusting relationship.

Encourage family members to stay with the patient, especially during times of anxiety, *to promote relaxation, which reduces oxygen demand.*

Manage: Request for a case manager to make a home visit to help prepare family for the patient's return to a safe environment.

Refer patient to community resources and offer written information *that can be referred to when needed*.

SUGGESTED NIC INTERVENTIONS

Airway Management; Airway Suctioning; Anxiety Reduction; Energy Management; Exercise Promotion; Fluid Management; Cough Enhancement

REFERENCES

Casaburi, R., & Duvall, K. (2014). Improving early-stage diagnosis and management of COPD in primary care. *Postgraduate Medicine, 126*(4), 141–154. doi:10.3810/pgm.2014.07.2792

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204 DYSFUNCTIONAL GASTROINTESTINAL MOTILITY

DEFINITION

Increased, decreased, ineffective, or lack of peristaltic activity within the gastrointestinal system

DEFINING CHARACTERISTICS

- Abdominal cramping
- Abdominal distension
- Abdominal pain
- Absence of flatus
- Acceleration of gastric emptying
- Bile-colored gastric residual
- Change in bowel sounds
- Diarrhea
- Difficulty with defecation
- Hard, formed stool
- Increased gastric residual
- Nausea
- Regurgitation
- Vomiting

RELATED FACTORS

- Aging
- Anxiety
- Enteral feedings
- Food intolerance
- Immobility
- Ingestion of contaminated material (e.g., radioactive, food, water)
- Malnutrition
- Prematurity
- Sedentary lifestyle
- Treatment regimen

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Elimination
- Fluid and electrolytes
- Physical regulation

EXPECTED OUTCOMES

- The patient will verbalize strategies to promote healthy bowel function.
- The patient will acknowledge the importance of seeking medical help for persistent alteration in GI motility.
- The patient will not experience any fluid and electrolyte imbalance as a result of altered motility.

- The patient will understand the need for early ambulation following abdominal surgery.

SUGGESTED NOC OUTCOMES

Bowel Elimination; Electrolyte & Acid/Base Balance; Gastrointestinal Function

INTERVENTIONS AND RATIONALES

Determine: Assess abdomen including auscultation in all four quadrants noting character and frequency *to determine increased or decreased motility.*

Assess current manifestations of altered GI motility *to help identify the cause of the alteration and guide development of nursing interventions.*

Monitor intake and output *to identify need for restoration of fluid balance.*

Perform: Collect and evaluate laboratory electrolyte specimens. *Some altered motility states may require electrolyte replacement therapy.*

Insert nasogastric tube, as prescribed, for patients with absent bowel sounds *to relieve the pressures caused by accumulation of air and fluid.*

Inform: Educate patients regarding importance of maintaining diet high in natural fiber and adequate fluid intake. *Fiber increases stool bulk and softens the stool. Fluid will promote normal bowel elimination pattern.*

Attend: Encourage activities such as walking, as tolerated, for patients with decreased GI motility. *Increased activity will stimulate peristalsis and facilitate elimination.*

Manage: Coordinate with dietitian and other health care professionals, as needed, *to meet the unique needs of each individual patient.*

SUGGESTED NIC INTERVENTIONS

Fluid/Electrolyte Management; Gastrointestinal Intubation; Tube Care: Gastrointestinal

REFERENCES

Bing, L., Sheng, T., Yan-Lan, M., Jingping, T., Bin, W., & Jian-Rong, W. (2014). Analysis of bowel sounds application status for gastrointestinal function monitoring in the intensive care unit. *Critical Care Nursing Quarterly, 37*(2), 199–206. doi:10.1097/CNQ.0000000000000019

Neighbour, C. (2014). Improving bowel care after surgery for hip fracture. *Nursing Older People, 26*(10), 16–22. doi:10.7748/nop.26.10.16.e649

Wallström, Å., & Frisman, G. H. (2014). Facilitating early recovery of bowel motility after colorectal surgery: A systematic review. *Journal of Clinical Nursing, 23*(1/2), 24–44. doi:10.1111/jocn.12258

206 RISK FOR DYSFUNCTIONAL GASTROINTESTINAL MOTILITY

DEFINITION

Vulnerable to a decrease in normal frequency of defecation accompanied by difficult or incomplete passage of stool, which may compromise health

RISK FACTORS

- Aging
- Anxiety
- Change in water source
- Decrease in gastrointestinal circulation
- Diabetes mellitus
- Eating habit change (e.g., foods, eating times)
- Food intolerance
- Gastroesophageal reflux disease
- Immobility
- Infection
- Pharmaceutical agent
- Prematurity
- Sedentary lifestyle
- Stressors
- Unsanitary food preparation

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Nutrition
- Elimination
- Fluid and electrolytes
- Physical regulation

EXPECTED OUTCOMES

- The patient will maintain adequate fluid and electrolyte balance.
- The patient will identify diet selections and lifestyle changes that would promote healthy GI function.
- The patient will not experience altered GI motility related to prescribed medications.
- The patient will recognize chronic conditions that may contribute to altered GI motility, for example, diabetes, GERD.

SUGGESTED NOC OUTCOMES

Electrolyte & Acid/Base Balance; Fluid Balance; Bowel Elimination

INTERVENTIONS AND RATIONALES

Determine: Assess patient for signs of fluid or electrolyte imbalance related to increased or decreased GI motility. *Fluid and electrolyte alterations can result from either increased or decreased GI motility.*

Assess patient for positive risk factors for altered GI motility. *This will allow for timely interventions to prevent complications associated with GI dysfunction.*

Perform: Assist patients taking prescribed medications that affect motility with strategies to avoid GI complications. *Awareness of preventive measures will decrease GI complications.*

Encourage early ambulation for postoperative patients receiving opioids for pain control. *Early ambulation will reduce the risk of narcotic-related constipation.*

Inform: Educate patient regarding the risk factors related to altered GI motility, including certain food choices, fluid intake, medications, and activity. *Promotion of healthy lifestyle choices will contribute to positive patient outcomes.*

Attend: Provide encouragement and support for behaviors that enhance GI health. *Positive reinforcement results in improved confidence in self-management of health behaviors.*

Manage: Coordinate care with other disciplines, as needed, *to reinforce positive behaviors or to assist with complex situations.*

SUGGESTED NIC INTERVENTIONS

Diarrhea Management; Electrolyte Monitoring; Fluid Management; Nutrition Management; Electrolyte Management; Acid–Base Management; Acid–Base Monitoring

REFERENCES

Bing, L., Sheng, T., Yan-Lan, M., Jingping, T., Bin, W., & Jian-Rong, W. (2014). Analysis of bowel sounds application status for gastrointestinal function monitoring in the intensive care unit. *Critical Care Nursing Quarterly, 37*(2), 199–206. doi:10.1097/CNQ.0000000000000019

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Wallström, Å., & Frisman, G. H. (2014). Facilitating early recovery of bowel motility after colorectal surgery: A systematic review. *Journal of Clinical Nursing, 23*(1/2), 24–44. doi:10.1111/jocn.12258

208 RISK FOR INEFFECTIVE GASTROINTESTINAL PERFUSION

DEFINITION

Vulnerable to decrease in gastrointestinal circulation, which may compromise health

RISK FACTORS

- Abdominal aortic aneurysm
- Abdominal compartment syndrome
- Abnormal partial thromboplastin time (PTT)
- Abnormal prothrombin time (PT)
- Acute gastrointestinal hemorrhage
- Age >60 years
- Anemia
- Cerebral vascular accident
- Coagulopathy (e.g., sickle cell anemia)
- Decrease in left ventricular performance
- Diabetes mellitus
- Disseminated intravascular coagulopathy
- Female gender
- Gastroesophageal varices
- Gastrointestinal condition (e.g., ulcer, ischemic colitis, ischemic pancreatitis)
- Hemodynamic instability
- Impaired liver function (e.g., cirrhosis, hepatitis)
- Myocardial infarction
- Renal disease (e.g., polycystic kidney, renal artery stenosis, failure)
- Smoking
- Trauma
- Treatment regimen
- Vascular disease

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Elimination
- Fluid and electrolytes

EXPECTED OUTCOMES

- The patient will acknowledge the need to report any sudden increase in abdominal pain.
- The patient will not experience any organ injury related to decrease in GI perfusion.
- The patient will understand the rationale and need for frequent abdominal assessment.
- The patient will verbalize strategies to decrease identified individual risk factors.

SUGGESTED NOC OUTCOMES

Tissue Perfusion: Abdominal Organs, Fluid Balance, Gastrointestinal Function; Vital Signs

INTERVENTIONS AND RATIONALES

Determine: Assess bowel sounds for motility. *Impaired motility can cause functional, nonmechanical obstruction, for example, ileus.*

Assess abdomen for distension *that can compromise blood flow and result in ischemia.*

Perform: Monitor vital signs closely and provide early intervention for those at risk *to ensure adequate GI perfusion.*

Inform: Educate patients at risk to promptly report any abdominal pain. *Abdominal pain is a sensitive, nonspecific indicator of GI dysfunction.*

Attend: Encourage at-risk patients to ask questions and share concerns *to promote understanding and decrease anxiety.*

Manage: Coordinate care and promote early intervention for evidence of decreased GI perfusion. *Early intervention will result in improved patient outcomes.*

SUGGESTED NIC INTERVENTIONS

Risk Identification; Circulatory Care: Arterial Insufficiency; Vital Signs Monitoring

REFERENCES

Chelvanayagam, S., & Newell, C. (2015). Differentiating between eating disorders and gastrointestinal problems. *Gastrointestinal Nursing*, *13*(7), 56–62.

Li, G., Ren, J., Wang, G., Wu, Q., Gu, G., Ren, H., . . . Li, J. (2015). Prevalence and risk factors of acute lower gastrointestinal bleeding in Crohn disease. *Medicine*, *94*(19), 1–7. doi:10.1097/MD.0000000000000804

Wani, Z. A., Bhat, R. A., Bhadoria, A. S., Maiwall, R., & Choudhury, A. (2015). Gastric varices: Classification, endoscopic and ultrasonographic management. *Journal of Research in Medical Sciences*, *20*(12), 1200–1207. doi:10.4103/1735-1995.172990

DEFINITION

A normal complex process that includes emotional, physical, spiritual, social, and intellectual responses and behaviors by which individuals, families, and communities incorporate an actual, anticipated, or perceived loss into their daily lives

DEFINING CHARACTERISTICS

- Alterations in activity level
- Alteration in dream pattern
- Alteration in immune functioning
- Alteration in neuroendocrine functioning
- Alteration in sleep pattern
- Anger
- Blaming
- Despair
- Detachment
- Disorganization
- Finding meaning in a loss
- Guilt about feeling relieved
- Maintaining a connection to the deceased
- Pain
- Panic behavior
- Personal growth
- Psychological distress
- Suffering

RELATED FACTORS

- Anticipatory loss of significant object (e.g., possession, job, status)
- Anticipatory loss of significant other
- Death of significant other
- Loss of significant object (e.g., possession, job, status, home, body part)

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication
- Emotional
- Growth and development
- Risk management
- Roles/relationships
- Values/beliefs

EXPECTED OUTCOMES

- The patient will express and accept feelings about anticipated death.
- The patient will progress through stages of grieving process in patient's own way.

- The patient will practice religious rituals and use other coping mechanisms appropriate to end of life.
- The patient will have participation of family members or significant other in providing supportive care and comfort to patient.

SUGGESTED NOC OUTCOMES

Coping; Family Coping; Grief Resolution; Psychosocial Adjustment: Life Change; Dignified Life Closure; Comfortable Death

INTERVENTIONS AND RATIONALES

Determine: Assess stage of grieving *to establish a baseline.*

Perform: Demonstrate acceptance of patient's response to the patient's anticipated death, whatever that response may be: crying, sadness, anger, fear, or denial. Each patient responds to dying in own way. *Helping patient express feelings freely will enhance ability to cope.*

Help patient progress through psychological stages associated with anticipated death, including shock and denial, anger, bargaining, depression, and acceptance, *to help you anticipate the dying patient's psychological needs.* Keep in mind, however, that not all dying patients go through each stage.

Provide time for patient to express feelings about death or terminal illness. *Active listening helps the patient lessen feelings of loneliness and isolation.* Refrain from approaching patient with a busy, hurried attitude, *which can block communication.*

Establish a relationship that encourages patient to express concerns about death. *Basic nursing care combined with genuine interest in the patient fosters trust and understanding.*

Guide patient in life review. Encourage patient to write or tape-record patient's life history as a lasting gift to family members. *Life review allows patient to survey events from past and give them meaningful interpretation.*

Inform: Inform patient about hospice services that emphasize symptomatic relief and caring, with the aim of improving patient and family comfort until death occurs, instead of prolonging life for its own sake. *Hospice care is an appropriate alternative for a patient with an incurable illness.*

Attend: Encourage family members to become involved in the care of the dying patient. Communicate with patient and family members honestly and compassionately. Giving family members a role in patient care helps relieve anxiety and lessen feelings of regret and guilt. *Honest communication is important because family members need an opportunity to acknowledge their loss and say farewell.*

Support patient's spiritual coping behaviors. For example, arrange for patient to have objects that provide spiritual comfort (such as a copy of Bible, prayer shawl, pictures, statues, or rosary beads) at the bedside. *Even patients for whom religious practice hasn't been a dominant*

part of life may turn to religion when confronted by death or serious illness.

Manage: Involve an interdisciplinary team (including a psychologist, nurse, the patient, a nutritionist, physician, physical therapist, and chaplain) in providing care for a dying patient. *Each team member offers unique expertise for meeting the dying patient's needs.*

Provide referrals for home health care assistance if the patient will be cared for at home, *to support the patient's decision to remain at home.*

SUGGESTED NIC INTERVENTIONS

Anticipatory Guidance; Coping Enhancement; Family Support; Grief Work Facilitation; Dying Care

REFERENCES

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DEFINITION

A disorder that occurs after the death of a significant other, in which the experience of distress accompanying bereavement fails to follow normative expectations and manifests in functional impairment

DEFINING CHARACTERISTICS

- Anger
- Anxiety
- Avoidance of grieving
- Decreased functioning in life roles
- Depression
- Disbelief
- Distress about the deceased person
- Excessive stress
- Experiencing symptoms the deceased experienced
- Fatigue
- Feeling dazed
- Feeling detachment from others
- Feeling shock
- Feeling stunned
- Feelings of emptiness
- Insufficient sense of well-being
- Longing for the deceased
- Low levels of intimacy
- Mistrust
- Nonacceptance of a death
- Persistent painful memories
- Preoccupation with thoughts about a deceased person
- Rumination
- Searching for a deceased person
- Self-blame
- Separation distress
- Traumatic distress
- Yearning for deceased person

RELATED FACTORS

- Death of significant other
- Emotional disturbance
- Insufficient social support

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Emotional
- Nutrition

- Roles/relationships
- Sleep/rest
- Values/beliefs

EXPECTED OUTCOMES

- The patient will express appropriate feelings of loss, guilt, fear, anger, or sadness.
- The patient will identify the loss and describe what it means to the patient.
- The patient will appropriately move through stages of grief.
- The patient will maintain healthy patterns of sleep, activity, and eating.
- The patient will verbalize understanding that grief is normal.
- The patient will use healthy coping mechanisms and social support systems.
- The patient will seek fulfillment through preferred spiritual practices.
- The patient will begin planning for future.

SUGGESTED NOC OUTCOMES

Grief Resolution; Psychosocial Adjustment: Life Change

INTERVENTIONS AND RATIONALES

Determine: Identify previous losses and assess for depression. Older patients may experience losses frequently and without adequate recovery time before the next loss. *Multiple losses contribute to depression.*

Perform: Help patient identify an area of hope in life. *Focusing on a life purpose may decrease anger and feelings of frustration.*

Help patient focus realistically on changes the loss has brought about. *This will assist patient in forming plans for the future and improving social relationships.*

Help patient formulate goals for the future *to place loss in perspective and move on to new situations and relationships.*

Attend: Encourage patient to express grief and feelings of anger, guilt, and sadness. *Inability to express these feelings may result in maladaptive behaviors.*

Encourage journaling to express grief and loss. *Writing and exploring feelings is an active process, which may assist in grieving.*

Encourage patient and family to engage in reminiscing *to give purpose and meaning to the loss and assist in maintenance of self-esteem.*

Manage: Contact patient's preferred spiritual leader, if patient desires, *to provide relief from spiritual distress.*

Refer patient to community support systems to help patient deal with bereavement and grief process.

SUGGESTED NIC INTERVENTIONS

Coping Enhancement; Counseling; Emotional Support; Family Therapy; Grief Facilitation Work; Reminiscence Therapy

REFERENCES

Coelho, A., Delalibera, M., Barbosa, A., & Lawlor, P. (2015). Prolonged grief in palliative family caregivers. *Omega: Journal of Death & Dying, 72*(2), 151–164. doi:10.1177/0030222815574833

Nam, I. S. (2016). Effects of psychoeducation on helpful support for complicated grief: A preliminary randomized controlled single-blind study. *Psychological Medicine, 46*(1), 189–195. doi:10.1017/S0033291715001658

Supiano, K. P., & Luptak, M. (2014). Complicated grief in older adults: A randomized controlled trial of complicated grief group therapy. *Gerontologist, 54*(5), 840–856. doi:geront/gnt076

216 RISK FOR COMPLICATED GRIEVING

DEFINITION

Vulnerable to a disorder that occurs after death of a significant other in which the experience of distress accompanying bereavement fails to follow normative expectations and manifests in functional impairment, which may compromise health

RISK FACTORS

- Death of a significant other
- Emotional disturbance
- Insufficient social support

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Emotional status
- Nutrition status
- Roles/relationships
- Sleep/rest
- Values/beliefs

EXPECTED OUTCOMES

- The patient will express appropriate feelings of loss, guilt, fear, anger, or sadness.
- The patient will identify loss and describe meaning of loss.
- The patient will appropriately move through stages of grieving.
- The patient will maintain healthy patterns of sleep, activity, and eating.
- The patient will list personal strengths.
- The patient will use healthy coping mechanisms and social support systems.
- The patient will seek fulfillment through preferred spiritual practices.
- The patient will begin planning for future.

SUGGESTED NOC OUTCOMES

Grief Resolution; Psychosocial Adjustment: Life Change; Comfort Status: Psychospiritual; Hope

INTERVENTIONS AND RATIONALES

Determine: Identify areas of hope in patient's life *to help decrease anger and feelings of frustration.*

Identify previous losses and assess for depression *to establish a baseline.*

Perform: Perform interventions to promote sleep such as giving snack, pillows, back rub, or shower, *to enhance rest.*

Inform: Teach patient relaxation techniques such as guided imagery, meditation, or progressive muscle relaxation *to promote feelings of comfort.*

Attend: Encourage patient to express grief and feelings of anger, guilt, and sadness. *Inability to express these feelings may result in maladaptive behaviors.*

Encourage patient to express feelings in a way the patient is most comfortable with, for example, crying, talking, writing, and/or drawing. *Dysfunctional grieving may result from an inability to express feelings freely.*

Encourage patient to keep a journal to express feelings of grief and loss. The act of writing about feelings may aid in grieving process. *Help patient form goals for the future to place the loss in perspective and to move on to new situations and relationships.*

Manage: Refer patient to community support systems to assist with grieving process. Contact patient's preferred spiritual leader, if patient desires. *This may provide relief from spiritual distress.*

SUGGESTED NIC INTERVENTIONS

Coping Enhancement; Counseling; Emotional Support; Family Therapy; Grief Facilitation Work; Hope Inspiration

REFERENCES

Coelho, A., Delalibera, M., Barbosa, A., & Lawlor, P. (2015). Prolonged grief in palliative family caregivers. *Omega: Journal of Death & Dying, 72*(2), 151–164. doi:10.1177/0030222815574833

Nam, I. S. (2016). Effects of psychoeducation on helpful support for complicated grief: A preliminary randomized controlled single-blind study. *Psychological Medicine, 46*(1), 189–195. doi:10.1017/S0033291715001658

Supiano, K. P., & Luptak, M. (2014). Complicated grief in older adults: A randomized controlled trial of complicated grief group therapy. *Gerontologist, 54*(5), 840–856. doi:geront/gnt076

218 RISK FOR DISPROPORTIONATE GROWTH

DEFINITION

Vulnerable to growth above the 97th percentile or below the 3rd percentile for age, crossing two percentile channels, which may compromise health

RISK FACTORS

Caregiver

- Alteration of cognitive functioning
- Learning disability
- Mental health issue (e.g., depression, psychosis, personality disorder, substance abuse)
- Presence of abuse (e.g., physical, psychological, sexual)

Environmental

- Deprivation
- Economically disadvantaged
- Exposure to teratogen
- Exposure to violence
- Lead poisoning
- Natural disaster

Individual

- Anorexia
- Chronic illness
- Infection
- Insatiable appetite
- Maladaptive feeding behavior by caregiver
- Maladaptive self-feeding behavior
- Malnutrition
- Prematurity
- Substance abuse

Prenatal

- Congenital disorder
- Exposure to teratogen
- Genetic disorder
- Inadequate maternal nutrition
- Maternal infection
- Multiple gestation
- Substance abuse

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Nutrition
- Activity

- Sleep
- Coping

EXPECTED OUTCOMES

- The child will grow and gain weight as expected on the basis of growth-chart norms for age and gender.
- The child will consume _____ calories and ___ mL of fluids representing ____ servings (specify for each food group).
- The child will achieve ____ hours of uninterrupted sleep daily.
- The child will maintain age-appropriate activity level.
- Parents will identify risk factors that may lead to disproportionate growth.
- Parents will state understanding of preventive measures to reduce risk of disproportionate growth.

SUGGESTED NOC OUTCOMES

Appetite; Body Image; Child Development: 1 month through Adolescence; Risk Control; Weight: Body Mass; Knowledge: Parenting

INTERVENTIONS AND RATIONALES

Determine: Monitor weight and height weekly *to evaluate progress.*

Monitor temperature, activity levels, sleep patterns, and changes in nutritional status. Monitor prescribed and over-the-counter medications taken. Determine exposure to tobacco smoke and/or other environmental contaminants. *These assessment parameters will assist in developing appropriate interventions.*

Perform: Weigh and measure the child weekly *to evaluate progress.* Review growth-chart curve *to compare with growth history.*

Establish meal program *that meets the child's nutritional needs.*

Establish routine sleep schedule for the child. Help child keep a chart *to encourage increased levels of self-care.*

List age-appropriate activities and exercises for the child *to stimulate bone and muscle development and promote cardiovascular health.*

Administer prescribed drugs and treatments, as ordered. Ensure that the child and parents understand the intended action and side effects that may *occur, to ensure that therapy can continue without interruption.*

Provide an environment that is conducive to promote changes the child must make. *Environment can be a powerful motivator.*

Inform: Educate child and parents on nutritional requirements for child's age and gender. Discuss meals available to the child at home *to promote growth.*

Teach child and parents about risk factors associated with disproportionate growth, such as poor nutrition, lack of regular sleep, environmental hazards, or lack of age-appropriate activities. Help to identify preventive measures to be taken in the home *to promote continuity of care.*

Attend: Encourage healthy, loving interactions between child and other family members. Demonstrate healthy and positive interactions with the child. *Disproportionate growth may be associated with emotional deprivation.*

Encourage child and parents to express feelings about present state of child's health. Listen attentively with understanding about the self-esteem associated with what is considered by peers to be other than normal. *Parents will need help in supporting the child through difficulties coping with normal peers.*

Manage: If a medical or psychiatric illness places child at risk for disproportionate growth, make sure child gets adequate follow-up medical care and ensure that the care is appropriate and professional. *This will ensure the child's right to receive remedial and educational care in accordance with the child's disability, as guaranteed by federal law.*

If financial hardship interferes with the family's ability to provide for child with disproportionate growth, offer a referral to a social worker *to improve the family's access to community resources.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Behavior Modification; Coping Enhancement; Counseling; Nutritional Management; Patient Contracting; Weight Management; Developmental Enhancement: Child and Adolescent; Financial Resource Assistance

REFERENCES

Allvin, K., Hellström, A., Dahlgren, J., & Andersson Grönlund, M. (2014). Birth weight is the most important predictor of abnormal retinal vascularisation in moderately preterm infants. *Acta Paediatrica*, *103*(6), 594–600. doi:10.1111/apa.12599

Knopf, A. (2015). Growth chart for the mind may be able to detect psychosis early. *Brown University Child & Adolescent Behavior Letter*, *31*(7), 1–2.

Michaelsen, K. F. (2014, May). Are the new Danish 2014 growth references really more appropriate than the World Health Organization standards? *Acta Paediatrica*, *103*(5), 464–465. doi:10.1111/apa.12586

DEFINITION

Presence of one or more health problems or factors that deter wellness or increase the risk of health problems experienced by an aggregate

DEFINING CHARACTERISTICS

- Health problem experienced by aggregates or populations
- Program unavailable to eliminate health problem(s) of an aggregate or population
- Program unavailable to enhance wellness of an aggregate or population
- Program unavailable to prevent health problem(s) of an aggregate or population
- Program unavailable to reduce health problem(s) of an aggregate or population
- Risk of hospitalization experienced by aggregates or populations
- Risk of physiologic states experienced by aggregates or populations
- Risk of psychological states experienced by aggregates or populations

RELATED FACTORS

- Inadequate consumer satisfaction with program
- Inadequate program budget
- Inadequate program evaluation plan
- Inadequate program outcome data
- Inadequate social support for program
- Insufficient access to health care provider
- Insufficient community experts
- Insufficient resources (e.g., financial, social, knowledge)
- Program incompletely addresses health problem

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Values/beliefs
- Populations
- Roles/relationships
- Health care system

EXPECTED OUTCOMES

- The community will conduct a formal comprehensive survey assessing the parameters of the community that impact its health.
- The community will develop a plan to secure professional, governmental, social, and financial/economic resources that sustain a community's health.
- The community will develop processes that enable individuals, organizations, and agencies to work together to accomplish the community's health goals.
- The community will implement systems that meet the community's health needs.

SUGGESTED NOC OUTCOMES

Health-Promoting Behavior; Health-Seeking Behavior; Knowledge: Health Behavior; Knowledge: Health Resources; Community Health Status

INTERVENTIONS AND RATIONALES

Determine: Select a qualified leader/coordinator to establish and direct community resources to assess the health care needs of the residents. *A leader is necessary to coordinate the efforts of individuals working to improve the structures supporting community health.*

Communicate widely and through multiple media outlets the need for participation in surveys and assessments to determine deficiencies in community health. *Understanding proposed actions and expectations reduces anxiety and suspicion; it increases cooperation among the community and residents.*

Assess the community demographics. *An understanding of who has health needs to be addressed provides efficiency and effectiveness in delivering care.*

Evaluate the prevalence of health problems and risk behaviors. *An understanding of what the medical conditions and nursing needs are is helpful to align professional services for the continuum of care.*

Establish the scope of need and the reality of resources available to meet the needs. *Integrating the knowledge gained about the community deficit enables the community leaders to identify scope of need, scope of work, and means to accomplish it.*

Perform: Create opportunities for community resources to begin services to the community residents in need. *Volunteers and concerned individuals can provide local services to meet the needs of "their neighbors" and promote goodwill.*

Foster relationships at all levels (local, regional, and national) that secure resources to enable policy, funding, and action plans to evolve for solutions to deficiencies in the community health. *In communities of any size, working together for common goals creates synergy and moves the agendas forward.*

Plan for resident (community)-centered, safe, equitable, effective, efficient, quality, and timely delivery of health care. *These aims from the Institute of Medicine provide guidance in the outcomes desired for the community health care delivery.*

Inform: Teach the community members about their roles in self-care, disease management, and community care. *This facilitates autonomy to improve health and promote community-centered care.*

Educate students within the school systems about their responsibilities, self-care, health maintenance, and health protection. *Positive health habits, positive self-esteem, disease avoidance, pregnancy avoidance, and*

successful completion of high school coupled with plans for a vocation or higher education reduce the current and future burden on the community's health.

Attend: Support and encourage the community as it moves forward. *Barriers and challenges to initiatives may develop and can be surmounted with professional guidance.*

Encourage groups, agencies, and residents to find common ground and goals to work on together to identify solutions to meet the needs of the community. *In finding common ground, a commitment to the group process and the outcomes goal evolve into a solution.*

Manage: Solicit a cadre of individuals with expertise to enhance the assessment, planning, and implementation phases of the community health plan. *Advanced knowledge of the community health assessment and promotion process enables local leaders and residents to move steadily toward positive health outcomes.*

Engage local educators and community leaders to provide insight and recommendations into approaches for segments of the population. *Local experts can be translational leaders in bringing the right residents forward to benefit from the ideas and resources made available through the community health initiatives.*

SUGGESTED NIC INTERVENTIONS

Community Health Development; Program Development; Environmental Management: Community; Health Screening; Community Disease Management

REFERENCES

Best, S. (2015). Innovating in rural health in Wales: Applied findings from the practitioner's perspective. *British Journal of Community Nursing*, *20*(11), 559–563. doi:10.12968/bjcn.2015.20.11.559

Mohammad, Y., Jan, R., McIntyre, H., Lakhani, A., Anwar, S., & Levi, A. J. (2015). Community midwives' workplace experiences: A case study from a resource-poor country. *British Journal of Midwifery*, *23*(12), 886–893. doi:10.12968/bjom.2015.23.12.886

Turner, C. (2015). Mobile working: Positively engaging community nurses. *British Journal of Community Nursing*, *20*(3), 134–138.

DEFINITION

Impaired ability to modify lifestyle/behaviors in a manner that improves health status

DEFINING CHARACTERISTICS

- Failure to achieve optimal sense of control
- Failure to take action that prevents health problems
- Minimizes health status change
- Nonacceptance of health status change

RELATED FACTORS

- Economically disadvantaged
- Inadequate comprehension
- Insufficient social support
- Low self-efficacy
- Negative attitude toward health care
- Smoking
- Stressors
- Substance abuse

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication
- Coping
- Knowledge
- Self-perception

EXPECTED OUTCOMES

- The patient will identify inability to cope and will adjust adequately.
- The patient will express understanding of the illness or disease.
- The patient will participate in health care regimen including planning activities.
- The patient will demonstrate ability to manage health problems.
- The patient will help perform self-care activities.
- The patient will show ability to accept and adapt to a new health status and integrate learning.
- The patient will demonstrate new coping abilities.

SUGGESTED NOC OUTCOMES

Acceptance: Health Status; Adaptation to Physical Disability; Coping; Health Seeking Behavior; Participation in Healthcare Decisions; Psychosocial Adjustment: Life Change; Social Support; Treatment Behavior: Illness

INTERVENTIONS AND RATIONALES

Determine: Assess patient's present understanding of health status and treatment *to form the basis for any further planning*. Assess feelings about

present health status. Do this in a safe, nonthreatening environment *to allow the patient to gain insight into and rationally define fears, goals, and potential problems.* Monitor patient involvement in care-related activities.
Perform: *Make changes in the environment that will encourage healthy behavior.*
Inform: Teach patient and caregiver the skills necessary to manage care adequately. *Teaching will encourage compliance and adjustment to optimum wellness.*

Teach patient how to find areas in which it is possible to maintain control, *to avoid feelings of powerlessness and allow the patient to feel like a member of the team's effort to assist the patient.*

Teach caregivers to assist patient with self-care activities in a way that maximizes patient's potential. *This enables caregivers to participate in patient's care and encourages them to support patient's independence.*
Attend: Provide emotional support and encouragement by listening to the patient's feelings. *This will reassure the patient that you care.*

Allow patient to grieve. *Grieving is a normal and essential aspect of any kind of negative change in health status. After working through denial and isolation, anger, bargaining, and depression, the patient will progress toward acceptance.*

Provide reassurance that the patient's feelings, under the circumstances, are normal. *By realizing that it is acceptable to grieve, the patient will be willing to look for positive ways of coping.*

Involve patient in planning and decision making. *Having the ability to participate will encourage greater compliance with the plan for activity.*

Discuss health problems with family members *to encourage participation in the patient's care.*
Manage: Refer to a mental health specialist if patient develops severe depression or other psychiatric problem. *Although trauma or illness commonly causes some depression or other psychiatric disorders, consultation with a mental health professional may help minimize it.*

Arrange for an individual who has the same problem to meet with the patient. This exposes the patient to suitable role models and may encourage a supportive relationship to evolve.

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Behavior Modification; Coping; Enhancement; Counseling; Decision-Making Support; Mutual Goal-Setting; Role Enhancement; Support System Enhancement

REFERENCES

Leong, C. M., & Palos, G. R. (2014). Oncology nurses and indoor tanning: Stylish or risky behavior? *Clinical Journal of Oncology Nursing, 18*(3), 363–365. doi:10.1188/14.CJON.363-365

McDonald, C. C., Sommers, M. S., & Fargo, J. D. (2014). Risky driving, mental health, and health-compromising behaviours: Risk clustering in late adolescents and adults. *Injury Prevention, 20*(6), 365–372. doi:10.1136/injuryprev-2014-041150

Roth, A. M., Armenta, R. A., Wagner, K. D., Roesch, S. C., Bluthenthal, R. N., Cuevas-Mota, J., & Garfein, R. S. (2015). Patterns of drug use, risky behavior, and health status among persons who inject drugs living in San Diego, California: A latent class analysis. *Substance Use & Misuse, 50*(2), 205–214. doi:10.3109/10826084.2014.962661

DEFINITION

Inability to identify, manage, and/or seek out help to maintain health

DEFINING CHARACTERISTICS

- Absence of adaptive behaviors to environmental changes
- Absence of interest in improving health behaviors
- Inability to take responsibility for meeting basic health practices
- Insufficient knowledge about basic health practices
- Insufficient social support
- Pattern of lack of health-seeking behavior

RELATED FACTORS

- Alteration in cognitive functioning
- Complicated grieving
- Decrease in fine motor skills
- Decrease in gross motor skills
- Impaired decision making
- Ineffective communication skills
- Ineffective coping strategies
- Insufficient resources (e.g., financial, social, knowledge)
- Perceptual impairment
- Spiritual distress
- Unachieved developmental tasks

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Communication
- Coping
- Health care system
- Knowledge
- Risk management
- Values and beliefs

EXPECTED OUTCOMES

- The patient will maintain current health status.
- The patient will sustain no harm or injury.
- The patient will verbalize feelings and concerns.
- The patient will explain health maintenance program.
- The patient will identify available health resources.

SUGGESTED NOC OUTCOMES

Coping; Decision Making; Health Beliefs: Perceived Resources; Health-Promoting Behavior; Social Support; Spiritual Health; Knowledge: Treatment Regimen

INTERVENTIONS AND RATIONALES

Determine: Assess current health status; personal habits such as use of tobacco, drugs, and alcohol; level of knowledge about disease process; level of family and community assistance; coping mechanisms and communication skills (verbal and written); and degree of motivation to maintain health. *Assessment factors will assist the nurse in establishing interventions for this diagnosis.*

Perform: Provide assistance with self-care, as needed. Encourage increasing levels of independence. *The patient should be as independent in activities of living as possible.*

Administer medications, as prescribed, *to ensure continuation of therapy.*

Adapt environment to that which is best suited to the particular patient. Reorient the patient, as needed. In the disoriented patient, *reorientation should take place frequently to keep the person as close to knowing person, place, and time as possible.*

Provide a consistent caretaker whenever possible *to promote stability for the patient.*

Plan a health maintenance program for patient and family members addressing current disabilities. Provide patient and family with a written copy. *Giving instructions in writing will reinforce the various aspects of the program and increase the possibility of compliance.*

Inform: Fully describe all aspects of the patient's care to the family *to elicit cooperation from them in continuing a plan.*

Instruct family members how to carry out health maintenance practices. Demonstrate skills such as bathing, feeding, and reality orientation; then, have family members do return demonstration under supervision. *Involving family members allows them the opportunity to perform skills and solve problems with support and supervision.*

Provide specific instructions on how to maintain a safe environment for the patient *to avoid falls and other types of accidental injuries.*

Teach relaxation techniques (e.g., guided imagery, progressive muscle relaxation, and meditation) that can be done by the patient and the family *to enhance coping ability and restore psychological and physical equilibrium by decreasing autonomic response to anxiety.*

Attend: Encourage patient and family to verbalize feelings and concerns related to health maintenance. *This promotes better understanding and greater ease in managing challenging situations.*

Demonstrate willingness to repeat instruction and demonstrate skills needed *to care for the patients until they feel comfortable.*

Manage: Refer to social and community resources, such as stroke support group, and Alzheimer's family support group. *This helps the family*

gain support and receive factual information. It provides opportunity to express feeling in a group where others are experiencing similar issues.

Making referrals is appropriate to mental health professional *to assist with prevention of burnout for the family.*

SUGGESTED NIC INTERVENTIONS

Anticipatory Guidance; Coping Enhancement; Counseling; Discharge Planning; Health Education; Health System Guidance; Physician Support; Referral; Support System Enhancement

REFERENCES

Best, S. (2015). Innovating in rural health in Wales: Applied findings from the practitioner's perspective. *British Journal of Community Nursing*, *20*(11), 559–563. doi:10.12968/bjcn.2015.20.11.559

Cross, S. L., Suharwardy, S. H., Bodavula, P., Schechtman, K., Overton, E. T., Onen, N. F., & Lane, M. A. (2014). Improving cervical cancer screening rates in an urban HIV clinic. *AIDS Care*, *26*(9), 1186–1193. doi:10.1080/09540121.2014.894610

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230 INEFFECTIVE HEALTH MANAGEMENT

DEFINITION

Pattern of regulating and integrating into daily living a therapeutic regimen for the treatment of illness and its sequelae that is unsatisfactory for meeting specific health goals

DEFINING CHARACTERISTICS

- Difficulty with prescribed regimen
- Failure to include treatment regimen in daily living
- Failure to take action to reduce risk factor
- Ineffective choices in daily living for meeting health goal

RELATED FACTORS

- Complex treatment regimen
- Complexity of health care system
- Decisional conflict
- Economically disadvantaged
- Excessive demands
- Family conflict
- Family pattern of health care
- Inadequate number of cues to action
- Insufficient knowledge of therapeutic regimen
- Insufficient social support
- Perceived barrier
- Perceived benefit
- Perceived seriousness of condition
- Perceived susceptibility
- Powerlessness

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Self-care
- Behavior
- Knowledge

EXPECTED OUTCOMES

- The patient will acknowledge responsibility to manage own health condition.
- The patient will identify any barriers to optimal self-health management and determine plan to address them.
- The patient will refine problem-solving skills over time.
- The patient will increase self-efficacy, the confidence that one can carry out a behavior necessary to reach a desired goal.

SUGGESTED NOC OUTCOMES

Adherence Behavior; Compliance Behavior; Decision-Making; Health Orientation; Health Promoting Behavior; Personal Health Status; Self-Direction of Care; Knowledge: Health Promotion

INTERVENTIONS AND RATIONALES

Determine: Monitor patient's self-efficacy and use of problem-solving skills as patient manages own health. *These concepts reflect a new paradigm in health management that acknowledges that patients need many skills and confidence to carry out plan of care.*

Perform: Assist patient in setting goals and making informed choices. *This patient–nurse collaborative relationship helps patient and nurse identify barriers to optimal health management and overcome them.*

Inform: Teach patients about their disease states and regimens, but, more importantly, teach patients problem-solving skills *to ensure that they actively participate in their self-health management despite any setbacks that they might experience.*

Attend: Provide encouragement to help motivate patient to maximize healthy behaviors. *This highlights that behavior is best changed by internal motivation rather than by external motivation.*

Manage: Coordinate with social services and colleagues in other disciplines *to ensure that family, economic, and social barriers to optimal self-health management have been addressed.*

SUGGESTED NIC INTERVENTIONS

Behavior Modification; Complex Relationship Building; Decision-Making Support; Health Education; Learning Facilitation; Mutual Goal-Setting; Self-Awareness Enhancement

REFERENCES

Risendal, B., Dwyer, A., Seidel, R., Lorig, K., Katzenmeyer, C., Coombs, L., . . . Ory, M. (2014). Adaptation of the chronic disease self-management program for cancer survivors: Feasibility, acceptability, and lessons for implementation. *Journal of Cancer Education, 29*(4), 762–771. doi:10.1007/s13187-014-0652-8

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Zaldonis, J., Alrawashdeh, M., Atman, K. S., Fatigati, A., Dabbs, D., & Bermudez, C. A. (2015). Predictors and influence of goal orientation on self-management and health-related quality of life after lung transplant. *Progress in Transplantation, 25*(3), 230–242. doi:10.7182/pit2015189

232 INEFFECTIVE FAMILY HEALTH MANAGEMENT

DEFINITION

A pattern of regulating and integrating into family processes a program for the treatment of illness and its sequelae that is unsatisfactory for meeting specific health goals

DEFINING CHARACTERISTICS

- Acceleration of illness symptoms of a family member
- Decrease in attention to illness
- Difficulty with prescribed regimen
- Failure to take action to reduce risk factor
- Inappropriate family activities for meeting health goal

RELATED FACTORS

- Complex treatment regimen
- Complexity of health care system
- Decisional conflict
- Economically disadvantaged
- Family conflict

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication
- Coping
- Roles/relationships
- Values/beliefs

EXPECTED OUTCOMES

- Family members will identify behaviors that lead to conflict.
- Family members will participate in family therapy sessions and openly express feelings about illness of family member.
- Family members will express desire to have help in resolving conflicts.
- Family members will describe coping mechanisms that help reduce conflicts.
- Family members will cooperate in finding ways to incorporate therapeutic regimen into their lifestyle.
- Family members will express desire to carry out therapeutic regimen.
- Family members will plan for future course of illness.

SUGGESTED NOC OUTCOMES

Compliance Behavior; Family Coping; Family Functioning; Family Normalization; Family Participation in Professional Care; Knowledge: Treatment Regimen; Risk Control; Symptom Control

INTERVENTIONS AND RATIONALES

Determine: Spend time with family, get to know each family member individually, and establish a trusting relationship. Elicit family members' personal beliefs about the illness and review relevant information *to establish their support for improving management of therapeutic regimen.*
Perform: Help family members clarify values associated with their lifestyle *to enhance understanding of conflicts between their lifestyle and demands of therapeutic regimen.*
Inform: Educate family members about the pathophysiology of illness, and explain the relationship between the pathophysiology and the therapeutic regimen. *If family members know reasons for specific behaviors, they may be more willing to adjust their lifestyle.*
Attend: Encourage family members to address individual needs assertively *to promote healthy interactions within family.*

Work with family members to develop a daily routine for managing the therapeutic regimen that fits with their lifestyle. *Collaboration with family members makes it possible to incorporate lifestyle factors, such as culture, family dynamics, and finances, into a plan for managing the illness.*
Manage: Encourage family members to attend and participate in family therapy sessions *to strengthen family unit and promote resolution of conflict.*

Refer the family members to appropriate agencies, if needed. This can ensure continued family support and help reduce conflicts.

SUGGESTED NIC INTERVENTIONS

Case Management; Coping Enhancement; Decision-Making Support; Family Involvement Promotion; Family Process Maintenance; Family Therapy

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234 IMPAIRED HOME MAINTENANCE

DEFINITION

Inability to independently maintain a safe growth-promoting immediate environment

DEFINING CHARACTERISTICS

- Difficulty maintaining a comfortable environment
- Excessive family responsibilities
- Financial crisis (e.g., debt, insufficient finances)
- Insufficient clothing
- Insufficient cooking equipment
- Insufficient equipment for maintaining home
- Insufficient linen
- Pattern of disease caused by unhygienic condition
- Pattern of infection caused by unhygienic conditions
- Request for assistance with home maintenance
- Unsanitary environment

RELATED FACTORS

- Alteration in cognitive functioning
- Condition impacting ability to maintain home (e.g., disease, illness, injury)
- Illness impacting ability to maintain home
- Injury impacting ability to maintain home
- Insufficient family organization
- Insufficient family planning
- Insufficient knowledge of home maintenance
- Insufficient knowledge of neighborhood resources
- Insufficient role model
- Insufficient support system

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Communication
- Coping
- Knowledge
- Roles/relationships
- Self-perception

EXPECTED OUTCOMES

- The patient and family members will express concern about poor home maintenance.
- The patient and family members will verbalize plans to correct health and safety hazards in home.
- The patient and family members will identify community resources available to help maintain home.

SUGGESTED NOC OUTCOMES

Family Functioning: Role Performance; Self-Care: IADLs; Comfort Status: Environment

INTERVENTIONS AND RATIONALES

Determine: Assess home environment, financial resources, patient's knowledge about self-care, and communication patterns in the family. *Assessment information will assist in identifying appropriate interventions.*

Perform: List obstacles to effective home maintenance management with patient and family *to develop understanding of potential and actual health and safety hazards.* Begin discussions at patient's level of comfort. *Adult learners learn best where they have specific needs to fulfill.*

Assist family members to assign daily and weekly responsibility for home maintenance activities. *Having a schedule will promote consistency in following the plan of care.*

Inform: Teach patient and family the importance of home maintenance *to ensure safety.* Provide written materials on environmental aspects of home maintenance.

Teach skills such as setting down and choosing from a list of options, and assertiveness skills *to enhance coping strategies.* Help patient and family develop a program by using relaxation strategies (i.e., meditation, guided imagery, yoga, exercise) *to reduce anxiety.*

Attend: Encourage weekly discussions about progress in maintaining home maintenance *schedule to develop family unity and allow members to address problems before they become overwhelming.*

Manage: Assist family members to contact community agencies *that can assist them in their efforts to improve home maintenance management, such as self-help groups, cleaning services, and exterminators. Community resources can lessen family's burden while members learn to function independently.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Coping Enhancement; Counseling; Emotional Support; Family Integrity Promotion; Family Support; Home Maintenance Assistance; Environmental Management: Home Preparation & Safety; Referral

REFERENCES

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DEFINITION

Subjective state in which an individual sees limited or no alternatives or personal choices available and is unable to mobilize energy on own behalf

DEFINING CHARACTERISTICS

- Alteration in sleep pattern
- Decrease in affect
- Decreased appetite
- Decreased initiative
- Decrease in response to stimuli
- Decrease in verbalization
- Despondent verbal cues (e.g., "I can't," sighing)
- Inadequate involvement in care
- Passivity
- Poor eye contact
- Shrugging in response to speaker
- Turning away from speaker

RELATED FACTORS

- Chronic stress
- Deterioration in physiologic condition
- History of abandonment
- Loss of belief in spiritual power
- Loss of belief in transcendent values
- Prolonged activity restriction
- Social isolation

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Roles/responsibilities
- Values/beliefs

EXPECTED OUTCOMES

- The patient will identify feelings of hopelessness regarding present situation.
- The patient will demonstrate more effective communication skills.
- The patient will resume appropriate rest and activity pattern.
- The patient will participate in self-care activities and decisions regarding care planning.
- The patient will begin to develop feelings of hope.

SUGGESTED NOC OUTCOMES

Acceptance: Health Status; Adaptation to Physical Disability; Depression Control; Hope; Quality of Life; Spiritual Health

INTERVENTIONS AND RATIONALES

Determine: Assess the following: nature of current medical diagnosis, patient's knowledge about medical diagnosis, actual or perceived self-care deficits, mental status, communication patterns and support systems, nutritional status and appetite, and sleep patterns. Also monitor heart rate and blood pressure, respiratory rate, quality and depth of respirations, and breath sounds. *Assessment factors will help identify appropriate interventions.*
Perform: Follow medical regimen *to manage the patient's physiologic condition.* Build non-care-related time into the daily schedule *to allow time to develop a trusting relationship with the patient.*

Provide comfort measures: adjust lighting and sound *to minimize irritating stimuli*; offer back rubs and space procedures *to promote relaxation.*
Inform: Keep patient informed about what to expect and when to expect it. *Accurate information reduces anxiety.*

Teach self-healing techniques to both the patient and the family, such as meditation, guided imagery, yoga, and prayer, *to enhance coping strategies.* Teach patient how to incorporate the use of self-healing techniques in carrying out usual daily activities.
Attend: Encourage patient to talk about personal assets and accomplishments and about improvements in the patient's condition, no matter how small they may seem. Give positive feedback. *Conversation assists evaluation of patient's self-concept and adaptive abilities.*

Direct the patient's focus beyond the present state. For example, "Your nasogastric tube will come out tomorrow and you will feel more comfortable." *This helps instill hope.*

Encourage patient to talk about appropriate diversions and to participate in them. *Pleasurable activity decreases potential hazard of crisis.*
Manage: Refer patient and family to other professional caregivers, for example, dietitian, social worker, clergy, mental health professional, and support groups such as Ostomy Club, I Can Cope, and Reach for Recovery. Assist patient to utilize appropriate resources by contacting family and scheduling follow-up appointments. *These measures help give the patient a sense of direction and control over the future care.*

SUGGESTED NIC INTERVENTIONS

Coping Enhancement; Decision-Making Support; Energy Management; Mutual Goal Setting; Sleep Enhancement; Spiritual Growth Facilitation; Support Group; Relaxation Therapy

REFERENCES

Gudmundsdottir, R. M., & Thome, M. (2014). Evaluation of the effects of individual and group cognitive behavioral therapy and of psychiatric rehabilitation on hopelessness of depressed adults: A comparative analysis. *Journal of Psychiatric & Mental Health Nursing*, *21*(10), 866–872. doi:10.1111/jpm.12157

Konukbay, D., & Arslan, F. (2015). The analysis of hopelessness levels and problem solving skills of parents with the disabled children. *International Journal of Caring Sciences*, *8*(2), 344–355.

Steeg, S., Haigh, M., Webb, R. T., Kapur, N., Awenat, Y., Gooding, P., . . . Cooper, J. (2016). The exacerbating influence of hopelessness on other known risk factors for repeat self-harm and suicide. *Journal of Affective Disorders*, *190*, 522–528. doi:10.1016/j.jad.2015.09.050

240 RISK FOR COMPROMISED HUMAN DIGNITY

DEFINITION

Vulnerable for perceived loss of respect and honor, which may compromise health

RISK FACTORS

- Cultural incongruence
- Dehumanizing treatment
- Disclosure of confidential information
- Exposure of the body
- Humiliation
- Insufficient comprehension of health information
- Invasion of privacy
- Limited decision-making experience
- Loss of control of body functions
- Stigmatization

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Communication
- Behavior
- Values and beliefs
- Coping

EXPECTED OUTCOMES

- The patient will express satisfaction with level of respect.
- The patient will identify those things that will reduce feelings of powerlessness and vulnerability and increase perception of autonomy.
- The patient and family will agree on a plan to protect patient's privacy and respect patient's confidentiality; family members will evaluate the progress they are making in protecting the patient's right to confidentiality.
- The patient and family will express satisfaction with the level of respect shown to patient's human dignity.

SUGGESTED NOC OUTCOMES

Client Satisfaction; Protection of Rights; Coping; Personal Autonomy; Self-Esteem

INTERVENTIONS AND RATIONALES

Determine: Assess patient's perception of the current health problem and problem-solving techniques the patient uses to cope. Determine level of family involvement and support. Ask about support systems, including family, friends, and clergy. Determine patient's legal status, including the authority to give consent for treatments or procedures. *Assessment of these factors will assist in identifying appropriate interventions.*

Perform: Schedule time to spend with the patient *to listen to concerns and feelings about current situation.*

Develop a plan visiting with patient *to ensure that the desirable level of privacy is being maintained.*

Incorporate questions into discussions with the patient that are open-ended, and start with such words as "what," "how," and "could," rather than "why." *Open-minded, nonthreatening questioning encourages the patient to discuss issues of concern and improve ability to articulate what the patient desires.*

Schedule team meetings with staff *to ensure that communication with the patient is consistent and truthful.*

Inform: Provide education on legal and ethical rights of the patient to have the patient's human dignity respected, as well as the hospital or agency's policies on respecting the rights of patients. Include family in this process. *Every patient is entitled to have a copy of the hospital's Bill of Patient's Rights.*

Arrange a team conference with the staff *to review with patient and family information on bioethics and moral rights of patients.* Role model or provide case studies with situations *to allow staff to design strategies for handling difficult issues associated with patient's rights.*

Attend: Encourage discussion of thoughts and feelings about the overuse of negative expressions on the part of the patient by suggesting strategies such as a rubber band on the wrist to snap every time negative expressions begin. *Negative expressions can impair the patient's progress toward a healthy lifestyle.*

Encourage role-playing of verbal and nonverbal communication techniques in a safe environment *to enhance communication skills.*

Provide support through active listening, appropriate periods of silence, reflection on feelings, and paraphrasing and summarizing comments. *Active listening techniques encourage patient participation in communication.*

Make sure that patient has clear explanations for everything that will happen to the patient. Ask for feedback to ensure that patient understands. *Anxiety may impair patient's cognitive abilities.*

Manage: Refer patient and/or family to a support network that will relate to them in regards to caregiving, the pressures of illness, and other issues related to respecting human dignity. *A support network will provide an outlet for the family members as they work through the various issues.*

SUGGESTED NIC INTERVENTIONS

Body Image Enhancement; Self-Awareness Enhancement; Self-Esteem Enhancement; Referral

REFERENCES

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DEFINITION

Core body temperature above the normal diurnal range due to failure of thermoregulation

DEFINING CHARACTERISTICS

- Abnormal posturing
- Apnea
- Coma
- Convulsions
- Flushed skin
- Hypotension
- Infant does not maintain suck
- Irritability
- Lethargy
- Seizure
- Skin warm to touch
- Stupor
- Tachycardia
- Tachypnea
- Vasodilation

RELATED FACTORS

- Decreased sweat response
- Dehydration
- High environmental temperature
- Illness
- Inappropriate clothing
- Increase in metabolic rate
- Ischemia
- Pharmaceutical agent
- Sepsis
- Trauma
- Vigorous activity

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Fluid and electrolytes
- Pharmacologic function
- Physical regulation
- Neurocognition
- Respiratory function
- Tissue integrity

EXPECTED OUTCOMES

- The patient will remain afebrile.

- The patient will maintain balance of intake and output within normal limits.
- The patient will maintain urine specific gravity between 1.005 and 1.015.
- The patient will exhibit moist mucous membranes.
- The patient will exhibit good skin turgor.
- The patient will remain alert and responsive.

SUGGESTED NOC OUTCOMES

Hydration; Infection Severity; Thermoregulation; Vital Signs; Risk Control: Hyperthermia

INTERVENTIONS AND RATIONALES

Determine: Monitor heart rate and rhythm, blood pressure, respiratory rate, level of consciousness and level of responsiveness, and capillary refill time every 1 to 4 hours *to evaluate effectiveness of interventions and monitor for complications.*

Determine patient's preferences for oral fluids, and encourage patient to drink as much as possible, unless contraindicated. Monitor and record intake and output, and administer intravenous fluids, if indicated. *Because insensible fluid loss increases by 10% for every 1.8° F (1° C) increase in temperature, patient must increase fluid intake to prevent dehydration.*

Perform: Take temperature every 1 to 4 hours *to obtain an accurate core temperature.* Identify route and record measurements.

Administer antipyretics, as prescribed, and record effectiveness. *Antipyretics act on hypothalamus to regulate temperature.*

Use nonpharmacologic measures *to reduce excessive fever,* such as removing sheets, blankets, and most clothing; placing ice bags on axillae and groin; and sponging with tepid water. Explain these measures to patient. *Nonpharmacologic measures lower body temperature and promote comfort. Sponging reduces body temperature by increasing evaporation from skin. Tepid water is used because cold water increases shivering, thereby increasing metabolic rate and causing temperature to rise.*

Use a hypothermia blanket if patient's temperature rises above 103° F (39.4° C), if ordered. Monitor vital signs every 15 minutes for 1 hour and then as indicated. *Prolonged hyperthermia may lead to complications such as seizures.* Turn off blanket if shivering occurs. *Shivering increases metabolic rate, increasing temperature.*

Manage: Report lack of responses to interventions to physician *to prevent complications.*

SUGGESTED NIC INTERVENTIONS

Environmental Management; Fever Treatment; Fluid Management; Temperature Regulation

REFERENCES

Dam, N. M., & McCarthy, A. L. (2015). Nursing fever management in adult oncology patients: A literature review. *Australian Journal of Cancer Nursing*, *16*(2), 12–17.

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DEFINITION

Core body temperature below the normal diurnal range due to failure of thermoregulation

DEFINING CHARACTERISTICS

- Acrocyanosis
- Bradycardia
- Cyanotic nail beds
- Decrease in blood glucose level
- Decrease in ventilation
- Hypertension
- Hypoglycemia
- Hypoxia
- Increase in metabolic rate
- Increase in oxygen consumption
- Peripheral vasoconstriction
- Piloerection
- Shivering
- Skin cool to touch
- Slow capillary refill
- Tachycardia

Accidental Low Body Temperature in Children and Adults

- Mild hypothermia, core temperature 32° C to 35° C
- Moderate hypothermia, core temperature 30° C to 32° C
- Severe hypothermia, core temperature <30° C

Injured Adults and Children

- Hypothermia, core temperature <35° C
- Severe hypothermia, core temperature <32° C

Neonates

- Grade 1 hypothermia, core temperature 36° C to 36.5° C
- Grade 2 hypothermia, core temperature 35° C to 35.9° C
- Grade 3 hypothermia, core temperature 34° C to 34.9° C
- Grade 4 hypothermia, core temperature <34° C
- Infant with insufficient energy to maintain sucking
- Infant with insufficient weight gain (<30 g/day)
- Irritability
- Jaundice
- Metabolic acidosis
- Pallor
- Respiratory distress

RELATED FACTORS

- Alcohol consumption
- Damage to hypothalamus

- Decrease in metabolic rate
- Economically disadvantaged
- Extremes of age
- Extremes of weight
- Heat transfer (e.g., conduction, convection, evaporation, radiation)
- Inactivity
- Insufficient caregiver knowledge of hypothermia prevention
- Insufficient clothing
- Insufficient supply of subcutaneous fat
- Low environmental temperature
- Malnutrition
- Pharmaceutical agent
- Radiation
- Trauma

Neonates

- Delay in breast-feeding
- Early bathing of newborn
- High-risk out-of-hospital birth
- Immature stratum corneum
- Increased body surface area to weight ratio
- Increase in oxygen demand
- Increase in pulmonary vascular resistance (PVR)
- Ineffective vascular control
- Inefficient nonshivering thermogenesis
- Unplanned out-of-hospital birth

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Fluid and electrolytes
- Pharmacologic function
- Physical regulation
- Neurocognition
- Respiratory function
- Tissue integrity

EXPECTED OUTCOMES

- The patient will maintain body temperature within normal range.
- The patient will have warm and dry skin.
- The patient will maintain heart rate and blood pressure within normal range.
- The patient will not shiver.
- The patient will express feelings of comfort.
- The patient will show no complications associated with hypothermia, such as soft tissue injury, fracture, dehydration, and hypovolemic shock, if warmed too quickly.

- The patient will state an understanding of how to prevent further episodes of hypothermia.

SUGGESTED NOC OUTCOMES

Neurological Status: Autonomic; Thermoregulation; Vital Signs; Risk Control: Hypothermia

INTERVENTIONS AND RATIONALES

Determine: Monitor body temperature at least every 4 hours or more frequently, if indicated, *to evaluate effectiveness of interventions.*

Record temperature and route *to allow accurate data comparison.* Baseline temperatures vary, depending on route used. If temperature drops below 95° F (35° C), use a low-reading thermometer *to obtain accurate reading.*

Monitor and record neurologic status at least every 4 hours. *Falling body temperature and metabolic rate reduce pulse rate and blood pressure, which reduces blood perfusion to brain, resulting in disorientation, confusion, and unconsciousness.*

Monitor and record heart rate and rhythm, blood pressure, and respiratory rate at least every 4 hours. *Blood pressure and pulse decrease in hypothermia. During rewarming, patient may develop hypovolemic shock. During warming, ventricular fibrillation and cardiac arrest may occur, possibly signaled by irregular pulse.*

Perform: Provide supportive measures, such as placing patient in warm bed and covering with warm blankets, removing wet or constrictive clothing, and covering metal or plastic surfaces that contact patient's body. *These measures protect patient from heat loss.*

Follow prescribed treatment regimen for hypothermia: As ordered, administer medications *to prevent shivering to avoid overheating.* Monitor and record effectiveness. As ordered, administer analgesic *to relieve pain associated with warming.* Monitor and record effectiveness.

Use hyperthermia blanket, as ordered, *to warm patient* if temperature drops below 95° F (35° C). Warm patient to 97° F (36.1° C).

As appropriate, administer fluids during rewarming *to prevent hypovolemic shock.* If administering large volumes of intravenous fluids, consider using a fluid warmer to avoid heat loss.

Inform: Discuss precipitating factors with patient, if indicated. *Patient may require community outreach assistance with certain precipitating factors, including inadequate living conditions, insufficient finances, and abuse of medications (such as sedatives and alcohol).*

Instruct patient on precautionary measures to avoid hypothermia, such as dressing warmly even when indoors, eating proper diet, and remaining as active as possible. *Precautions help to prevent accidental hypothermia.*

Manage: Report lack of responses to interventions to physician *to prevent complications.*

SUGGESTED NIC INTERVENTIONS

Comfort Level; Fluid Management; Hypothermia Treatment; Temperature Regulation; Vital Signs Monitoring

REFERENCES

Singh, T., & Hallows, K. R. (2014). Hemodialysis for the treatment of severe accidental hypothermia. *Seminars in Dialysis*, *27*(3), 295–297. doi:10.1111/sdi.12156

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250 RISK FOR HYPOTHERMIA

DEFINITION

Vulnerable to a failure of thermoregulation that may result in a core body temperature below the normal diurnal range, which may compromise health

RISK FACTORS

- Alcohol consumption
- Damage to hypothalamus
- Economically disadvantaged
- Extremes of age
- Extremes of weight
- Heat transfer (e.g., conduction, convection, evaporation, radiation)
- Inactivity
- Insufficient caregiver knowledge of hypothermia prevention
- Insufficient clothing
- Insufficient supply of subcutaneous fat
- Low environmental temperature
- Malnutrition
- Pharmaceutical agent
- Radiation
- Trauma

Children and Adults: Accidental

- Mild hypothermia, core temperature approaching 35° C
- Moderate hypothermia, core temperature approaching 32° C
- Severe hypothermia, core temperature approaching 30° C

Children and Adults: Injured Patients

- Hypothermia, core temperature approaching 35° C
- Severe hypothermia, core temperature approaching 32° C

Neonates

- Decrease in metabolic rate
- Delay in breast-feeding
- Early bathing of newborn
- Grade 1 hypothermia, core temperature approaching 36.5° C
- Grade 2 hypothermia, core temperature approaching 36.0° C
- Grade 3 hypothermia, core temperature approaching 35.0° C
- Grade 4 hypothermia, core temperature approaching 34.0° C
- High-risk out-of-hospital birth
- Immature stratum corneum
- Increased body surface area to weight ratio
- Increase in oxygen demand
- Increase in pulmonary vascular resistance (PVR)
- Ineffective vascular control
- Inefficient nonshivering thermogenesis
- Unplanned out-of-hospital birth

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Fluid and electrolytes
- Pharmacologic function
- Physical regulation
- Neurocognition
- Respiratory function
- Tissue integrity

EXPECTED OUTCOMES

- The patient will maintain body temperature within normal range.
- The patient will have warm and dry skin.
- The patient will maintain heart rate and blood pressure within normal range.
- The patient will express feelings of comfort.
- The patient will state an understanding of how to prevent episodes of hypothermia.

SUGGESTED NOC OUTCOMES

Neurological Status: Autonomic; Thermoregulation; Vital Signs; Risk Control: Hypothermia

INTERVENTIONS AND RATIONALES

Determine: Monitor body temperature at least every 4 hours or more frequently, if indicated, *to evaluate effectiveness of interventions.*

Record temperature and route *to allow accurate data comparison.* Baseline temperatures vary, depending on route used. If temperature drops below 95° F (35° C), use a low-reading thermometer *to obtain accurate reading.*

Monitor and record neurologic status at least every 4 hours. *Falling body temperature and metabolic rate reduce pulse rate and blood pressure, which reduces blood perfusion to brain, resulting in disorientation, confusion, and unconsciousness.*

Monitor and record heart rate and rhythm, blood pressure, and respiratory rate at least every 4 hours. *Blood pressure and pulse decrease in hypothermia. During rewarming, patient may develop hypovolemic shock. During warming, ventricular fibrillation and cardiac arrest may occur, possibly signaled by irregular pulse.*

Perform: Provide supportive measures, such as placing patient in warm bed and covering with warm blankets, removing wet or constrictive clothing, and covering metal or plastic surfaces that contact patient's body. *These measures protect patient from heat loss.*

Use hyperthermia blanket, as ordered, *to warm patient* if temperature drops below 95° F (35° C). Warm patient to 97° F (36.1° C).

As appropriate, administer fluids during rewarming *to prevent hypovolemic shock*. If administering large volumes of intravenous fluids, consider using a fluid warmer to avoid heat loss.

Inform: Discuss precipitating factors with patient, if indicated. *Patient may require community outreach assistance with certain precipitating factors, including inadequate living conditions, insufficient finances, and abuse of medications (such as sedatives and alcohol).*

Instruct patient in precautionary measures to avoid hypothermia, such as dressing warmly even when indoors, eating proper diet, and remaining as active as possible. *Precautions help to prevent accidental hypothermia.*

Manage: Report lack of responses to interventions to physician *to prevent complications.*

SUGGESTED NIC INTERVENTIONS

Comfort Level; Fluid Management; Hypothermia Treatment; Temperature Regulation; Vital Signs Monitoring

REFERENCES

Singh, T., & Hallows, K. R. (2014). Hemodialysis for the treatment of severe accidental hypothermia. *Seminars in Dialysis*, *27*(3), 295–297. doi:10.1111/sdi.12156

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DEFINITION

Vulnerable to an inadvertent drop in core body temperature below 36° C/96.8° F occurring 1 hour before to 24 hours after surgery, which may compromise health

RISK FACTORS

- American Society of Anesthesiologists (ASA) Physical Status classification score >I
- Cardiovascular complications
- Combined regional and general anesthesia
- Diabetic neuropathy
- Heat transfer (e.g., high volume of unwarmed infusion, unwarmed irrigation >20 L)
- Low body weight
- Low environmental temperature
- Low preoperative temperature (<36° C/96.8° F)
- Surgical procedure

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Fluid and electrolytes
- Pharmacologic function
- Physical regulation
- Neurocognition
- Respiratory function
- Tissue integrity

EXPECTED OUTCOMES

- The patient will maintain body temperature within normal range.
- The patient will have warm and dry skin.
- The patient will maintain heart rate and blood pressure within normal range.

SUGGESTED NOC OUTCOMES

Neurological Status: Autonomic; Thermoregulation; Vital Signs; Risk Control: Hypothermia

INTERVENTIONS AND RATIONALES

Determine: Measure patient's temperature 1 to 2 hours before start of anesthesia and either continuously or every 15 minutes during surgery, and every hour post-surgery. *Monitor for higher risk for hypothermia.*

Record temperature and route *to allow accurate data comparison.* Baseline temperatures vary, depending on route used. If temperature drops below 95° F (35° C), use a low-reading thermometer *to obtain accurate reading.*

Monitor and record heart rate and rhythm, blood pressure, and respiratory rate at least every 4 hours. *Blood pressure and pulse decrease in hypothermia. During rewarming, patient may develop hypovolemic shock. During warming, ventricular fibrillation and cardiac arrest may occur, possibly signaled by irregular pulse.*

Perform: Provide supportive measures, such as placing patient in warm bed and covering with warm blankets, removing wet or constrictive clothing, and covering metal or plastic surfaces that contact patient's body. *These measures protect patient from heat loss.*

Follow prescribed treatment regimen for hypothermia: As ordered, administer medications *to prevent* shivering *to avoid overheating*. Monitor and record effectiveness. As ordered, administer analgesic *to relieve pain associated with warming*. Monitor and record effectiveness.

Use hyperthermia blanket, as ordered, *to warm patient* if temperature drops below 95° F (35° C). Warm patient to 97° F (36.1° C).

As appropriate, administer fluids during rewarming *to prevent hypovolemic shock*. If administering large volumes of intravenous fluids, consider using a fluid warmer to avoid heat loss.

Inform: Discuss precipitating factors with patient, if indicated. *Patient may require community outreach assistance with certain precipitating factors, including inadequate living conditions, insufficient finances, and abuse of medications (such as sedatives and alcohol).*

Manage: Report lack of responses to interventions to physician *to prevent complications.*

SUGGESTED NIC INTERVENTIONS

Comfort Level; Fluid Management; Hypothermia Treatment; Temperature Regulation; Vital Signs Monitoring

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DEFINITION

A pattern of performing rapid, unplanned reactions to internal or external stimuli without regard for the negative consequences of these reactions to the impulsive individual or to others

DEFINING CHARACTERISTICS

- Acting without thinking
- Asking personal questions despite discomfort of others
- Gambling addiction
- Inability to save money or regulate finances
- Inappropriate sharing of personal details
- Irritability
- Overly familiar with strangers
- Sensation seeking
- Sexual promiscuity
- Temper outburst
- Violent behavior

RELATED FACTORS

- Alteration in cognitive functioning
- Alteration in development
- Hopelessness
- Mood disorder
- Organic brain disorder
- Personality disorder
- Smoking
- Substance abuse

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication
- Coping
- Emotional
- Pharmacologic function
- Risk management

EXPECTED OUTCOMES

- The patient will identify triggers that lead to self-destructive actions.
- The patient will identify appropriate coping mechanisms to prevent self-harm and minimize engaging in impulsive behaviors.
- The patient will identify strategies that will aid in maintaining positive relationships.
- The patient will report any thoughts of harming self or others to staff.
- The patient will work with staff in planning ongoing treatment.

SUGGESTED NOC OUTCOMES

Aggression Control; Anxiety Control; Coping; Impulse Control; Self-Esteem; Self-Mutilation Restraint; Social Interaction Skills

INTERVENTIONS AND RATIONALES

Determine: Assess patient for thoughts of suicide, homicide, or self-mutilation. *Findings may require immediate safety precautions and psychological support.*

Assess for history of previous or current medical conditions and any pharmacologic side effects that may be contributing to current symptoms *as brain trauma, organic brain disorders, or medications can present with impulse control symptoms.*

Perform: Decrease environmental stimuli if patient is feeling unsafe. *A quiet and nonstimulating environment will assist in decreasing level of anxiety.*

Assist the patient in identifying stressors that lead to inappropriate or harmful impulsive behaviors *as the patient is usually unaware of impulsive behaviors and will require assistance in identifying them.*

Inform: Educate the patient regarding cognitive therapies that can be used *to reinforce appropriate coping and social skills.*

Attend: Dedicate quality time to patient in a therapeutic and consistent manner *to help patient feel safe and allow an open and trusting relationship to develop.*

Encourage patient to attend milieu therapies. *Milieu therapies will offer the patient an opportunity to share feelings and learn/practice new coping and social skills with peers.*

Manage: Refer patient for treatment, which may include but is not limited to medication management, individual therapy sessions, peer support groups, and crisis center contacts *to ensure continuation of treatment.*

SUGGESTED NIC INTERVENTIONS

Anger Control Assistance; Anxiety Reduction; Cognitive Restructuring; Coping Enhancement; Impulse Control Training; Support Group

REFERENCES

Amirkhan, J. H., Urizar, G. G., & Clark, S. (2015). Criterion validation of a stress measure: The stress overload scale. *Psychological Assessment*, *27*(3), 985–996. doi:10.1037/pas0000081

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DEFINITION

Change in normal bowel habits characterized by involuntary passage of stool

DEFINING CHARACTERISTICS

- Bowel urgency
- Constant passage of soft stool
- Does not recognize urge to defecate
- Fecal odor
- Fecal staining of bedding
- Fecal staining of clothing
- Inability to delay defecation
- Inability to expel formed stool despite recognition of rectal fullness
- Inability to recognize rectal fullness
- Inattentive to urge to defecate
- Reddened perianal skin

RELATED FACTORS

- Abnormal increase in abdominal pressure
- Abnormal increase in intestinal pressure
- Alteration in cognitive functioning
- Chronic diarrhea
- Colorectal lesion
- Deficient dietary habits
- Difficulty with toileting self-care
- Dysfunctional rectal sphincter
- Environmental factor (e.g., inaccessible bathroom)
- Generalized decline in muscle tone
- Immobility
- Impaction
- Impaired reservoir capacity
- Incomplete emptying of bowel
- Laxative abuse
- Lower motor nerve damage
- Pharmaceutical agent
- Rectal sphincter abnormality
- Stressors
- Upper motor nerve damage

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Fluid and electrolytes
- Elimination
- Neurocognition

EXPECTED OUTCOMES

- The patient will experience a bowel movement every ___ day(s) when placed on commode or toilet at ___ a.m./p.m.
- The patient will maintain clean and intact skin.
- The patient will have improved control of incontinent episodes.
- The patient will state understanding of bowel routine.
- The patient will demonstrate skill in using commode.
- The patient will demonstrate skill in the use of suppository if indicated.
- The patient will express an understanding of the relationship between food and fluid regulation and the promotion of continence.
- The patient will maintain self-respect and dignity through participation and acceptance within group.

SUGGESTED NOC OUTCOMES

Bowel Continence; Bowel Elimination; Self-Care: Toileting

INTERVENTIONS AND RATIONALES

Determine: Establish a regular pattern for bowel care; for example, after breakfast every other day, place patient on the commode chair 1 hour, allow patient to remain upright for 30 minutes for maximum response, and then clean the anal area. *Procedure encourages adaptation and routine physiologic function.*

Monitor and record incontinent episodes; keep baseline record for 3 to 7 days *to track effectiveness of toileting routine.*

Perform: Clean and dry perianal area after each incontinent episode *to prevent infection and promote comfort.*

Inform: Demonstrate bowel care routine to family or caregiver *to reduce anxiety from lack of knowledge or involvement in care.*

Arrange for return demonstration of bowel care routine *to help establish therapeutic relationship with patient and family or caregiver.*

Establish a date when family or caregiver will carry out bowel care routine with supportive assistance; *this will ensure that patient receives dependable care.*

Discuss bowel care routine with family or caregiver *to foster compliance.*

Instruct family or caregiver on need to regulate foods and fluids that cause diarrhea or constipation, *to encourage helpful nutritional habits.*

Attend: Maintain patient's dignity by using protective padding under clothing, by removing patient from group activity after incontinent episode, and by cleaning and returning patient to the group without undue attention. *These measures prevent odor, skin breakdown, and embarrassment and promote patient's positive self-image.*

Manage: Maintain diet log *to identify irritating foods,* and then eliminate them from patient's diet.

SUGGESTED NIC INTERVENTIONS

Bowel Incontinence Care; Bowel Management; Perineal Care; Skin Surveillance

REFERENCES

Collins, E., Hibberts, F., Lyons, M., Williams, A. B., & Schizas, A. P. (2014). Outcomes in non-surgical management for bowel dysfunction. *British Journal of Nursing, 23*(14), 776–780. doi:10.12968/bjon.2014.23.14.776

Flanagan, L., Roe, B., Jack, B., Shaw, C., Williams, K. S., Chung, A., & Barrett, J. (2014). Factors with the management of incontinence and promotion of continence in older people in care homes. *Journal of Advanced Nursing, 70*(3), 476–496. doi:10.1111/jan.12220

Peart, J., & Richardson, A. (2015). Developing a critical care bowel management assessment tool to manage fecal incontinence. *Nursing in Critical Care, 20*(1), 34–40. doi:10.1111/nicc.12101

260 FUNCTIONAL URINARY INCONTINENCE

DEFINITION

Inability of a usually continent person to reach the toilet in time to avoid unintentional loss of urine

DEFINING CHARACTERISTICS

- Completely empties bladder
- Early morning urinary incontinence
- Sensation of need to void
- Time between sensation of urge and ability to reach toilet is too short
- Voiding prior to reaching toilet

RELATED FACTORS

- Alteration in cognitive functioning
- Alteration in environmental factor
- Impaired vision
- Neuromuscular impairment
- Psychological disorder
- Weakened supporting pelvic structure

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Behavior
- Elimination
- Fluid and electrolytes
- Physical regulation
- Self-care

EXPECTED OUTCOMES

- The patient will void at appropriate intervals.
- The patient will have minimal, if any, complications.
- The patient will demonstrate skill in managing incontinence.
- The patient will discuss impact of incontinence on self and family members.
- The patient will identify resources to assist with care following discharge.

SUGGESTED NOC OUTCOMES

Coordinated Movement; Self-Care: Toileting; Symptom Control; Urinary Continence; Urinary Elimination

INTERVENTIONS AND RATIONALES

Determine: Monitor and record patient's voiding patterns *to ensure correct fluid replacement therapy*.

Perform: Stimulate patient's voiding reflexes (give patient drink of water while on toilet, stroke area over bladder, or pour water over perineum) to *trigger bladder's spastic reflex*. Provide hyperactive patient with distraction, such as a magazine, *to occupy attention while on toilet, reduce anxiety, and ease voiding*.

Maintain adequate hydration up to 3,000 mL daily, unless contraindicated. *Scheduling fluid intake promotes regular bladder distension and optimal time intervals between voidings.* Limit fluid intake to 150 mL after dinner *to reduce need to void at night.*

Assist with specific bladder elimination procedures, such as the following: **bladder training**—this involves muscle-strengthening exercises, adequate fluid intake, and carefully scheduled voiding times (encourage voiding every 2 hours while awake and once during night); **rigid toilet regimen**—place patient on toilet at specific intervals (every 2 hours or after meals) and note whether voiding occurred at each interval (*this helps patient adapt to routine physiologic function*); **behavior modification**—refrain from punishing unwanted behavior (e.g., voiding in wrong place), and reinforce positive behavior using social or material rewards (*this helps patient learn alternatives to maladaptive behaviors*); **use of external catheter**—apply according to established procedure and maintain patency, observe condition of perineal skin, and clean with soap and water at least twice daily (*this ensures effective therapy and prevents infection and skin breakdown*); **application of protective pads and garments**—use only when interventions have failed to prevent infection and skin breakdown, and allow at least 4 to 6 weeks for trial period (*establishing continence requires prolonged effort*).

Maintain continence based on patient's voiding patterns and limitations. Respond to call light promptly *to avoid delays in voiding routine.*

Orient patient to toileting environment: time, place, and activity *to offer security.* Provide privacy and adequate time to void *to allow patient to void easily without anxiety.*

Replace wet clothes immediately. Select clothing that promotes easy dressing and undressing (e.g., Velcro fasteners and gowns) *to reduce patient's frustration with voiding routine.*

Inform: Teach family members and support personnel *to reduce anxiety that results from noninvolvement.* Instruct patient and family members on continence techniques to use at home *to increase chances of successful bladder retraining.*

Attend: Encourage patient and family members to share feelings related to incontinence. This allows specific problems to be identified and resolved. *Attentive listening conveys recognition and respect.*

Manage: Refer patient/family to home health care agency or support group *to provide access to additional community resources.*

SUGGESTED NIC INTERVENTIONS

Pelvic Muscle Exercise; Prompted Voiding; Self-Care Assistance; Urinary Elimination Management; Urinary Habit Training; Urinary Incontinence Care

REFERENCES

Block, V., Rivera, M., Melnick, M., & Allen, D. D. (2015). Do physical therapy interventions affect urinary incontinence and quality of life in people with multiple sclerosis? *International Journal of MS Care*, *17*(4), 172–180. doi:10.7224/1537-2073.2014-031

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Gosch, M., Talasz, H., Nicholas, J. A., Kammerlander, C., & Lechleitner, M. (2015). Urinary incontinence and poor functional status in fragility fracture patients: An under recognized and underappreciated association. *Archives of Orthopaedic & Trauma Surgery*, *135*(1), 59–67. doi:10.1007/s00402-014-2113-6

DEFINITION

Involuntary loss of urine associated with overdistension of the bladder

DEFINING CHARACTERISTICS

- Bladder distension
- High postvoid residual volume
- Involuntary leakage of small volumes of urine
- Nocturia

RELATED FACTORS

- Bladder outlet obstruction
- Detrusor external sphincter dyssynergia
- Detrusor hypocontractility
- Fecal impaction
- Severe pelvic prolapse
- Treatment regimen
- Urethral obstruction

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Behavior
- Elimination
- Fluid and electrolytes
- Physical regulation
- Self-care

EXPECTED OUTCOMES

- The patient will void 200 to 300 mL of clear, yellow urine every 3 to 4 hours while awake.
- The patient will have postvoid residual of less than 50 mL.
- The patient will have reduction in urinary incontinence episodes or complete absence of urinary incontinence.
- The patient will experience relief of most bothersome aspect of urinary incontinence.
- The patient will remain clean and dry without urine odor.
- The patient will express understanding of condition and activities to prevent/reduce overflow incontinence.
- The patient will express improvement in quality of life.

SUGGESTED NOC OUTCOMES

Knowledge: Treatment Regimen; Urinary Continence; Urinary Elimination

INTERVENTIONS AND RATIONALES

Determine: Monitor and record patient's voiding patterns *to determine existence and extent of overflow incontinence.*

Monitor and record patient's intake and output *to determine fluid balance.*

Perform: Ask patient to keep a bladder diary of continent and incontinent voids *to promote understanding of the extent of the problem of overflow incontinence.* Discuss voiding and fluid intake patterns. *Accurate understanding of patient's pattern provides a baseline for introducing new activities.*

Provide privacy and adequate time to void *to decrease anxiety and promote relaxation of sphincter.*

Assist patient to assume usual position for voiding. *Some patients are unable to void while lying in bed and may develop urinary retention and overflow incontinence.*

Massage (credé) the bladder area during urination *to increase pressure in the pelvic area to encourage drainage of urine from the bladder.*

Institute indwelling or intermittent catheterization, as ordered. Catheterization is used as a last resort *to empty the bladder, preventing overflow incontinence.*

Assist with application of pads and protective garments (used only as a last resort) *to prevent skin breakdown and odor and to promote social acceptance.*

Inform: Teach patient and/or family to catheterize patient with chronic overflow incontinence related to urinary retention using clean technique *to manage long-term overflow incontinence.*

Teach stress management and relaxation techniques. *Stress and anxiety interfere with sphincter relaxation, causing urinary* retention *and overflow incontinence.*

Attend: Encourage patient to share feelings related to incontinence *to reduce anxiety.*

Encourage patient to drink six to eight glasses of noncaffeinated, nonalcoholic, and noncarbonated liquid, preferably water, per day (unless contraindicated). *An intake of 1,500 to 2,000 mL/day promotes optimal renal function and flushes bacteria and solutes from the urinary tract. Caffeine and alcohol promote diuresis and may contribute to excess fluid loss and irritation of the bladder wall.*

Encourage patient to respond to the urge to void in a timely manner. *Ignoring the urge to urinate may cause incontinence.*

Encourage patient to participate in regular exercise, including walking and modified sit-ups (unless contraindicated). *Weak abdominal and perineal muscles weaken bladder and sphincter control.*

Encourage patient to avoid anticholinergics, opioids, psychotropics, α-adrenergic agonists, β-adrenergic agonists, and calcium channel blockers (unless contraindicated), *which inhibit relaxation of the urinary sphincter and cause urinary retention.*

Manage: Provide referrals for physical therapy or psychological counseling, as necessary, *to enhance success*.

SUGGESTED NIC INTERVENTIONS

Urinary Incontinence Care; Urinary Retention Care; Urinary Elimination Management; Tube Care: Urinary; Teaching: Prescribed Activity/Exercise

REFERENCES

Fawcett, J. (2014). Effective management in male urinary incontinence. *British Journal of Community Nursing*, *19*(7), 318–321. doi:10.12968/bjcn.2014.19.7.318

Parker, W. P., & Griebling, T. L. (2015). Nonsurgical treatment of urinary incontinence in elderly women. *Clinics in Geriatric Medicine*, *31*(4), 471–485. doi:10.1016/j.cger.2015.07.003

Stanley, A. Y., & Conner, B. T. (2015). Implementing a clinical practice guideline to manage postpartum urinary retention. *Journal of Nursing Care Quality*, *30*(2), 175–180. doi:10.1097/NCQ.0000000000000087

DEFINITION

Involuntary loss of urine at somewhat predictable intervals when a specific bladder volume is reached

DEFINING CHARACTERISTICS

- Absence of sensation of bladder fullness
- Absence of urge to void
- Absence of voiding sensation
- Inability to voluntarily inhibit voiding
- Inability to voluntarily initiate voiding
- Incomplete emptying of bladder with lesion above pontine micturition center
- Predictable pattern of voiding
- Sensation of bladder fullness
- Sensations of urgency to void without voluntary inhibition of bladder contraction

RELATED FACTORS

- Neurologic impairment above level of pontine or sacral micturition center
- Neurologic impairment above level of sacral micturition center
- Tissue damage

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Behavior
- Elimination
- Fluid and electrolytes
- Physical regulation
- Self-care

EXPECTED OUTCOMES

- The patient will maintain fluid balance, with intake approximately equaling output.
- The patient will have minimal, if any, complications.
- The patient will achieve urinary continence.
- The patient will demonstrate skill in managing urinary incontinence.
- The patient will discuss impact of incontinence on patient and family.
- The patient will identify resources to assist with care following discharge.

SUGGESTED NOC OUTCOMES

Knowledge: Treatment Regimen; Nutritional Status: Food & Fluid Intake; Tissue Integrity: Skin & Mucous Membranes; Urinary Continence; Urinary Elimination

INTERVENTIONS AND RATIONALES

Determine: Monitor intake and output *to ensure correct fluid replacement therapy*. Report output greater than intake.

Perform: Implement and monitor effectiveness of specific bladder elimination procedure, such as the following:

- Stimulate reflex arc. Patient who voids at somewhat predictable intervals may be able to regulate voiding by reflex arc stimulation. Trigger voiding at regular intervals (e.g., every 2 hours) by stimulating skin of abdomen, thighs, or genitals to initiate bladder contractions. Avoid stimulation at nonvoiding times. Stimulate primitive voiding reflexes by giving patient water to drink while the patient sits on toilet or pouring water over perineum. External stimulation triggers bladder's spastic reflex.
- Apply external catheter according to established procedure and maintaining patency. Observe condition of perineal skin and clean with soap and water at least twice daily. Cleanliness prevents skin breakdown and infection. External catheter protects surrounding skin, promotes accurate output measurement, and keeps patient dry. Applying foam strip in spiral fashion increases adhesive surface and cuts risk of impaired circulation.
- Insert indwelling catheter. Monitor patency and keep tubing free from kinks to avoid drainage pooling and ensure accurate therapy. Keep drainage bag below level of bladder to avoid urine reflux into bladder. Perform catheter care according to established procedure. Maintain closed drainage system to prevent bacteriuria. Secure catheter to leg (female) or abdomen (male) to avoid tension on bladder and sphincter.
- Apply suprapubic catheter. Change dressing according to established procedure to avoid skin breakdown. Monitor patency and keep tubing free from kinks to avoid drainage pooling in loops of catheter. Keep drainage bag below bladder level to avoid urine reflux into bladder. Maintain closed drainage system to prevent bacteriuria.
- Change wet clothes to prevent patient from becoming accustomed to wet clothes.

Inform: Instruct patient and family members on continence techniques to use at home. Have patient and family members do return demonstrations until they can perform procedure well. *Patient education begins with assessment and depends on nurse's therapeutic relationship with patient and family.*

Attend: Encourage high fluid intake (3,000 mL daily, unless contraindicated) *to stimulate micturition reflex*. Limit fluid intake after 7 p.m. *to prevent nocturia.*

Encourage patient and family members to share feelings and concerns regarding incontinence. *A trusting environment allows nurse to make specific recommendations to resolve patient's problems.*

Manage: Refer patient and family members to psychiatric liaison nurse, home health care agency, support group, or other resources, as appropriate. *Community resources typically provide health care not available from other health care agencies.*

SUGGESTED NIC INTERVENTIONS

Pelvic Muscle Exercise; Urinary Bladder Training; Urinary Elimination Management; Urinary Incontinence Care; Urinary Catheterization; Urinary Catheterization: Intermittent

REFERENCES

Rasmussen, M. M., Krogh, K., Clemmensen, D., Tankisi, H., Fuglsang-Frederiksen, A., Rawashdeh, Y., . . . Christensen, P. (2015). The artificial somato-autonomic reflex arch does not improve bowel function in subjects with spinal cord injury. *Spinal Cord*, *53*(9), 705–710. doi:10.1038/sc.2015.75

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Woodward, S. (2014). Managing urinary incontinence after stroke. *British Journal of Neuroscience Nursing*, *10*, 25–31.

DEFINITION

Sudden leakage of urine with activities that increase intra-abdominal pressure

DEFINING CHARACTERISTICS

- Involuntary leakage of small volume of urine (e.g., with coughing, laughing, sneezing, on exertion)
- Involuntary leakage of small volume of urine in the absence of detrusor contraction
- Involuntary leakage of small volume of urine in the absence of overdistended bladder

RELATED FACTORS

- Degenerative changes in pelvic muscles
- Increase in intra-abdominal pressure
- Intrinsic urethral sphincter deficiency
- Weak pelvic muscles

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Behavior
- Elimination
- Fluid and electrolytes
- Physical regulation
- Self-care

EXPECTED OUTCOMES

- The patient will maintain continence.
- The patient will state increased comfort.
- The patient will state understanding of treatment.
- The patient will state understanding of surgical procedure.
- The patient will demonstrate skill in managing urinary elimination problems.
- The patient will identify resources to assist with care following discharge.

SUGGESTED NOC OUTCOMES

Tissue Integrity: Skin & Mucous Membranes; Urinary Continence; Urinary Elimination

INTERVENTIONS AND RATIONALES

Determine: Observe patient's voiding patterns, time of voiding, amount voided, and whether voiding is provoked by stimuli. *Accurate, thorough assessment forms basis of an effective treatment plan.*

Perform: Provide appropriate care for patient's urologic condition, monitor progress, and report patient's responses to treatment. Patient expects to receive adequate care and *to participate in decisions regarding care.*

Help patient to strengthen pelvic floor muscles by Kegel exercises for sphincter control. *Exercises increase muscle tone and restore cortical control.*

Promote patient's awareness of condition through education *to help patient understand illness as well as treatment.*

Help patient reduce intra-abdominal pressure by losing weight, avoiding heavy lifting, and avoiding chairs or beds that are too high or too low. *These measures reduce intra-abdominal pressure and bladder pressure.*

Provide supportive measures as follows:

- Respond to call bell quickly, assign patient bed next to bathroom, put night-light in bathroom, and have patient wear easily removable clothing (gown rather than pajamas and Velcro fasteners rather than buttons or zippers). Early recognition of problems promotes continence; easily removable clothing reduces patient frustration and helps achieve continence.
- Provide privacy during toileting to reduce anxiety and promote elimination.
- Have patient empty bladder before meals, at bedtime, and before leaving accessible bathroom area to promote elimination, avoid accidents, and help relieve intra-abdominal pressure.
- Limit fluids to 150 mL after dinner to reduce need to void at night.
- Encourage high fluid intake, unless contraindicated, to moisten mucous membranes and maintain hydration.
- Suggest patient eat increased amount of salty food before going on a long trip (unless contraindicated). Increased sodium decreases urine production.
- Make protective pads available for patient's undergarments, if needed, to absorb urine, protect skin, and control odors.

If surgery is scheduled, give attentive, appropriate preoperative and postoperative instructions and care *to reduce patient's anxiety and build trust in caregivers.*

Inform: Alert patient and family members about need for toilet schedule. Prepare for discharge according to individual needs *to ensure that patient will receive proper care.*

Attend: Encourage patient to express feelings and concerns related to urologic problems. *This helps patient focus on specific problem.*

Manage: Refer patient and family members to psychiatric liaison nurse, support group, or other resources, as appropriate. *Community resources typically provide health care not available from other health care agencies.*

SUGGESTED NIC INTERVENTIONS

Pelvic Muscle Exercise; Teaching: Individual; Urinary Elimination Management; Urinary Habit Training; Urinary Incontinence Care

REFERENCES

Knarr, J., Musil, C., Warner, C., Kless, J. R., & Long, J. (2014). Female stress urinary incontinence: An evidence-based, case study approach. *Urologic Nursing*, *34*(3), 143–151. doi:10.7257/1053-816X.2014.34.3.143

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DEFINITION

Involuntary passage of urine occurring soon after a strong sense of urgency to void

DEFINING CHARACTERISTICS

- Inability to reach toilet in time to avoid urine loss
- Involuntary loss of urine with bladder contractions
- Involuntary loss of urine with bladder spasms
- Urinary urgency

RELATED FACTORS

- Alcohol consumption
- Atrophic urethritis
- Atrophic vaginitis
- Bladder infection
- Caffeine intake
- Decrease in bladder capacity
- Detrusor hyperactivity with impaired bladder contractility
- Fecal impaction
- Treatment regimen

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Behavior
- Elimination
- Fluid and electrolytes
- Physical regulation
- Self-care

EXPECTED OUTCOMES

- The patient will have fewer episodes of incontinence.
- The patient will state increased comfort.
- The patient will state understanding of treatment.
- The patient will have minimal, if any, complications.
- The patient will discuss impact of disorder on patient and family members.
- The patient will demonstrate skill in managing incontinence.

SUGGESTED NOC OUTCOMES

Tissue Integrity: Skin & Mucous Membranes; Urinary Continence; Urinary Elimination

INTERVENTIONS AND RATIONALES

Determine: Observe voiding pattern; document intake and output. *This ensures correct fluid replacement therapy and provides information about patient's ability to void adequately.*

Perform: Provide appropriate care for patient's urologic condition, monitor progress, and report patient's responses to treatment. *Patient should receive adequate care and take part in decisions about care as much as possible.*

Assist with specific bladder elimination procedures, such as the following: **bladder training**—place patient on commode every 2 hours while awake and once during night, provide privacy, and gradually increase intervals between toileting (*these measures aim to restore a regular voiding pattern*); as well as **rigid toilet regimen**—place patient on toilet at specific times (*to aid adaptation to routine physiologic function*), *and* keep baseline micturition record for 3 to 7 days (*to monitor toileting effectiveness*).

Administer pain medication; discuss effectiveness with patient *to reinforce that pain can be alleviated, which reduces tension and anxiety.*

Place commode next to bed, or assign patient bed next to bathroom. *A bedside commode or convenient bathroom requires less energy expenditure than bedpan.* If using commode, keep bed and commode at same level *to facilitate patient's movements.* If using bathroom, provide good lighting from bed to bathroom *to reduce sensory misinterpretation*; remove all obstacles between bed and bathroom *to reduce chance of falling.* Prepare pleasant toilet environment that is warm, clean, and free from odors, *to promote continence.*

Provide a clock *to help patient maintain voiding schedule through self-monitoring.*

Unless contraindicated, maintain fluids to 3,000 mL daily *to moisten mucous membranes and ensure hydration*; limit patient to 150 mL after dinner to reduce need to void at night.

Have patient wear easily removable clothes (gown instead of pajamas and Velcro fasteners instead of buttons or zippers) *to reduce frustration and delay in voiding routine.*

If patient loses control on the way to bathroom, instruct patient to stop and take a deep breath. *Anxiety and rushing may strengthen bladder contractions.*

Inform: Explain urologic condition to patient and family members; include instructions on preventive measures and established bladder schedule. *Patient education begins with educational assessment and depends on establishing a therapeutic relationship with patient and family.* Prepare patient for discharge according to individual needs *to allow patient to practice under supervision.*

Instruct patient and family members on continence techniques to use at home. *This reduces fear and anxiety resulting from lack of knowledge of patient's condition and reassures patient of continuing care.*

Attend: Encourage patient to express feelings and concerns related to patient's urologic problem *to identify patient's fears.*

Manage: Refer patient and family members to psychiatric liaison nurse, support group, or other resources, as appropriate. *Community resources typically provide health care not available from other health care agencies.*

SUGGESTED NIC INTERVENTIONS

Fluid Monitoring; Perineal Care; Self-Care Assistance: Toileting; Urinary Elimination Management; Urinary Habit Training; Urinary Incontinence Care; Referral

REFERENCES

O'Connell, K. A., Torstrick, A., & Victor, E. (2014). Cues to urinary urgency and urge incontinence. *Journal of Wound, Ostomy & Continence Nursing*, *41*(3), 259–267. doi:10.1097/WON.0000000000000023

Reid, J. (2014). Managing urinary incontinence: Guidelines for community nurses. *Journal of Community Nursing*, *28*(6), 20–26.

Weatherall, M. (2014). Current thinking about overactive bladder symptoms and urge urinary incontinence. *Australian & New Zealand Continence Journal*, *20*(2), 32–33.

DEFINITION

Vulnerable to involuntary passage of urine occurring soon after a strong sensation of urgency to void, which may compromise health

RISK FACTORS

- Alcohol consumption
- Atrophic urethritis
- Atrophic vaginitis
- Detrusor hyperactivity with impaired bladder contractility
- Fecal impaction
- Impaired bladder contractility
- Ineffective toileting habits
- Involuntary sphincter relaxation
- Small bladder capacity
- Treatment regimen

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Behavior
- Elimination
- Fluid and electrolytes
- Physical regulation
- Self-care

EXPECTED OUTCOMES

- The patient will state ability to anticipate if incontinence is likely to occur.
- The patient will state understanding of potential causes of urge incontinence and its treatment.
- The patient will avoid or minimize complications of urge incontinence.
- The patient will discuss potential effects of urologic dysfunction on self and family members.
- The patient will demonstrate skills in managing incontinence.
- The patient will identify community resources to cope with alterations in urinary status.

SUGGESTED NOC OUTCOMES

Knowledge: Treatment Regimen; Urinary Continence; Urinary Elimination

INTERVENTIONS AND RATIONALES

Determine: Observe patient's voiding pattern and document intake and output *to ensure correct fluid replacement therapy and provide information about the patient's ability to void adequately.*

Determine patient's premorbid elimination status *to ensure that interventions are realistic and based on the patient's health status and goals.*

Assess patient's ability to sense and communicate elimination needs *to maximize self-care.*

Perform: Unless contraindicated, provide 2.5 to 3 L of fluid daily *to moisten mucous membranes and ensure adequate hydration.* Space out fluid intake through the day and limit it to 150 mL after supper *to reduce the need to void at night.*

Place commode next to bed, or assign patient bed next to bathroom. *A bedside commode or convenient bathroom requires less energy expenditure than bedpan.* If using commode, keep bed and commode at same level *to facilitate patient's movements.* If using bathroom, provide good lighting from bed to bathroom *to reduce sensory misinterpretation*; remove all obstacles between bed and bathroom *to reduce chance of falling.* Prepare pleasant toilet environment that is warm, clean, and free from odors, *to promote continence.*

Have patient wear easily removable articles of clothing (a gown instead of pajamas, Velcro fasteners instead of buttons or zippers) *to facilitate the removal of clothing and foster independence.*

Have patient keep a diary recording episodes of incontinence, *to use as a basis for planning bladder training interventions*; interventions may include voiding every 2 hours, avoiding high fluid intake, maintaining proper hygiene, or notifying a health care professional if urge incontinence occurs frequently. *Individualized interventions help promote self-care, foster motivation, and avoid incontinence.*

Incorporate patient's suggestions for managing incontinent episodes into a care plan *to foster motivation.*

Inform: Explain urge incontinence to patient and family members, especially preventive measures and potential underlying causes, *to foster compliance.*

Instruct patient to stop and take a deep breath if experiencing an intense urge to urinate before reaching a bathroom. *Anxiety and rushing may increase bladder contraction.*

Attend: Encourage patient to express feelings about incontinence, *to provide emotional support and identify needed areas for further patient teaching.*

Manage: Use an interdisciplinary approach to caring for incontinence. Incorporate recommendations from an urologist, urology nurse specialist, other health care providers, and the patient. Monitor progress and report the patient's response to interventions. *An interdisciplinary approach helps ensure that the patient receives adequate care. Encouraging patient participation on the team will help foster motivation.*

Note if patient expresses concern about the effect of incontinence on sexuality. If appropriate, refer the patient to a sex therapist *to promote sexual health.*

Refer patient and family members to community resources such as support groups, as appropriate, *to help ensure continuity of care.*

SUGGESTED NIC INTERVENTIONS

Fluid Monitoring; Urinary Elimination Management; Urinary Habit Training; Urinary Incontinence Care; Journaling; Urinary Bladder Training

REFERENCES

Amano, T., Earle, C., Imao, T., & Takemae, K. (2016). Are urge incontinence and aging risk factors of erectile dysfunction in patients with male lower urinary tract symptoms? *Aging Male*, *19*(1), 54–57. doi:10.3109/13685538.2015.1103219

Tenfelde, S., & Janusek, L. W. (2014). Yoga: A biobehavioral approach to reduce symptom distress in women with urge urinary incontinence. *Journal of Alternative & Complementary Medicine*, *20*(10), 737–742. doi:10.1089/acm.2013.0308

Testa, A. (2015). Understanding urinary incontinence in adults. *Urologic Nursing*, *35*(2), 82–86. doi:10.7257/1053-816X.2015.35.2.82

278 RISK FOR INFECTION

DEFINITION

Vulnerable to invasion and multiplication of pathogenic organisms, which may compromise health

RISK FACTORS

- Chronic illness (e.g., diabetes mellitus)
- Inadequate vaccination
- Insufficient knowledge to avoid exposure to pathogens
- Invasive procedure
- Malnutrition
- Obesity

Inadequate Primary Defenses

- Alteration in peristalsis
- Alteration in pH of secretions
- Alteration in skin integrity
- Decrease in ciliary action
- Premature rupture of amniotic membrane
- Prolonged rupture of amniotic membrane
- Smoking
- Stasis of body fluids

Inadequate Secondary Defenses

- Decrease in hemoglobin
- Immunosuppression
- Leukopenia
- Suppressed inflammatory response (e.g., IL-6, CRP)
- Inadequate vaccination

Increased Environmental Exposure to Pathogens

- Exposure to disease outbreak

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Fluid/electrolytes
- Neurocognition
- Risk management
- Sensation/perception

EXPECTED OUTCOMES

- The patient will have normal temperature, WBC count, and differential.
- The patient will maintain good personal and oral hygiene.
- The patient will have clear and odorless respiratory secretions.
- The patient will have normal urine and be free from evidence of diarrhea.
- The patient will exhibit wounds and incisions that show no signs of infection, and intravenous sites with no signs of inflammation.

- The patient will take ___ mL of fluid and ___ g of protein daily.
- The patient will identify infection risk factors and signs and symptoms of infection.

SUGGESTED NOC OUTCOMES

Immune Status; Infection Severity; Knowledge: Treatment Procedure(s) and Infection Management; Nutritional Status; Risk Control: Infectious Process; Risk Detection; Wound Healing: Primary and Secondary Intention

INTERVENTIONS AND RATIONALES

Determine: Monitor and record temperature after surgery at least every 4 hours; report elevations immediately, *as this may signal onset of pulmonary complications, wound infection or dehiscence, urinary tract infection, or thrombophlebitis.*

Monitor WBC count, as ordered. Report elevations or depressions. *Elevated total WBC count indicates infection. Markedly decreased WBC count may indicate decreased production resulting from extreme debilitation or severe lack of vitamins and amino acids. Any damage to bone marrow may suppress WBC formation.*

Monitor culture results of urine, respiratory secretions, wound drainage, or blood according to facility policy and physician's order. *This identifies pathogens and guides antibiotic therapy.*

Perform: Perform hand hygiene before and after providing care, and direct patient to do this before and after meals and after using bathroom, bedpan, or urinal, *to avoid spread of pathogens;* also, use strict sterile technique when handling dressings *to maintain asepsis.*

Offer frequent oral hygiene *to prevent colonization of bacteria and reduce risk of descending infection. Disease and malnutrition may reduce moisture in mucous membranes of mouth and lips.*

Change intravenous tubing and give site care every 24 to 48 hours or as facility policy dictates, *to help keep pathogens from entering body.* Rotate intravenous sites every 48 to 72 hours or as facility policy dictates, *to reduce chances of infection at individual sites.*

Have patient cough and deep-breathe every 4 hours after surgery *to help remove secretions and prevent pulmonary complications.* Provide tissues to *encourage expectoration* and convenient disposal bags for expectorated sputum *to reduce spread of infection.*

Help patient turn every 2 hours. Provide skin care, particularly over bony prominences, *to help prevent venous stasis and skin breakdown.*

Assist patient, when necessary, to ensure that perianal area is clean after elimination. *Cleaning perineal area by wiping from the area of least contamination (urinary meatus) to the area of most contamination (anus) helps prevent genitourinary infections.*

Use sterile water for humidification or nebulization of oxygen. *This prevents drying and irritation of respiratory mucosa, impaired ciliary action, and thickening of secretions within respiratory tract.*

Inform: Instruct patient to immediately report loose stools or diarrhea, *which may indicate need to discontinue or change antibiotic therapy, or to test for* Clostridium difficile.

Instruct patient about good hand hygiene, factors that increase infection risk, and signs and symptoms of infection *to encourage patient to participate in care and modify lifestyle to maintain optimum health.*

Attend: Unless contraindicated, encourage fluid intake of 3,000 to 4,000 mL daily *to help thin mucous secretions*, and offer high-protein supplements *to help stabilize weight, improve muscle tone and mass, and aid wound healing.*

Manage: Arrange for protective isolation if patient has compromised immune system. Monitor flow and number of visitors. *These measures protect patient from pathogens in environment.*

SUGGESTED NIC INTERVENTIONS

Incision Site Care; Infection Protection; Teaching: Procedure/Treatment; Wound Care; Surveillance

REFERENCES

Albert, N. M., Slifcak, E., Roach, J. D., Bena, J. F., Horvath, G., Wilson, S., . . . Murray, T. (2014). Infection rates in intensive care units by electrocadiographic lead wire type: Disposable vs reusable. *American Journal of Critical Care*, *23*(6), 460–468. doi:10.4037/ajcc2014362

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Spruce, L., & Wood, A. (2014). Back to basics: Environmental cleaning. *AORN Journal*, *100*(1), 54–64. doi:10.1016/j.aorn.2014.02.018

DEFINITION

Vulnerable to physical damage due to environmental conditions interacting with the individual's adaptive and defense resources, which may compromise health

RISK FACTORS

External

- Alteration in cognitive functioning
- Alteration in psychomotor functioning
- Compromised nutritional source (e.g., vitamins, food types)
- Exposure to pathogen
- Exposure to toxic chemical
- Immunization level within community
- Nosocomial agent
- Physical barrier (e.g., design, structure, arrangement of community, building, equipment)
- Unsafe mode of transport

Internal

- Abnormal blood profile
- Alteration in affective orientation
- Alteration in sensation (resulting from spinal cord injury, diabetes mellitus, etc.)
- Autoimmune dysfunction
- Effector dysfunction
- Extremes of age
- Immune dysfunction
- Impaired primary defense mechanisms (e.g., broken skin)
- Malnutrition
- Sensory integration dysfunction
- Tissue hypoxia

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Emotional
- Knowledge
- Risk management

EXPECTED OUTCOMES

- The patient will acknowledge presence of environmental hazards in patient's everyday surroundings.
- The patient will take safety precautions in and out of home.
- The patient will instruct children in safety habits.
- The patient will childproof house to ensure safety of young children and cognitively impaired adults.

SUGGESTED NOC OUTCOMES

Immune Status; Risk Control; Safety Home Environment; Personal Safety Behavior; Falls Occurrence; Falls Prevention Behavior; Physical Injury Severity; Risk Detection

INTERVENTIONS AND RATIONALES

Determine: Help patient identify situations and hazards that can cause accidents, *to increase patient's awareness of potential dangers.*

Perform: Arrange environment of patient with dementia *to minimize risk of injury:*

- Place furniture against walls.
- Avoid use of throw rugs.

Maintain lighting so that patient can find way around room and to bathroom. *Poor lighting is a major cause of falls.*

Prevent iatrogenic harm to hospitalized patient by following the 2007 National Patient Safety goals. *This resource provides comprehensive measures designed to prevent harm.*

Follow agency policy regarding the use of restraints—they are generally used as a last resort after other measures have failed. *Agency policies will provide clear direction to use restraints safely.*

Inform: Encourage adult patient to discuss safety rules with children *to foster household safety.* For example:

- Don't play with matches.
- Use electrical equipment carefully.
- Know location of the fire escape route.
- Don't speak to strangers.
- Dial 911 in an emergency.

Attend: Encourage patient to make repairs and remove potential safety hazards from environment *to decrease possibility of injury.*

Manage: Refer patient to appropriate community resources for more information about identifying and removing safety hazards. *This enables patient and family to alter environment to achieve optimal safety level.*

SUGGESTED NIC INTERVENTIONS

Environmental Management; Fall Prevention; Health Education; Parent Education: Adolescent; Parent Education: Childrearing Family; Risk Identification; Surveillance: Safety; Environmental Management: Home Preparation and Safety; Fire-Setting Precautions

REFERENCES

Murphy, M. P., Carmine, H., & Kolakowsky-Hayner, S. (2014). Modifiable and nonmodifiable risk factors for falls after traumatic brain injury: An exploratory investigation with implications for medication use. *Rehabilitation Nursing*, *39*(3), 113–122. doi:10.1002/rnj.89

Sherwood, G., & Zomorodi, M. (2014). A new mindset for quality and safety: The QSEN competencies redefine nurses' roles in practice. *Nephrology Nursing Journal*, *41*(1), 15–72.

Ulrich, B., & Kear, T. (2014). Patient safety and patient safety culture: Foundations of excellent health care delivery. *Nephrology Nursing Journal*, *41*(5), 447–457.

284 RISK FOR CORNEAL INJURY

DEFINITION

Vulnerable to infection of inflammatory lesion in the corneal tissue that can affect superficial or deep layers, which my compromise health

RISK FACTORS

- Blinking <5 times/minute
- Exposure of the eyeball
- Glasgow Coma Scale score <7
- Intubation
- Mechanical ventilation
- Periorbital edema
- Pharmaceutical agent
- Prolonged hospitalization
- Tracheostomy
- Use of supplemental oxygen

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Sensation/perception
- Risk management

EXPECTED OUTCOMES

- The patient will not develop dry eyes.
- The patient will not develop eye infection.
- The patient will not develop corneal abrasion or injury.

SUGGESTED NOC OUTCOMES

Risk Control; Risk Detection; Tissue Integrity: Skin/Mucous Membranes; Knowledge: Health Behavior

INTERVENTIONS AND RATIONALES

Determine: Assess the eyes with each head-to-toe assessment *to identify any changes as soon as they occur.*

Assess work, exercise, and lifestyle behaviors that may potentiate eye injury conditions, *to identify potential risk factors.*

Perform: Complete hand hygiene prior to performing eye care. *This reduces the potential for infection.*

Perform eye care as indicated by hospital policy or protocol *to keep eyes clean.*

When performing eye care, wipe eye from nasal edge and outward *to avoid whipping discharge into the lacrimal duct.*

When performing eye care, use a new sterile gauze for the second eye *to reduce the risk for infection.*

Implement prescribed treatments to protect the eyes such as prescribed eye drops or hydrogel dressings, *to maintain the moisture in the eyes.*

Inform: Educate client on prescribed eye care regimen *to alleviate fears.*

Teach about environmental modifications *to reduce risk of injury to eyes.*

Instruct patient on the use of safety goggles *to limit exposure to possible debris.*

Attend: Encourage annual eye exam *to monitor for any changes.*

Encourage adherence to lifestyle modifications, *which will improve quality of life and decrease the risk of eye damage*

Offer written treatment guidelines, as needed, *to reinforce learning.*

Manage: Refer to eye specialist if injury occurs, *for further evaluation and continued care.*

Collaborate with primary care provider regarding possible changes in medications *that may be contributing to eye irritation.*

SUGGESTED NIC INTERVENTIONS

Risk Management; Risk Identification; Behavior management

REFERENCES

Harmer, B. A. (2016). President's message. Sports eye safety month. *Insight: The Journal of the American Society of Ophthalmic Registered Nurses*, *41*(2), 3.

Jhun, P., Aguilera, P., Swaminathan, A., Bright, A., & Herbert, M. (2015). Use safety glasses, save an eye. . .enough said. *Annals of Emergency Medicine*, *65*(6), 637–639. doi:10.1016/j.annemergmed.2015.03.022

Tovar-Aguilar, J. A., Monaghan, P. F., Bryant, C. A., Esposito, A., Wade, M., Ruiz, O., & McDermott, R. J. (2014). Improving eye safety in citrus harvest crews through the acceptance of personal protective equipment, community-based participatory research, social marketing, and community health workers. *Journal of Agromedicine*, *19*(2), 107–116. doi:10.1080/1059924X.2014.884397

286 RISK FOR URINARY TRACT INJURY

DEFINITION

Vulnerable to damage of the urinary tract structures from use of catheters, which may compromise health

RISK FACTORS

- Condition preventing ability to secure catheter (e.g., burn, trauma, amputation)
- Long-term use of urinary catheter
- Multiple catheterizations
- Retention balloon inflated to ≥30 mL
- Use of large-caliber urinary catheter

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Elimination
- Fluid and electrolytes
- Nutrition
- Reproduction

EXPECTED OUTCOMES

- The patient will not experience injury from urinary catheter.
- The patient will verbalize no discomfort with catheter placement.
- The patient will verbalize understanding of treatment.
- The patient will demonstrate skill in managing urinary elimination.

SUGGESTED NOC OUTCOMES

Fluid Balance; Hydration; Knowledge: Treatment Regimen; Mobility; Physical Aging; Urinary Continence; Urinary Elimination; Symptom Control; Self -Care Toileting;

INTERVENTIONS AND RATIONALES

Determine: Monitor intake and output and report if intake exceeds output, *to promote adequate fluid replacement therapy.*

Monitor voiding pattern. Record data on time, place, amount, and patient's awareness of micturition, *to establish a pattern of incontinence.* Perform: Monitor patency of indwelling urinary catheter. Keep tubing free from kinks and keep the drainage bag below the level of the bladder *to avoid urine reflux.*

Apply appropriate catheter care and monitoring of secure device. *Appropriate care prevents complications and alerts health care team to developing problems.*

Clean the urinary meatus according to the established policy, and maintain a closed drainage system *to prevent skin irritation and bacteriuria.*

Secure the catheter to patient's leg (female) or abdomen (male); avoid tension on the sphincter. *Anchoring the catheter avoids straining the trigone muscle of the bladder and prevents friction leading to inflammation.*
Inform: Instruct patient and family members on catheter care and insertion techniques to be used at home. Provide for return demonstrations until they can perform the procedure well. *Knowledge of procedures and rationales reduces anxiety and promotes comfort. Demonstrations may progress through several sessions until patient can perform independently.*
Attend: Encourage high fluid intake 2,000 mL (2 L)/day, unless contraindicated, *to moisten mucous membranes and dilute chemical materials in the body.* Limit fluid intake after 7 p.m. *to prevent nocturia.*

Encourage patient and family members to share feelings and concerns related to urologic problems. *Ventilation helps pinpoint patient's fears and establishes an environment of trust in which patient and family members can begin to deal with the situation.*
Manage: Refer patient and family members to a psychiatric liaison nurse, enterostomal therapist, sex counselor, support group, or home health care agency, when appropriate. *These resources help patient gain knowledge of the situation, reduce anxiety, and help promote personal growth. Community resources usually provide services not available at other health care agencies.*

SUGGESTED NIC INTERVENTIONS

Fluid Management; Perineal Care; Self-Care Assistance: Toileting; Urinary Bladder Training; Urinary Catheterization: Intermittent; Urinary Elimination Management

REFERENCES

Esparaz, A. M., Pearl, J. A., Herts, B. R., LeBlanc, J., & Kapoor, B. (2015). Iatrogenic urinary tract injuries: Etiology, diagnosis, and management. *Seminars in Interventional Radiology*, *36*(2), 195–208. doi:10.1055/s-0035-1549378

Magers, T. L. (2013). Using evidence-based practice to reduce catheter-associated urinary tract infections. *American Journal of Nursing*, *113*(6), 34–44. doi:10.1097/01.NAJ.0000431270.01203.4b

DEFINITION

A disruption in amount and quality of sleep that impairs functioning

DEFINING CHARACTERISTICS

- Alteration in affect
- Alteration in concentration
- Alteration in mood
- Alteration in sleep pattern
- Compromised health status
- Decrease in quality of life
- Difficulty initiating sleep
- Difficulty maintaining sleep
- Early awakening
- Increase in absenteeism
- Increase in accidents
- Insufficient energy
- Nonrestorative sleep pattern (i.e., due to caregiver responsibilities, parenting practices, sleep partner)
- Sleep disturbance producing next-day consequences

RELATED FACTORS

- Alcohol consumption
- Anxiety
- Average daily physical activity is less than recommended for gender and age
- Depression
- Environmental barrier (e.g., ambient noise, daylight/darkness exposure, ambient temperature/humidity, unfamiliar setting)
- Fear
- Frequent naps
- Grieving
- Hormonal change
- Inadequate sleep hygiene
- Pharmaceutical agent
- Physical discomfort
- Stressors

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Emotional
- Sleep/rest
- Values/beliefs

EXPECTED OUTCOMES

- The patient will identify factors that prevent or promote sleep.
- The patient will achieve sleep for ___ hours without interruption.

- The patient will report feeling well-rested.
- The patient will be free from signs of sleep deprivation.
- The patient will alter diet and habits to promote sleep, such as reducing caffeine and alcohol intake before bedtime.
- The patient will not exhibit sleep-related behavioral symptoms, such as restlessness, irritability, lethargy, and disorientation.
- The patient will perform relaxation exercises at bedtime.

SUGGESTED NOC OUTCOMES

Anxiety Level; Anxiety Self-Control; Fear Level; Mood Equilibrium; Personal Well-Being; Rest; Sleep

INTERVENTIONS AND RATIONALES

Determine: Assess patient's daytime activity and work patterns; travel history; normal bedtime; problems associated with sleep; quality of sleep; sleeping environment; personal beliefs about sleep; use of alcohol, caffeine, hypnotics, and nicotine. *Assessment information will assist in selecting appropriate interventions.*

Perform: Ask patient to help make changes in the environment that would promote sleep. *This allows patient to have an active role in treatment.*

Administer medications on a schedule that will allow for maximum rest. *Disturbing for medication administration during rest periods will disrupt sleep patterns.* If the patient requires diuretics in the evening, give far enough in advance *to allow peak effect before bedtime.* Other medications that may interfere with sleep are β-blockers, MAO inhibitors, and phenytoin.

Provide patient with sleep aids, such as pillows, bath before sleep, food or drink, and reading *materials, to promote ease in falling asleep.* Milk and some high-protein snacks, such as cheese and nuts, contain L-tryptophan, a sleep promoter. Personal hygiene and prebedtime rituals promote sleep in some patients.

Develop a sleep log with the patient describing sleep disturbances and the effect on daytime functioning. *The log will help both patient and nurse to evaluate progress in evaluating sleep* patterns.

Inform: Teach patient relaxation techniques such as guided imagery, deep breathing, meditation, aromatherapy, and progressive muscle relaxation. Practice with the patient at bedtime. *Purposeful relaxation efforts usually help promote sleep.*

Instruct patient to eliminate or reduce caffeine and alcohol intake and avoid foods that interfere with sleep (e.g., spicy foods). *Foods and beverages containing caffeine consumed fewer than 4 hours before bedtime may interfere with sleep. Alcohol disrupts normal sleep, especially when ingested immediately before retiring.*

When anxiety is a factor in sleep deprivation, teach coping techniques *to reduce the frustration of being unable to sleep.*

Attend: Listen to the patient's description of insomnia. Allow time for the patient to talk about frustration. *Being able to have a sensitive listener may help reduce some of the frustration and may lead to new ideas about how to help the patient resolve sleep issues.*

Ask the patient each day to describe the quality of sleep. *Patients are sometimes unaware of the periods in which they do sleep.*

Manage: Refer to case manager/social worker *to ensure that follow-up is provided.*

SUGGESTED NIC INTERVENTIONS

Biofeedback; Calming Techniques; Coping Enhancement; Energy Management; Security Enhancement; Relaxation Therapy; Sleep Enhancement; Journaling; Aromatherapy

REFERENCES

Ashworth, D. K., Sletten, T. L., Junge, M., Simpson, K., Clarke, D., Cunnington, D., & Rajaratnam, S. M. (2015). A randomized controlled trial of cognitive behavioral therapy for insomnia: An effective treatment for comorbid insomnia and depression. *Journal of Counseling Psychology*, *62*(2), 115–123. doi:10.1037/cou0000059

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Richter, K., Myllymaeki, J., Scharold-Schaefer, S., Tomova, I., Mayrer, R., & Niklewski, G. (2014). Treating comorbid insomnia in older adults via cognitive-behavioural treatment, bright light and exercise. *Health*, *6*(10), 960–968. doi:10.4236/health.2014.610121

DEFINITION

The yellow-orange tint of the neonate's skin and mucous membranes that occurs after 24 hours of life as a result of unconjugated bilirubin in the circulation

DEFINING CHARACTERISTICS

- Abnormal blood profile
- Bruised skin
- Yellow mucous membranes
- Yellow sclera
- Yellow-orange skin color

RELATED FACTORS

- Age <7 days
- Deficient feeding pattern
- Delay in meconium passage
- Infant experiences difficulty making the transition to extrauterine life
- Unintentional weight loss

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Elimination
- Fluid and electrolytes
- Growth and development
- Nutrition

EXPECTED OUTCOMES

- The neonate will establish effective feeding pattern (breast or bottle) that enhances stooling.
- The neonate will not experience injury as a result of increasing bilirubin levels.
- The neonate will receive bilirubin assessment and screening within the first week of life to detect increasing levels of serum bilirubin.
- The neonate will receive appropriate therapy to enhance bilirubin excretion.
- The neonate will receive nursing assessments to determine the risk for severity of jaundice.

SUGGESTED NOC OUTCOMES

Bowel Elimination; Breast-Feeding Establishment: Infant; Nutritional Status; Risk Control; Risk Detection

INTERVENTIONS AND RATIONALES

Determine: Evaluate maternal and delivery history for risk factors for neonatal jaundice (Rh, ABO, G6PD deficiency, direct Coombs, prolonged labor, maternal viral illness, medications) *to anticipate which neonates are at higher risk for jaundice.*

Perform: Collect and evaluate laboratory blood specimens as ordered or per unit protocol *to permit accurate and timely diagnosis and treatment of neonatal jaundice.*

Inform: Educate parents regarding newborn care at home in relation to appearance of jaundice in association with any of the following: no stool in 48 hours, lethargy with refusal to nurse or bottle feed, less than one wet diaper in 12 hours, abnormal infant behavior. *Parent education is crucial for the time after the neonate is discharged. Parents are the major decision makers concerning whether and when to bring the neonate back for medical and nursing assessments after being discharged from the hospital.*

Attend: Provide caring support to the family if a breast-fed neonate must receive supplementation. *It can be upsetting and can result in feelings of inadequacy to a breast-feeding mother for her neonate to require supplementation.*

Manage: Coordinate care and facilitate communication between family, nursing staff, pediatrician, and lactation specialist. *A multidisciplinary approach that includes the family enhances communication and improves outcomes.*

SUGGESTED NIC INTERVENTIONS

Attachment Promotion; Bottle Feeding; Bowel Management; Breast-Feeding Assistance; Capillary Blood Sample; Discharge Planning; Infant Care; Kangaroo Care; Newborn Monitoring; Nutritional Monitoring; Risk Identification: Childbearing Family; Surveillance; Teaching: Infant Nutrition; Vital Signs Monitoring; Lactation Counseling

REFERENCES

Aydin, D., Karaca Ciftci, E., & Karatas, H. (2014). Identification of the traditional methods of newborn mothers regarding jaundice in Turkey. *Journal of Clinical Nursing, 23*(3/4), 524–530. doi:10.1111/jocn.12150

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Fullwood, D., & Sargent, S. (2014). Complications in acute liver failure: Managing hepatic encephalopathy and cerebral oedema. *Gastrointestinal Nursing, 12*(3), 27–34.

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DEFINITION

Vulnerable to the yellow-orange tint of the neonate's skin and mucous membranes that occur after 24 hours of life as a result of unconjugated bilirubin in the circulation, which may compromise health

RISK FACTORS

- Abnormal weight loss (>7% to 8% in breast-feeding newborn, 15% in non-breast-feeding newborn)
- Age <7 days
- Delay in meconium passage
- Feeding pattern not well established
- Infant experiences difficulty making the transition to extrauterine life
- Prematurity

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Growth and development
- Nutrition
- Tissue integrity
- Roles/relationships
- Risk management

EXPECTED OUTCOMES

- The parents will identify factors that place infant at risk for neonatal jaundice.
- The parents will identify potential signs of neonatal jaundice in infant.
- The neonate will establish effective feeding pattern (breast or bottle) that enhances stooling.
- The neonate will not experience injury as a result of increasing bilirubin levels.
- The neonate will receive bilirubin assessment and screening within first week of life to detect increasing levels of serum bilirubin.

SUGGESTED NOC OUTCOMES

Bowel Elimination; Breast-Feeding Establishment: Infant; Nutritional Status; Risk Control; Risk Detection; Newborn Adaptation; Knowledge: Infant Care

INTERVENTIONS AND RATIONALES

Determine: Review history of mother and prior obstetrical and medical histories in determining risk factors leading to neonatal jaundice. *Utilizing the knowledge about the maternal factors and blood type incompatibilities that can lead to neonatal jaundice aids the provider team preparations.*

At birth, assess the neonate for gestational age. *Neonates less than 38 weeks are at higher risk for jaundice.*

At birth, assess the neonate for birthing trauma such as excessive bruising. *Bruising is indicative of increased bleeding, which results in hemolysis and leads to increased bilirubin.*

At birth, place the neonate to the breast for initial feeding. *This stimulates the production of milk, initiating the process to produce sufficient milk for the infant over the next days.*

Rely on laboratory analysis for total serum bilirubin (TSB) or calibrated transcutaneous bilirubin (TcB) graphed on the Bhutani nomogram. *Accurate clinical observations of the neonate's skin color for jaundice are difficult in varying lighting settings and varying skin tone pigmentation. Laboratory and calibrated cutaneous readings provide consistent accurate measures and are interpreted using the nomogram.*

Adhere to nursery protocol on time intervals to obtain readings/heel-stick blood. *Clinical protocols are critical for assessment and treatment of hyperbilirubinemia since there are specific time–rate increase factors. This differentiates "normal physiologic" hyperbilirubinemia from more serious hemolytic forms.*

Perform: Inject vitamin K (phylloquinone) into the vastus lateralis muscle of the newborn. *Newborns lack vitamin K and cannot produce sufficient amounts for several weeks; injecting vitamin K provides a primary chemical for the clotting factors.*

Examine the skin and head of the neonate carefully to determine bruising or the presence of cephalohematoma. *Presence of bruising/hematoma indicates bleeding and increases the risk for jaundice as the RBCs are reabsorbed.*

If the neonate is less than 38 weeks, at 12 hours postpartum, obtain a heel-stick blood sample for TSB; graph results to the Bhutani nomogram; and continue every 12 hours per protocol or provider orders. *At-risk premature neonates have elevated TSB in comparison with 38-week neonates; the rate of TSB rise will determine the treatment plan and therapies I.*

Maintain the nursery protocol on assessing vital signs, bilirubin, weight, intake, diaper output, and other parameters. *Close vigilance by the caregivers will inform the providers of progress in the neonate's health status and hydration status.*

Institute the treatment plan—aggressive breast-feeding and/or phototherapy. *Sufficient breast milk intake by the neonate prevents dehydration and assists in the elimination of bilirubin; exposure to therapeutic photo-light converts insoluble bilirubin to a water-soluble form that can be easily eliminated.*

Inform: Provide information to the mother/family unit of the identified factors that may lead to neonatal jaundice. *Understanding information and expectations reduces anxiety.*

Breast-feeding 8 to 12 times a day (every 2 to 3 hours), beginning immediately at birth, with adequate amounts of milk decreases the incidence

of hyperbilirubinemia. *Understanding information and expectations allows the mother to participate in the care of her newborn.*

Provide detailed information to the family unit regarding the interventions to prevent bleeding and increased bilirubin, assessment findings, the lab values, and treatments for the neonate. *Understanding expectations improves confidence and reduces anxiety.*

Attend: Support the family when they receive the knowledge that risk factors exist. *Understanding information and expectations reduces anxiety and allows the family to prepare for their participation in the treatment plan.*

Encourage the mother to breast-feed her newborn. *This allows the mother to be the active agent intervening for her newborn by breast-feeding.*

Support bonding of the neonate and mother/family unit if the neonate receives phototherapy. *Understanding information and expectations of how the neonate will appear during therapy reduces anxiety and reduces barriers to bonding.*

Support the bonding of the neonate and mother/family unit if the neonate receives aggressive therapies that include blood exchange transfusions. *Understanding information and expectations of the implications and how the neonate appears during therapy reduces anxiety and reduces barriers to bonding.*

Manage: Refer to lactation consultant to manage breast-feeding and methods to enhance milk production. *Expertise and support provide the confidence to achieve success in breast-feeding.*

Emphasize the importance of follow-up at discharge for any level of hyperbilirubinemia; adhere to the clinical protocols and clinical pathways. *Newborns are frequently discharged after 24 hours and need to have professional evaluation to assure the bilirubin levels follow a predicted decrease.*

SUGGESTED NIC INTERVENTIONS

Attachment Promotion; Kangaroo Care; Newborn Monitoring; Vital Signs Monitoring; Infant Care; Breast-feeding Assistance; Bottle-Feeding; Teaching: Infant Nutrition; Capillary Blood Sample; Surveillance; Risk Identification: Childbearing Family; Bowel Management; Discharge Planning

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296 DEFICIENT KNOWLEDGE

DEFINITION

Absence or deficiency of cognitive information related to a specific topic

DEFINING CHARACTERISTICS

- Inaccurate follow-through of instruction
- Inaccurate performance on a test
- Inappropriate behavior (e.g., hysterical, hostile, agitated, apathetic)
- Insufficient knowledge

RELATED FACTORS

- Alteration in cognitive functioning
- Alteration in memory
- Insufficient information
- Insufficient interest in learning
- Insufficient knowledge of resources
- Misinformation presented by others

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity
- Communication
- Coping
- Knowledge
- Nutrition
- Sleep
- Values/beliefs

EXPECTED OUTCOMES

- The patient will communicate desire to understand disease state and need for treatment.
- The patient will demonstrate ability to perform new health-related procedures.
- The patient will set realistic learning goals within target dates.
- The patient will state intention to make needed modifications in lifestyle.

SUGGESTED NOC OUTCOMES

Cognition; Communication; Concentration; Information Processing; Knowledge: Disease Process; Knowledge: Health Behaviors; Knowledge: Health Resources; Knowledge: Illness Care; Stress Level; Memory

INTERVENTIONS AND RATIONALES

Determine: Determine level of knowledge and skills patient already possesses about health status; motivation to understand what is needed to improve health status; obstacles to learning; support systems; usual coping patterns; beliefs about health and treatment of disease; ethnicity; financial resources. *Assessment information will assist in identifying appropriate interventions.*

Perform: Establish an environment of mutual trust and respect *to enhance learning. Consistency between action and words, combined with the patient's self-awareness ability to share this awareness with others, and receptiveness to new experiences form the basis of a trusting relationship.*

Develop with patient specific learning goals with target dates. *Involving patient in planning meaningful goals encourages compliance.*

Select teaching strategies *that will enhance teaching/learning effectiveness,* such as discussion, demonstration, role-playing, and visual materials. Provide all the equipment needed for the patient to learn. *This reduces frustration, aids learning, and minimizes dependence by promoting self-care.*

Inform: Teach those skills that the patient must incorporate into daily living. Have patient do return demonstration of each skill *to aid in gaining confidence.*

When teaching, go slowly and repeat frequently. Offer small amounts of information and present it in various ways. *By building cognition, patient will be better able to complete self-care measures.*

Demonstrate to family members how each self-care measure is broken down into simple tasks *to enhance patient's success and foster a sense of control.*

Attend: Encourage family members to participate in and have patience toward learning process (patient may need to repeat new skills multiple times) *to help create a therapeutic environment after discharge.*

Manage: Have patient incorporate learned skills into care while still in the hospital. *This allows practice and time for feedback.*

Provide patient and/or family with names and telephone numbers of resource people or community agencies *so that care is continuous and follow-up is possible after discharge.*

If financial hardship interferes with the ability of the family to provide equipment and supplies, offer a referral to a social worker *to improve the family's access to financial assistance.*

SUGGESTED NIC INTERVENTIONS

Behavior Management; Behavior Modification; Decision-Making Support; Energy Management; Family Support; Financial Resource Assistance; Health Education; Healthcare Information Exchange: Risk Identification; Learning Facilitation; Support System Enhancement; Teaching Procedure/Treatment

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DEFINITION

A hypersensitive reaction to natural latex rubber products

DEFINING CHARACTERISTICS

- *Life-Threatening Reactions within 1 Hour of Exposure:* Bronchospasm, chest tightness, contact urticarial progressing to generalized symptoms, dyspnea, edema (i.e., lips, throat, tongue, uvula), hypotension, myocardial infarction, respiratory arrest, syncope, wheezing
- *Type IV Reactions Occurring ≥1 Hour after Exposure:* Discomfort reaction to additives (e.g., thiurams and carbamates), eczema, skin irritation, skin redness
- *Generalized Characteristics:* Generalized discomfort, generalized edema, reports total body warmth, restlessness, skin flushing
- *Gastrointestinal Characteristics:* Abdominal pain, nausea
- *Orofacial Characteristics:* Erythema (e.g., eyes, facial, nasal), itching (e.g., eyes, facial, nasal, oral), nasal congestion, periorbital edema, rhinorrhea, tearing of the eyes

RELATED FACTORS

- Hypersensitivity to natural latex rubber protein

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Respiratory function
- Tissue integrity

EXPECTED OUTCOMES

- The patient will maintain normal vital signs, respiratory status, and laboratory values.
- The patient will exhibit skin that is moist, clear, and free of erythema, edema, itching, urticaria, and breakdown.
- The patient will express awareness of allergic response to latex-containing products.
- The patient will state intention to avoid contact with products containing latex.

SUGGESTED NOC OUTCOMES

Comfort Level; Immune Hypersensitivity Response; Knowledge: Infection Control; Tissue Integrity: Skin and Mucous Membrane

INTERVENTIONS AND RATIONALES

Determine: Determine whether patient has had past episodes of latex, food, pollen, or drug allergy. Report contacts with latex products including when, where, and what. *History will lead to more precise assessment.*

Monitor respiratory status; include rate, rhythm, skin color, and breath sounds. Be particularly alert for signs of bronchospasms and complaints

of dyspnea. Assess heart rate, rhythm, and blood pressure. Check skin carefully for urticaria. Document findings. *These measures detect changes in status to more accurately determine interventions.*

Remove all latex products from immediate proximity of patient and staff treating the patient, *to prevent inadvertent use of products by staff or patient that increases the risk for contact and allergic reaction.*

Perform: Administer prescribed drugs and treatments, as ordered. *Wheezing and shortness of breath can quickly deteriorate to respiratory distress and failure. Skin with urticaria and itching is uncomfortable and unsightly so patients appreciate timely administration of treatment.*

Inform: Teach patient and family to avoid latex products *to prevent future contact and allergic reactions.* Provide instruction about household items that contain latex (provide a written list) and tell them about nonlatex substitutes. *Prevention is the foundation of treatment of latex allergies.*

Instruct patient and family about importance of seeking immediate medical treatment of allergic reactions, *to foster timely intervention.*

Attend: Provide emotional support and encouragement *to help* improve patient's self-concept.

Involve patient in planning and decision making, and have patient perform self-care activities. *Having the ability to participate will encourage greater compliance with the plan for activity.*

Manage: When latex allergy is confirmed, document and label record clearly *to prevent future contact with the allergen.*

Emphasize need to inform all health care providers about patient's sensitivity to latex. Stress the importance of wearing a medical identification bracelet that specifies latex allergy, *to prevent future contact with allergic products and allergic reactions.*

Provide documentation of latex allergy for the patient to take to employer; with the patient's permission, communicate with employee health department and discuss patient's need to avoid contact with latex products *to prevent further contamination.*

SUGGESTED NIC INTERVENTIONS

Allergy Management; Anaphylaxis Management; Environmental Risk Protection; Latex Precautions; Risk Identification; Teaching: Individual

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302 RISK FOR LATEX ALLERGY RESPONSE

DEFINITION

Vulnerable to a hypersensitive reaction to natural latex rubber products, which may compromise health

RISK FACTORS

- Allergy to poinsettia plant
- Food allergy (e.g., avocado, banana, chestnut, kiwi, peanut, shellfish, mushroom, tropical fruit)
- Frequent exposure to latex product
- History of allergy
- History of asthma
- History of latex reaction
- History of surgery during infancy
- Multiple surgical procedures

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Nutrition
- Tissue integrity

EXPECTED OUTCOMES

- The patient will regain normal vital signs, respiratory status, and laboratory values.
- The patient will exhibit moist, clear skin that is free of erythema, edema, itching, urticaria, and breakdown.
- The patient will express awareness of allergic response to latex-containing products.

SUGGESTED NOC OUTCOMES

Allergy Response: Localized; Immune Hypersensitivity Response; Risk Control

INTERVENTIONS AND RATIONALES

Determine: Determine whether patient has had past episodes of latex, food, pollen, or drug allergy. Report contacts with latex products including when, where, and what. *History will lead to more precise assessment.*

Monitor respiratory status; include rate, rhythm, skin color, and breath sounds. Be particularly alert for signs of bronchospasms and complaints of dyspnea. Assess heart rate, rhythm, and blood pressure. Check skin carefully for urticaria. Document findings. *These measures detect changes in patient's response to latex or other substances that cause allergic reactions.*

Remove all latex products from the immediate proximity of the patient and staff treating the patient, *to prevent inadvertent use of latex*

products by the staff or patient that increases the risk for contact and allergic reaction.

Perform: Administer prescribed drugs and treatments, as ordered. *Wheezing and shortness of breath can quickly deteriorate to respiratory distress and failure. Skin with urticaria and itching is uncomfortable and unsightly so patients appreciate timely administration of treatment.*

Inform: Educate patient and family about allergic reaction *to latex products, to prevent future contact with allergic products and allergic reactions.* Provide a list of household items containing latex, emphasize importance of avoiding these, and tell them about nonlatex substitutes. *Prevention is the foundation of treatment of latex allergies.*

Educate patient and family about importance of seeking immediate medical treatment of allergic reactions *to foster timely intervention.*

Attend: Involve patient in planning and decision making, and have the patient perform self-care activities. *Having the ability to participate will encourage greater compliance with the plan for activity.*

Manage: Emphasize need to inform all health care providers about sensitivity to latex. Stress importance of wearing a medical identification bracelet that specifies possible latex allergy *to prevent contact with allergic products and allergic reactions.*

Provide documentation of the risk of latex allergy for the patient to take to employer. With patient's permission, communicate with employee health department and discuss patient's need *to avoid contact with latex products to prevent further contamination.*

SUGGESTED NIC INTERVENTIONS

Allergy Management; Anaphylaxis Management; Environmental Risk Protection; Latex Precautions; Risk Identification; Teaching: Individual

REFERENCES

Hohler, S. E. (2015). Latex allergies. *OR Nurse, 9*(1), 12–19. doi:10.1097/01.ORN.0000457107.47873.aa

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304 SEDENTARY LIFESTYLE

DEFINITION

Reports a habit of life that is characterized by a low physical activity level

DEFINING CHARACTERISTICS

- Average daily physical activity is less than recommended for gender and age
- Physical deconditioning
- Preference for activity low in physical activity

RELATED FACTORS

- Insufficient interest in physical activity
- Insufficient knowledge of health benefits associated with physical activity
- Insufficient motivation for physical activity
- Insufficient resources for physical activity
- Insufficient training for physical exercise

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Growth and development
- Knowledge
- Nutrition
- Risk management

EXPECTED OUTCOMES

- The patient will maintain independent living status with reduced risk for falling.
- The patient will identify barriers to increasing physical activity level.
- The patient will identify health benefits to increasing physical activity level.
- The patient will increase physical activity and limit inactive forms of diversion, such as television and computer games.
- The patient will seek professional consultation to develop an appropriate plan to increase physical activity.
- The patient will identify factors that enhance readiness for sleep.
- The patient will demonstrate readiness for enhanced sleep through the use of appropriate sleep hygiene measures.
- The patient will have amount of sleep congruent with developmental needs and experience rapid eye movement sleep.
- The patient will express a feeling of being rested after sleep.
- The patient will increase lean muscle and bone strength and decrease body fat.
- The patient will demonstrate weight control and, if appropriate, weight loss.
- The patient will exhibit enhanced psychological well-being and reduced risk of depression.

- The patient will have reduced depression and anxiety and an improved mood.
- The patient will demonstrate increased ability to perform activities of daily living within limits of chronic, disabling conditions.

SUGGESTED NOC OUTCOMES

Activity Tolerance; Endurance; Energy Conservation; Health Promoting Behavior; Immobility Consequences: Physiologic; Adherence Behavior Immobility Consequences: Physiologic and Psycho-Cognitive; Compliance Behavior; Endurance; Health Seeking Behavior

INTERVENTIONS AND RATIONALES

Determine: Identify barriers and enhancers to increasing physical activity, including time management, diet, lifestyle, access to facilities, and safe environments in which to be active. *Breaking down barriers and building opportunities for activity increase the probability of consistent physical activity.*

Perform: Develop a behavior-modification plan based on patient's condition, history, and precipitating factors, *to maximize physical activity and compliance.*

Inform: Instruct patient to keep a daily activity and dietary log to help the patient achieve a more objective view of behavior.

Educate patient about how sedentary lifestyle affects cardiovascular risk factors (such as hypertension, dyslipidemia, hyperinsulinemia, insulin resistance), *to motivate patient to be more active.*

Teach exercises for increasing strength and endurance to maintain mobility and prevent musculoskeletal degeneration.

Educate patient about using the bedroom only for sleep or sexual activity and avoiding other activities such as watching television, reading, and eating, *to increase sleep efficiency.*

Attend: Provide counseling tailored to patient's risk factors, needs, preferences, and abilities *to enhance emotional well-being and motivation for physical activity.*

Discuss the need for activity that will improve psychosocial well-being *to encourage compliance with activities.*

Discuss behavioral risk factors in lack of motivation such as ingestion of carbohydrates, caffeine, nicotine, alcohol, sedatives, hypnotics, and fluid intake, *to focus behavior on positive outcomes of increased physical activity.*

Manage: Provide education about community resources available *to increase physical activity to decrease barriers to activity.*

SUGGESTED NIC INTERVENTIONS

Activity Therapy; Energy Management; Teaching: Prescribed Activity/Exercise; Body Mechanics Promotion; Exercise Promotion

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DEFINITION

Vulnerable to a decrease in liver function, which may compromise health

RISK FACTORS

- HIV coinfection
- Pharmaceutical agent
- Substance abuse
- Viral infection

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Risk management
- Pharmacologic function
- Fluids/electrolytes

EXPECTED OUTCOMES

- The patient will state effects of environmental and ingested chemicals and substances on health and liver function.
- The patient will work with industry managers and with public health officials to lower or eliminate the presence of environmental chemicals and substances in their work or living environment.
- The patient will have liver function indicators within normal limits.
- The patient will modify lifestyle and risk behaviors to avoid behaviors leading to hepatic dysfunction and inflammation.
- The patient will maintain long-term follow-up for chronic illness with health care provider.
- The patient will manage concurrent disease processes that impact hepatic function.
- The patient will optimize nutritional intake for needs.
- The patient will acknowledge the impact of medications on hepatic function.
- The patient will observe measures to avoid the spread of infection to self and to others.

SUGGESTED NOC OUTCOMES

Health Promoting Behavior; Risk Control; Risk Control: Alcohol Use; Risk Control: Drug Use; Safe Home Environment; Substance Addiction Consequences; Nutritional Status

INTERVENTIONS AND RATIONALES

Determine: Assist patient and family to assess workplace and home environments for potential substances, *to increase patient's awareness of hazards in the environment and to lower potential for hepatic injury.*

Monitor for clinical manifestations of hepatic inflammation and dysfunction *to notify physician in order to initiate treatment if liver function is compromised.* Clinical manifestations may include fatigue, depression

or mood changes, anorexia, right-upper-quadrant tenderness, pruritus, jaundice, bruising, or nontraumatic bleeding.

Monitor customary clinical laboratory tests *to alert the health care provider of the status of the immune/inflammatory response, the degree of hepatic metabolic dysfunction, and the impact of concurrent disorders on liver function.* Clinical laboratory tests include complete blood cell (CBC) count (lower red blood cell count, elevated WBC [increased immunocyte and inflammatory responses]); basic metabolic panel (altered electrolyte balance, elevated glucose, elevated blood urea nitrogen and creatinine level, elevated HbA_{1c}); hepatic plasma markers (elevated liver enzymes [alanine aminotransferase, aspartate aminotransferase, and Γ-glutamyltranspeptidase]); positive immunoassays *for pathogen and viral antigens*; elevated ammonia; elevated bilirubin; low coagulation factors; low total protein/albumin; elevated lipid panel.

Perform: Carry out postprocedure measures, as ordered, *to identify and/or minimize complications.*

Inform: Teach patient about the following: perform hand hygiene before and after personal hygiene and care; cover draining and nonhealing wounds; report to care provider; inform others of infectious condition *so that each observes barrier precautions*; adhere to prescribed plan of care and treatment with immune system modifiers (antibiotics, antivirals, interferon, others); maintain a balanced nutritional diet intake. *These measures minimize patient's risk for self-infection and spread of infection and allow the patient to help modify lifestyle to maintain optimum health level for self and for others.*

Along with health care team, prepare the patient for and later evaluate the results of liver biopsy and provide explanation to patient and family.

The patient and family need understanding of purpose for and implications of results obtained from a liver biopsy. This support and education help the patient understand rationale for plan of treatment and genetic counseling for genetically linked hepatic disorders.

Attend: Provide a nonjudgmental attitude toward patient's lifestyle choices *to promote feelings of self-worth.*

Manage: Refer patient to counseling and therapy to address lifestyle choices and risk behaviors. *Modification of behaviors will provide risk avoidance for drug and alcohol abuse and exposure to body–substance pathogen infection.*

SUGGESTED NIC INTERVENTIONS

Behavior Modification; Environmental Risk Protection; Infection Protection; Risk Identification; Risk Identification: Genetic; Self-Modification Assistance; Surveillance; Referral

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DEFINITION

Vulnerable to experiencing discomfort associated with a desire or need for more contact with others, which may compromise health

RISK FACTORS

- Affectional deprivation
- Emotional deprivation
- Physical isolation
- Social isolation

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Emotional
- Roles/relationships
- Values/beliefs

EXPECTED OUTCOMES

- The patient will identify feelings of loneliness and express desire to socialize more.
- The patient will identify behaviors that lead to loneliness.
- The patient will identify people who will likely support and accept the patient.
- The patient will spend time with others.
- The patient will be comfortable in social settings, will interact with peers, and will receive support from others.
- The patient will make specific plans to continue involvement with others, such as through recreational activities or social interaction groups.

SUGGESTED NOC OUTCOMES

Decision-Making; Loneliness Severity; Risk Control; Social Involvement; Social Support; Social Interaction Skills

INTERVENTIONS AND RATIONALES

Determine: Work with patient to identify factors and behaviors that have contributed to loneliness, *to begin changing behaviors that may have alienated others.*

Help patient identify feelings associated with loneliness. *This lessens the impact of feelings and mobilizes energy to counteract them.*

Perform: Spend sufficient time with patient to allow patient to express feelings of loneliness *to establish trusting relationship.*

Work with patient to establish goals for reducing feelings of loneliness after patient leaves health care setting, *to focus energy on specific objectives.*

Inform: Inform patient that assistance is available to help patient express feelings of loneliness and identify ways to increase social activity, *to bring issue into open and help understand that you want to help the patient.*

Help patient curb feelings of loneliness by encouraging one-on-one interaction with others who are likely to accept the patient (e.g., church members or patients with similar health problems), *to promote feelings of acceptance and support.*

Help patient identify social activities the patient can initiate, such as becoming active in a support group or volunteering organization. *This fosters feelings of control and increase social contacts.*

Help patient accept that other people may view the patient differently because of the patient's illness, and explore ways of coping with their reactions *to help patient learn to cope with stigma associated with illness.*

Attend: Encourage patient to address the needs assertively. *By being assertive, patient assumes responsibility for meeting the needs without anger or guilt.*

As patient's comfort level improves, encourage him to attend group activities and social functions *to promote the use of social skills.*

Manage: Refer patient and family to social service agencies, mental health center, and appropriate support groups *to ensure continued care and to maintain social involvement.*

SUGGESTED NIC INTERVENTIONS

Activity Therapy, Anxiety Reduction, Emotional Support; Socialization Enhancement; Spiritual Support; Visitation Facilitation; Family Integrity Promotion; Behavior Management

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312 RISK FOR DISTURBED MATERNAL–FETAL DYAD

DEFINITION

Vulnerable to disruption of the symbiotic maternal–fetal dyad as a result of comorbid or pregnancy-related conditions, which may compromise health

RISK FACTORS

- Alteration in glucose metabolism (e.g., diabetes mellitus, steroid use)
- Compromised fetal oxygen transport (due to anemia, asthma, cardiac disease, hypertension, seizures, premature labor, hemorrhage, etc.)
- Inadequate prenatal care
- Pregnancy complication (e.g., premature rupture of membranes, placenta previa/abruption, multiple gestation)
- Presence of abuse (e.g., physical, psychological, sexual)
- Substance abuse
- Treatment regimen

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Emotional
- Roles/relationships

EXPECTED OUTCOMES

- The patient will be compliant with recommendations for self-care activities to minimize prenatal complications and optimize maternal–fetal health.
- The patient will verbalize fears and uncertainty related to prenatal condition.
- The patient will actively involve significant other/support systems with pregnancy expectations and plan of care.
- The patient will demonstrate the "maternal tasks of pregnancy" culminating in an unconditional acceptance of the fetus before delivery.

SUGGESTED NOC OUTCOMES

Prenatal Health Behavior; Knowledge: Pregnancy; Role Performance; Family Integrity

INTERVENTIONS AND RATIONALES

Determine: At each prenatal visit, assess physical condition, psychosocial well-being, and cultural beliefs, *to be able to counsel and/or refer as needed.*
Perform: Encourage support/involvement of significant other(s) during course of pregnancy *to enhance maternal role adaptation.*

Incorporate the cultural beliefs, rites, and rituals of the childbearing family into the plan of care *to foster feelings of normalcy with pregnancy.*
Inform: Educate patient/significant other on role transition and maternal tasks of pregnancy *to provide anticipatory guidance on expected psychosocial changes.*

Teach trimester-specific risks/danger signs, and emphasize importance of self-monitoring, *to empower the patient and reduce potential for adverse fetal effects.*

Attend: Encourage patient to express disappointment/concerns related to relationships, physical condition, and fetal well-being, *to promote therapeutic communication.*

Manage: Refer to community resources as needed (e.g., prenatal classes, psychological counseling, pastoral care, social services) *to facilitate appropriate role adaptation.*

SUGGESTED NIC INTERVENTIONS

Anticipatory Guidance; Childbirth Preparation; Coping Enhancement; Role Enhancement; Cultural Brokerage

REFERENCES

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314 IMPAIRED MEMORY

DEFINITION

Inability to remember or recall bits of information or behavioral skills

DEFINING CHARACTERISTICS

- Forgetfulness
- Forgets to perform a behavior at scheduled time
- Inability to learn new information
- Inability to learn new skill
- Inability to perform a previously learned skill
- Inability to recall events
- Inability to recall factual information
- Inability to recall if a behavior was performed
- Inability to retain new information

RELATED FACTORS

- Alteration in fluid volume
- Anemia
- Decrease in cardiac output
- Distractions in the environment
- Electrolyte imbalance
- Hypoxia
- Neurologic impairment (e.g., positive EEG, head trauma, seizure disorders)

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Emotional
- Fluids and electrolytes
- Neurocognition
- Self-care

EXPECTED OUTCOMES

- The patient/family will express feelings about memory impairment.
- The patient/family will acknowledge need to take measures to cope with memory impairment.
- The patient/family will identify coping skills to deal with memory impairment.
- The patient/family will state specific plans to modify lifestyle.
- The patient/family will establish realistic goals to deal with further memory loss.

SUGGESTED NOC OUTCOMES

Cognition; Cognitive Orientation; Concentration; Coping; Memory; Neurological Status: Consciousness

INTERVENTIONS AND RATIONALES

Determine: Observe patient's thought processes during every shift. Document and report any changes. *Changes may indicate progressive improvement or a decline in patient's underlying condition.*

Perform: Implement appropriate safety measures *to protect patient from injury. Patient may be unable to provide for own safety needs.*

Call patient by name and tell the patient your name. Provide background information (place, time, and date) frequently throughout the day, *to provide reality orientation.* Use a reality orientation board *to visually reinforce reality orientation.*

Spend sufficient time with patient *to allow the patient to become comfortable discussing memory loss and establish a trusting relationship.*

Be clear, concise, and direct in establishing goals *to promote maximal use of patient's remaining cognitive skills.* Offer short, simple explanations to patient each time you carry out any medical or nursing procedure, *to avoid confusion.*

Label patient's personal possessions and photos, keeping them in the same place as much as possible, *to reduce confusion and create a secure environment.*

Inform: Inform patient that you are aware of patient's memory loss and that you will help cope with the patient's condition *to bring the issue into the open and help patient understand that your goal is to help the patient.*

Teach patient ways to cope with memory loss (e.g., using a beeper to remind patient when to eat or take medications; using a pillbox organized by days of the week; keeping lists in notebooks or a pocket calendar; having family members or friends remind patient of important tasks). *Reminders help limit the amount of information patient must maintain in memory.*

Help patient and family members establish goals for coping with memory loss. Discuss with family members the need to maintain the least restrictive environment possible. Instruct them on how to maintain a safe home environment for patient. *This helps ensure that patient's needs are met and promotes patient's independence.*

Demonstrate reorientation techniques to family members and provide time for supervised return demonstrations *to prepare them to cope with patient with memory impairment.*

Attend: Encourage patient to develop a consistent routine for performing activities of daily living *to enhance self-esteem and increase self-awareness and awareness of patient's environment.*

Encourage patient to interact with others *to increase social involvement, which may decline with memory loss.*

Encourage patient to express the feelings associated with impaired memory *to reduce the impact of memory impairment on patient's self-image and lessen anxiety.*

Manage: Help family members identify appropriate community support groups, mental health services, and social service agencies *to assist in coping with the effects of patient's illness or injury.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Calming Technique; Cerebral Perfusion Promotion; Dementia Management; Memory Training; Neurologic Monitoring; Reality Orientation; Home Maintenance Assistance; Referral

REFERENCES

Calev, H., Spampinato, L. M., Press, V. G., Meltzer, D. O., & Arora, V. M. (2015). Prevalence of impaired memory in hospitalized adults and associations with in-hospital sleep loss. *Journal of Hospital Medicine*, *10*(7), 439–445. doi:10.1002/jhm.2364

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DEFINITION

Limitation of independent movement from one bed position to another

DEFINING CHARACTERISTICS

- Impaired ability to move between long sitting and supine positions
- Impaired ability to move between prone and supine positions
- Impaired ability to move between sitting and supine positions
- Impaired ability to reposition self in bed
- Impaired ability to turn from side to side

RELATED FACTORS

- Alteration in cognitive functioning
- Environmental barrier (e.g., bed size, bed type, equipment, restraints)
- Insufficient knowledge of mobility strategies
- Insufficient muscle strength
- Musculoskeletal impairment
- Neuromuscular impairment
- Obesity
- Pain
- Pharmaceutical agent
- Physical deconditioning

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Pharmacologic function
- Physical regulation

EXPECTED OUTCOMES

- The patient will have no complications associated with impaired bed mobility, such as altered skin integrity, contractures, venous stasis, thrombus formation, depression, altered health maintenance, and falls.
- The patient will maintain or improve muscle strength and joint range of motion (ROM).
- The patient will achieve the highest level of bed mobility possible (independence, independence with device, verbalization of needs for assistance with bed mobility, requires assistance of one person or two people).
- The patient will demonstrate ability to use equipment or devices to assist with moving about in bed safely.
- The patient will adapt to alteration in ability to move about in bed.
- The patient will participate in social, physical, and occupational activities to the extent possible.

SUGGESTED NOC OUTCOMES

Body Positioning: Self-Initiated; Immobility Consequences: Physiological; Immobility Consequences: Psycho-Cognitive; Joint Movement; Mobility; Neurological Status: Consciousness

INTERVENTIONS AND RATIONALES

Determine: Identify patient's level of independence using functional mobility scale and document findings *to provide continuity of care.*

Monitor and record daily evidence of complications related to impaired bed mobility (contractures, venous stasis, skin breakdown, thrombus formation, depression, altered health maintenance or self-care skills, falls). Assess patient's skin every 2 hours *to maintain skin integrity.*

Perform: Perform ROM exercises to affected joints, unless contraindicated, at least once per shift. Progress from passive to active ROM, as tolerated, *to prevent joint contractures and muscle atrophy.*

Assist patient in maintaining anatomically correct and functional body positioning *to relieve pressure, thereby preventing skin breakdown and fluid accumulation in dependent extremities.* Encourage repositioning every 2 hours while in bed.

Establish a turning schedule for immobile patient. Encourage progressive mobility within patient's limits *to maintain muscle tone, prevent complications, and promote self-care.*

If you are uncertain about your ability to move the patient, request help from colleagues, *to maintain safety.*

Inform: Instruct patient and family members on techniques to improve bed mobility and ways to prevent complications, *to help prepare the patient and family members for discharge.*

Demonstrate patient's bed mobility regimen and note the date. Have patient and family members perform a return demonstration *to ensure continuity of care and use of proper technique.*

Attend: Encourage patient to participate in physical and occupational therapy sessions. Incorporate equipment, devices, and techniques used by therapists into your care. Request written instructions from the patient's therapists to use as a reference *to help ensure continuity of care and reinforce learned skills.*

Manage: Refer patient to a physical therapist *to continue improvement in bed mobility and rehabilitate musculoskeletal deficits,* and an occupational therapist *to continue to maximize self-care skills.*

Assist patient in identifying and contacting resources for social and spiritual support *to promote the patient's reintegration into the community and help the patient maintain psychosocial health.*

SUGGESTED NIC INTERVENTIONS

Bed Rest Care; Body Mechanics Promotion; Exercise Promotion: Strength Training; Exercise Therapy: Joint Mobility; Exercise Therapy: Muscle Control; Positioning; Referral

REFERENCES

Janssens, J., Malfroid, K., Nyffeler, T., Bohlhalter, S., & Vanbellingen, T. (2014). Application of LSVT BIG intervention to address gait, balance, bed mobility, and dexterity in people with Parkinson Disease: A case series. *Physical Therapy*, *94*(7), 1014–1023. doi:10.2522/ptj.20130232

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Wysocki, A., Thomas, K. S., & Mor, V. (2015). Functional improvement among short-stay nursing home residents in the MDS 3.0. *Journal of the American Medical Directors Association*, *16*(6), 470–474. doi:10.1016/j.jamda.2014.11.018

320 IMPAIRED PHYSICAL MOBILITY

DEFINITION

Limitation in independent, purposeful physical movement of the body or of one or more extremities

DEFINING CHARACTERISTICS

- Alteration in gait
- Decrease in fine motor skills
- Decrease in gross motor skills
- Decrease in range of motion
- Decrease in reaction time
- Difficulty turning
- Discomfort
- Engages in substitutions for movement (e.g., attention to other's activity, controlling behavior, focus on pre-illness activity)
- Movement-induced tremor
- Postural instability
- Slowed movement
- Spastic movement
- Uncoordinated movements

RELATED FACTORS

- Activity intolerance
- Alteration in bone structure integrity
- Alteration in cognitive functioning
- Alteration in metabolism
- Anxiety
- Body mass index >75th age-appropriate percentile
- Contractures
- Cultural belief regarding appropriate activity
- Decrease in endurance
- Decrease in muscle control
- Decrease in muscle mass
- Decrease in muscle strength
- Depression
- Developmental delay
- Disuse
- Insufficient environmental support (e.g., physical, social)
- Insufficient knowledge of value of physical activity
- Joint stiffness
- Malnutrition
- Musculoskeletal impairment
- Neuromuscular impairment
- Pain
- Pharmaceutical agent

- Physical deconditioning
- Prescribed movement restrictions
- Reluctance to initiate movement
- Sedentary lifestyle
- Sensoriperceptual impairment

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Neurocognition

EXPECTED OUTCOMES

- The patient will maintain muscle strength and joint ROM.
- The patient will be free from complications (e.g., contractures, venous stasis, thrombus formation, skin breakdown, and hypostatic pneumonia).
- The patient will achieve the highest level of mobility (will transfer independently, will be wheelchair-independent, or will ambulate with assistive devices such as walker, cane, and braces).
- The patient will carry out mobility regimen.
- The patient will use resources to help maintain level of functioning.

SUGGESTED NOC OUTCOMES

Ambulation; Ambulation: Wheelchair; Joint Movement: Hip; Joint Movement: Passive; Mobility; Transfer Performance; Discharge Readiness: Independent Living; Discharge Readiness: Supported Living

INTERVENTIONS AND RATIONALES

Determine: Identify level of functioning using a functional mobility scale. Communicate patient's skill level to all staff members *to provide continuity and preserve identified level of independence.*

Monitor and record daily any evidence of immobility complications as they *may be more prone to develop complications.*

Perform: Perform ROM exercises to joints, unless contraindicated, at least once every shift *to prevent joint contractures and muscular atrophy.* Turn and reposition patient every 2 hours. Establish a turning schedule and post at bedside. Monitor frequency of turning *to prevent skin breakdown by relieving pressure. Place joints in functional position.* Use trochanter roll along the thigh, abduct thighs, use high-top sneakers, and pull a small pillow under patient's head *to maintain joints in a functional position and prevent musculoskeletal deformities.*

Place items within reach of the unaffected arm if patient has one-sided weakness or paralysis, *to promote patient's independence.*

Carry out medical regimen to manage or prevent complications (e.g., administer prophylactic heparin for venous thrombosis). *This promotes patient's health and well-being.*

Provide progressive mobilization to the limits of patient's condition (bed mobility to chair mobility to ambulation) *to maintain muscle tone and prevent complications of immobility.*

Inform: Instruct patient and family members on ROM exercises, transfers, skin inspection, and mobility regimen *to help prepare for discharge and promote continuity of care.* Request return demonstration *to ensure use of proper technique.*

Attend: Help patient use a trapeze and side rails to *encourage independence in mobility.* Instruct patient to perform self-care activities *to increase muscle tone.*

Encourage physical therapy sessions and support activities on the unit by using the same equipment and technique. Request written mobility plans for reference. Ensure all members of the health care team are reinforcing learned skills in the same manner.

Manage: Refer patient to a physical therapist for development of mobility regimen *to help rehabilitate musculoskeletal deficits.*

Assist patient in identifying resources such as American Heart Association *to provide a comprehensive approach to rehabilitation.*

SUGGESTED NIC INTERVENTIONS

Activity Therapy; Exercise Promotion: Strength Training; Exercise Therapy: Joint Mobility; Exercise Therapy: Muscle Control; Positioning: Wheelchair; Positioning; Energy Management

REFERENCES

Collins, B., & O'Mahony, P. (2015). Physically disabled adults' perceptions of personal autonomy. *OTJR: Occupation, Participation & Health*, *35*(3), 160–168. doi:10.1177/1539449215575264

Di Marco, F., Terraneo, S., Roggi, M. A., Repossi, A. C., Pellegrino, G. M., Veronelli, A., . . . Centanni, S. (2014). Physical activity impairment in depressed COPD subjects. *Respiratory Care*, *59*(5), 726–734. doi:10.4187/respcare.02848

Donoghue, O. A., Jansen, S., Dooley, C., De Rooij, S., Van Der Velde, N., & Kenny, R. A. (2014). Atrial fibrillation is associated with impaired mobility in community-dwelling older adults. *Journal of the American Medical Directors Association*, *15*(12), 929–933. doi:10.1016/j.jamda.2014.08.005

DEFINITION

Limitation of independent operation of wheelchair within environment

DEFINING CHARACTERISTICS

- Impaired ability to operate power wheelchair on a decline
- Impaired ability to operate power wheelchair on an incline
- Impaired ability to operate power wheelchair on curbs
- Impaired ability to operate power wheelchair on even surface
- Impaired ability to operate power wheelchair on uneven surface
- Impaired ability to operate wheelchair on a decline
- Impaired ability to operate wheelchair on an incline
- Impaired ability to operate wheelchair on curbs
- Impaired ability to operate wheelchair on even surface
- Impaired ability to operate wheelchair on uneven surface

RELATED FACTORS

- Alteration in cognitive functioning
- Alteration in mood
- Decrease in endurance
- Environmental barrier (e.g., stairs, inclines, uneven surfaces, obstacles, distance)
- Impaired vision
- Insufficient knowledge of wheelchair use
- Insufficient muscle strength
- Musculoskeletal impairment
- Neuromuscular impairment
- Obesity
- Pain
- Physical deconditioning

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Pharmacologic function
- Physical regulation
- Neurocognition

EXPECTED OUTCOMES

- The patient will have no complications associated with impaired wheelchair mobility, such as skin breakdown, contractures, venous stasis, thrombus formation, depression, alteration in health maintenance, and falls.
- The patient will maintain or improve muscle strength and joint range of motion (ROM).
- The patient will achieve the highest level of independence and safety possible with regard to wheelchair use.

- The patient will express feelings regarding alteration in ability to use wheelchair.
- The patient will participate in social and occupational activities to the greatest extent possible.
- The patient will demonstrate understanding of techniques to improve wheelchair mobility.

SUGGESTED NOC OUTCOMES

Ambulation: Wheelchair; Balance; Mobility Level; Muscle Function; Joint Movement Immobility Consequences: Physiological; Immobility Consequences: Psycho-Cognitive

INTERVENTIONS AND RATIONALES

Determine: Assess wheelchair status: Seat is wide and deep enough to support thighs, low enough for feet to touch the floor, yet high enough to allow easy transfer from bed to chair; the back is tall enough to support upper body; brakes on wheels lock; and seat belt is present (may attach at waist, hips, or chest). *Assessment ensures chair meets patient's physical needs (identifies need for modification), promotes comfort, and prevents injuries (e.g., falls).*

Assess patient's level of strength in arms, and if chair is easy for patient to operate when weak. *This determines the need for a motorized wheelchair to help maintain mobility and independence.*

Identify patient's level of independence using the functional mobility scale. Communicate findings to staff *to promote continuity of care and preserve the documented level of independence.*

Monitor and record daily evidence of complications related to impaired wheelchair mobility. *Patients with neuromuscular dysfunction are at risk for complications.*

Assess patient's skin on return to bed and request a wheelchair cushion, if necessary, *to maintain skin integrity.*

Perform: Perform ROM exercises for affected joints, unless contraindicated, at least once per shift. Progress from passive to active ROM, as tolerated. *This prevents joint contractures and muscle atrophy.*

Inform: Explain to patient location of vulnerable pressure points and instruct to shift and reposition weight *to prevent skin breakdown.* Ensure patient maintains anatomically correct and functional body positioning *to promote comfort.*

Demonstrate techniques to promote wheelchair mobility to the patient and family members and note the date; have them perform a return demonstration *to ensure continuity of care and use of proper technique.*

Attend: Encourage patient to operate wheelchair independently to the limits imposed by the patient's condition *to maintain muscle tone, prevent*

complications of immobility, and promote independence in self-care and health maintenance skills.

Encourage attendance at physical therapy sessions and reinforce prescribed activities on the unit by using equipment, devices, and techniques used in the therapy session. *To maintain continuity of care and promote patient safety.*

Manage: Refer patient to a physical therapist *to enhance wheelchair mobility and rehabilitation of musculoskeletal deficits.*

Help patient identify resources for maintaining highest level of mobility (e.g., community stroke program, sports associations for people with disabilities, and the National Multiple Sclerosis Society) *to promote reintegration into the community.*

SUGGESTED NIC INTERVENTIONS

Exercise Promotion: Strength Training; Exercise Therapy: Balance; Exercise Therapy: Muscle Control; Positioning: Wheelchair

REFERENCES

Best, K. L., Routhier, F., & Miller, W. C. (2015). A description of manual wheelchair skills training: current practices in Canadian rehabilitation centers. *Disability & Rehabilitation: Assistive Technology*, *10*(5), 393–400. doi:10.3109/17483107.2014.907367

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326 IMPAIRED MOOD REGULATION

DEFINITION

A mental state characterized by shifts in mood or affect and which is comprised of a constellation of affective, cognitive, somatic, and/or physiological manifestations varying from mild to severe.

DEFINING CHARACTERISTICS

- Changes in verbal behavior
- Disinhibition
- Dysphoria
- Excessive guilt
- Excessive self-awareness
- Excessive self-blame
- Flight of thoughts
- Hopelessness
- Impaired concentration
- Influenced self-esteem
- Irritability
- Psychomotor agitation
- Psychomotor retardation
- Sad affect
- Withdrawal

RELATED FACTORS

- Alteration in sleep pattern
- Anxiety
- Appetite change
- Functional impairment
- Hypervigilance
- Impaired social functioning
- Loneliness
- Pain
- Psychosis
- Recurrent thoughts of death
- Recurrent thoughts of suicide
- Social isolation
- Substance misuse
- Weight change

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Behavior
- Coping
- Emotional
- Neurocognition
- Sleep/rest

EXPECTED OUTCOMES

- The patient will not engage in self-harm and suicidal behavior.
- The patient will not engage in risky behavior.
- The patient will have a balanced pattern of activity and rest.
- The patient will verbalize having hope for the future.
- The patient will demonstrate awareness of distorted thoughts, if present, and will identify alternative balanced thought(s).

SUGGESTED NOC OUTCOMES

Anxiety Level; Coping; Depression Level; Impulse; Self-Control; Quality of Life; Stress Level

INTERVENTIONS AND RATIONALES

Determine: Assist the patient to evaluate strategies to meet goals. Emphasize gains made toward recovery goals and assist in problem-solving new solutions for strategies attempted but ineffective to meet goals. *To promote self-esteem, self-efficacy, development of problem-solving skills.*

Perform: Use short, simple phrases to convey instructions or questions. *Impaired concentration, psychomotor agitation, psychomotor retardation, or flight of ideas may inhibit processing of information and capability to remain on task.*

Ask the patient to identify specific thoughts about self that link to feelings of guilt or blame. *Cognitive Behavioral Therapy strategies can help the patients to become aware of their emotionally charged, distorted thoughts and to consider an alternative, more neutral, less emotionally charged thought.*

Initiate suicide and/or self-harm precautions, as necessary, *to ensure the patient remains safe from suicide and self-harm.*

Encourage and support appropriate levels of rest and activity (according to the patient's physiologic needs and capabilities) *to prevent complications of inactivity (e.g., skin breakdown, deep vein thrombosis, muscle atrophy, constipation, etc.) as well as to prevent complications of excessive activity (e.g., exhaustion, injury, electrolyte imbalances, exertional rhabdomyolysis).*

Inform: Discuss precipitating factors with patient, if indicated. *Patient may require community outreach assistance with certain precipitating factors, including inadequate living conditions, insufficient finances, and abuse of medications (such as sedatives and alcohol).*

Manage: Assist the patient with referral to specialty psychotherapy resources, as indicated by the patient's presentation and as determined by the clinical team. *Psychotherapies, such as Cognitive Behavioral Therapy (CBT), Interpersonal and Social rhythm therapy (IPSRT), Acceptance and Commitment Therapy (ACT), and Interpersonal Psychotherapy, have indications for use in persons with mood disturbances.*

Assist the patient to access psychoeducation resources appropriate to the patient's clinical situation *to promote understanding of etiology of mood symptoms, promote engagement in care, and build self-efficacy in symptom recognition and management.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Coping Enhancement; Emotional Support; Improved Quality of Life; Improved Well-Being; Mood Management

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Fountoulakis, K. N. (2015). *Bipolar disorder: An evidence-based guide to manic depression*. Berlin Heidelberg: Springer-Verlag.

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Videbeck, S. L. (2014). *Psychiatric-mental health nursing*. Philadelphia, PA: Lippincott Williams & Wilkins.

DEFINITION

Response to the inability to carry out one's chosen moral/ethical decision/action

DEFINING CHARACTERISTICS

- Anguish about acting on one's moral choice (e.g., powerlessness, anxiety, fear)

RELATED FACTORS

- Conflict among decision makers
- Conflicting information available for ethical decision making
- Conflicting information available for moral decision making
- Cultural incongruence
- End-of-life decisions
- Loss of autonomy
- Physical distance of decision maker
- Time constraints for decision making
- Treatment decision

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Roles/relationship
- Communication
- Coping
- Values/beliefs

EXPECTED OUTCOMES

- The patient and family will understand medical diagnosis, treatment regimen, and limitations related to extent of illness.
- The patient and family will identify ethical/moral dilemma.
- The patient and family will describe personal and family values and conflict with current situation.
- The patient and family will identify health care ethics resources to assist in resolution of conflict.
- The patient and family will verbalize relief from anguish, uneasiness, or distress.

SUGGESTED NOC OUTCOMES

Acceptance: Health Status; Client Satisfaction: Communication; Decision Making; Family Integrity; Family Functioning; Family Health Status; Family Integrity; Knowledge: Health Resources; Spiritual Health

INTERVENTIONS AND RATIONALES

Determine: Assess patient's and family's understanding of the diagnosis and prognosis, limitations, treatment options; description of their personal values; and their physical expressions of suffering. *Assessment factors assist in identifying appropriate interventions.*

Perform: Establish an environment in which family members can share comfortably and openly their issues and concerns.

Enlist assistance of health care ethics resources such as ethics committee or consultants. *Including experts in health care ethics will assist in identifying the patient/family values and reason for the dilemma. By identifying the source of the conflict, the process of resolution may begin, thus leading to better understanding by all parties and partial or full relief from moral suffering.*

Enlist assistance of chaplain or personal clergy *to assist in the process of resolution through clarification of values related to religious views. Chaplains and personal clergy may provide a more neutral "third party" that can help defuse the situation. Personal trusted clergy might recognize or facilitate patient/family verbal and physical expressions of suffering or relief.*

Inform: Educate patient and family about medical diagnosis, treatment regimen, and limitations involved in *to help both patient and family understand the limits of and read on for medical treatment related to medical diagnosis.*

Attend: Provide or set aside ample time for patient and family to express their feelings about the current situation. *Open, honest communication may clear misconceptions on both sides and facilitate relief from suffering in the mid of dilemma.*

Acknowledge ethical/moral position of the patient/family who may feel that their positions or views will go unrecognized in the mid of serious illness and high-tech treatments; they may not want to "bother" nurses and physicians with these concerns. *Acknowledging their concerns, values, and moral position allows for holistic care.*

Manage: Refer, where requested, for follow-up for a family member who needs exercise, weight management, diet assistance, health screenings, and so forth. *Assisting patient to make referrals will help ensure continued efforts on the part of the patient to live a healthier lifestyle.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Anger Control Assistance; Anxiety Reduction; Conflict Mediation; Consultation; Counseling; Family Integrity Promotion; Multidisciplinary Care Conference; Spiritual Support; Family Support; Family Integrity Promotion; Family Maintenance; Truth Telling; Spiritual Growth Facilitation

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332 IMPAIRED ORAL MUCOUS MEMBRANE

DEFINITION

Injury to the lips, soft tissue, buccal cavity, and/or oropharynx

DEFINING CHARACTERISTICS

- Bad taste in mouth
- Bleeding
- Cheilitis
- Coated tongue
- Decrease in taste sensation
- Desquamation
- Difficulty eating
- Difficulty speaking
- Enlarged tonsils
- Exposure to pathogen
- Geographic tongue
- Gingival hyperplasia
- Gingival pallor
- Gingival pocketing deeper than 4 mm
- Gingival recession
- Halitosis
- Hyperemia
- Impaired ability to swallow
- Macroplasia
- Mucosal denudation
- Oral discomfort
- Oral edema
- Oral fissure
- Oral lesion
- Oral mucosal pallor
- Oral nodule
- Oral pain
- Oral papule
- Oral ulcer
- Oral vesicles
- Presence of mass (e.g., hemangioma)
- Purulent oral-nasal drainage
- Purulent oral-nasal exudates
- Smooth atrophic tongue
- Spongy patches in mouth
- Stomatitis
- White patches in mouth
- White plaque in mouth
- White, curd-like oral exudate
- Xerostomia

RELATED FACTORS

- Alcohol consumption
- Allergy
- Alteration in cognitive functioning
- Autoimmune disease
- Autosomal disorder
- Barrier to dental care
- Barrier to self-care
- Behavior disorder (e.g., attention deficit, oppositional defiant)
- Chemical injury agent (e.g., burn, capsaicin, methylene chloride, mustard agent)
- Cleft lip
- Cleft palate
- Decrease in hormone level in women
- Decrease in platelets
- Decrease in salivation
- Dehydration
- Depression
- Immunodeficiency
- Immunosuppression
- Infection
- Insufficient knowledge or oral hygiene
- Insufficient oral hygiene
- Loss of oral support structure
- Malnutrition
- Mechanical factor (e.g., ill-fitting dentures, braces, endotracheal/nasogastric tube, oral surgery)
- Mouth breathing

- Nil per os (NPO) >24 hours
- Oral trauma
- Smoking
- Stressors
- Syndrome (e.g., Sjögren's)
- Treatment regimen

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Fluid and electrolytes
- Nutrition
- Tissue integrity

EXPECTED OUTCOMES

- The patient will maintain fluid balance (intake equals output).
- The patient will state increased comfort.
- The patient will have pink, moist oral mucous membranes.
- The patient will have minimal, if any, complications of the oral mucosa.
- The patient will correlate precipitating factors with appropriate oral care.
- The patient will demonstrate oral hygiene practices.

SUGGESTED NOC OUTCOMES

Oral Hygiene; Tissue Integrity: Skin & Mucous Membranes

INTERVENTIONS AND RATIONALES

Determine: Inspect patient's oral cavity every shift. Describe and document condition; report any change in status. *Regular assessments can anticipate or alleviate problems.*

Monitor progress, reporting favorable and adverse responses to the treatment regimen *to evaluate effectiveness.*

Perform: Perform the prescribed treatment regimen, including administering intravenous or oral fluids, *to improve the condition of patient's mucous membranes.*

Provide supportive measures, as indicated:

- Assist with oral hygiene before and after meals *to promote a feeling of comfort and well-being.*
- Use a toothbrush with suction if patient can't spit out water, *to minimize risk of aspiration.*
- Provide mouthwash or gargles, as ordered, *to increase patient comfort and maintain moisture in the mouth.*
- Lubricate patient's lips frequently with water-based lubricant *to prevent cracked, irritated skin. These measures improve oral health.*

Inform: Instruct patient in oral hygiene practices, if necessary. Have patient return a demonstration of the oral care routine.

- Use a soft-bristled toothbrush.
- Brush with a circular motion away from the gums.

- Include the tongue when brushing.
- Review the need for routine visits to a dentist (annually for adults).

These measures increase patient's awareness of oral hygiene practices and reduce discomfort, resulting in increased nutrition and hydration.

Tell patient to chew gum or suck on sugarless hard candy *to stimulate salivation.*

Discuss precipitating factors, if known, and work to prevent future episodes. For example, encourage patient to avoid exercising in heat and to report effects of medication. *Patient's increased awareness of causative factors will help prevent recurrence.*

Attend: Encourage adherence to other aspects of health care management (controlling diabetes, changing dietary habits, and avoiding alcoholic beverages) *to control or minimize effects on mucous membranes.*

Manage: Refer patient to a dentist, dental hygienist, or other appropriate resource to correct ill-fitting dentures, modify braces, and adjust jaw wires, as needed. *Regularly scheduled dental follow-up reduces the risk of trauma to oral mucous membranes.*

SUGGESTED NIC INTERVENTIONS

Fluid and Electrolyte Management; Oral Health Maintenance; Oral Health Restoration; Oral Health Promotion

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RISK FOR IMPAIRED ORAL MUCOUS MEMBRANE

DEFINITION

Vulnerable to injury to the lips, soft tissues, buccal cavity, and/or oropharynx, which may compromise health

RISK FACTORS

- Alcohol consumption
- Allergy
- Alteration in cognitive functioning
- Autoimmune disease
- Autosomal disorder
- Barrier to dental care
- Barrier to oral self-care
- Behavior disorder (e.g., attention deficit, oppositional defiant)
- Chemotherapy
- Decrease in hormone level in women
- Economically disadvantaged
- Immunodeficiency
- Immunosuppression
- Inadequate nutrition
- Infection
- Insufficient knowledge of oral hygiene
- Insufficient oral hygiene
- Mechanical factor (e.g., orthodontic appliance, device for ventilation or food, ill-fitting dentures)
- Radiation therapy
- Smoking
- Stressors
- Surgical procedure
- Syndrome (e.g., Sjögren's)
- Trauma

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Fluid and electrolytes
- Nutrition
- Tissue integrity

EXPECTED OUTCOMES

- The patient will maintain fluid balance (intake equals output).
- The patient will maintain oral comfort.
- The patient will maintain pink, moist oral mucous membranes.
- The patient will verbalize prevention measures of complications of the oral mucosa.
- The patient will demonstrate oral hygiene practices.

RISK FOR IMPAIRED ORAL MUCOUS MEMBRANE

SUGGESTED NOC OUTCOMES

Hydration; Immune Status; Knowledge: Health Promotion; Nutritional Status; Self-Care: Oral Hygiene

INTERVENTIONS AND RATIONALES

Determine: Inspect patient's oral cavity every shift. Describe and document condition; report any change in status. *Regular assessments can anticipate or alleviate problems.*

Perform: Perform the prescribed treatment regimen, including administering intravenous or oral fluids, *to improve the condition of patient's mucous membranes.*

Provide supportive measures, as indicated:

- Assist with oral hygiene before and after meals *to promote a feeling of comfort and well-being.*
- Use a toothbrush with suction if patient can't spit out water, *to minimize risk of aspiration.*
- Provide mouthwash or gargles, as ordered, *to increase patient comfort and maintain moisture in the mouth.*
- Lubricate patient's lips frequently with water-based lubricant *to prevent cracked, irritated skin. These measures improve oral health.*

Inform: Instruct patient in oral hygiene practices, if necessary. Have patient return a demonstration of the oral care routine.

- Use a soft-bristled toothbrush.
- Brush with a circular motion away from the gums.
- Include the tongue when brushing.
- Review the need for routine visits to a dentist (annually for adults).

These measures increase patient's awareness of oral hygiene practices and reduce discomfort, resulting in increased nutrition and hydration.

Tell patient to chew gum or suck on sugarless hard candy *to stimulate salivation.*

Discuss precipitating factors, if known, and work to prevent future episodes. For example, encourage patient to avoid exercising in heat and to report effects of medication. *Patient's increased awareness of causative factors will help prevent recurrence.*

Educate about regular dental checkups. *Can ensure health of teeth and gums*

Attend: Encourage adherence to other aspects of health care management (controlling diabetes, changing dietary habits, and avoiding alcoholic beverages) *to control or minimize effects on mucous membranes.*

Manage: Refer patient to a dentist, dental hygienist, or other appropriate resource to correct ill-fitting dentures, modify braces, and adjust jaw wires as needed. *Regularly scheduled dental follow-up reduces the risk of trauma to oral mucous membranes.*

SUGGESTED NIC INTERVENTIONS

Fluid Management; Nutrition Management; Oral Health Maintenance; Oral Health Promotion

REFERENCES

Dahm, T. S., Bruhn, A., & LeMaster, M. (2015). Oral care in the long-term care of older patients: How can the dental hygienist meet the need? *Journal of Dental Hygiene*, *89*(4), 229–237.

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DEFINITION

A subjective phenomenon of an unpleasant feeling in the back of the throat and stomach, which may or may not result in vomiting

DEFINING CHARACTERISTICS

- Aversion toward food
- Gagging sensation
- Increase in salivation
- Increase in swallowing
- Nausea
- Sour taste

RELATED FACTORS

Biophysical

- Biochemical dysfunction (e.g., uremia, diabetic ketoacidosis)
- Esophageal disease
- Exposure to toxin
- Gastric distension
- Gastrointestinal irritation
- Increased intracranial pressure (ICP)
- Intra-abdominal tumors
- Labyrinthitis
- Liver capsule stretch
- Localized tumor (e.g., acoustic neuroma, brain tumor, bone metastasis)
- Menière's disease
- Meningitis
- Motion sickness
- Pancreatic disease
- Pregnancy
- Splenic capsule stretch
- Treatment regimen

Situational

- Anxiety
- Fear
- Noxious environmental stimuli
- Noxious taste
- Psychological disorder
- Unpleasant visual stimuli

Treatment

- Gastric distension, irritation
- Pharmaceuticals

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Nutrition
- Fluid and electrolytes
- Pharmacologic function
- Knowledge
- Comfort

EXPECTED OUTCOMES

- The patient will state reasons for nausea and vomiting.
- The patient will take steps to manage episodes of nausea and vomiting.
- The patient will ingest sufficient nutrients to maintain health.
- The patient will take steps to ensure adequate nutrition when nausea abates.
- The patient will maintain weight within specified limits.

SUGGESTED NOC OUTCOMES

Appetite; Comfort Status: Physical; Fluid Balance; Hydration; Nausea & Vomiting Control; Nutritional Status: Food & Fluid Intake; Suffering Severity; Symptom Control; Nausea & Vomiting Severity; Nausea & Vomiting: Disruptive Effects

INTERVENTIONS AND RATIONALES

Determine: Assess for illness, pregnancy, medication use (prescription and over the counter); exposure to tainted foods, chemicals, occupational hazards; weight (fluctuation in last 6 months); food preferences and usual dietary patterns; history of gastric/esophageal problems. *Assessment information will help in identifying appropriate interventions.*

Monitor direct observation of food and fluid intake *to ensure whether or not the patient is receiving adequate nutritional intake.*

Perform: Provide comfort measures (e.g., back massage, warm bath) *to promote feelings of comfort for the patient.*

Reduce noise, control odors, and adjust light in the environment to help the patient relax and *to reduce environmental factors that produce nausea.*

Allow periods of uninterrupted sleep between procedures. *Procedures and medication administration sometimes trigger periods of nausea.*

Offer small amount of cool liquids or ice chips *to provide some fluid* to reduce the possibility of dehydration.

Suggest frequent mouth care *to reduce unpleasant taste in the mouth.*

Give dry, bland foods, such as dry toast or crackers, during periods of nausea *to make it possible to eat. These foods have been found to be effective.*

Administer antinausea medications, as prescribed.

Inform: Teach relaxation techniques and encourage patient to use these techniques during mealtime *to reduce stress and divert attention from the nausea.*

Teach patient how to use food and fluid during periods of nausea, *to avoid dehydration and lack of nutrients. Food should be taken in small, frequent feedings. Avoid drinking with meals.*

Attend: When nausea abates, encourage patient to increase food intake *to assist with adequate intake of nutrients.*

Assist patient to make a list of best tolerated and poorly tolerated foods *so the patient can choose quickly and wisely when nausea abates.*

Manage: If nausea persists, refer patient to a nutritionist to assist after discharge *to ensure that adequate nutrients will be ingested.*

Stress the importance of follow-up appointments with the physician. *Nausea is a preventable problem and should respond to appropriate measures.*

SUGGESTED NIC INTERVENTIONS

Diet Staging; Fluid and Electrolyte Management; Fluid Monitoring; Medication Management; Nausea Management; Nutrition Management; Massage; Relaxation Therapy

REFERENCES

Gonella, S., Berchialla, P., Bruno, B., & Di Giulio, P. (2014). Are orange lollies effective in preventing nausea and vomiting related to dimethyl sulfoxide? A multicenter randomized trial. *Supportive Care in Cancer*, *22*(9), 2417–2424. doi:10.1007/s00520-014-2227-y

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Moradian, S., & Howell, D. (2015). Prevention and management of chemotherapy-induced nausea and vomiting. *International Journal of Palliative Nursing*, *21*(5), 216–224.

Ng, T. L., Hutton, B., & Clemons, M. (2015). Chemotherapy-induced nausea and vomiting: Time for more emphasis on nausea? *Oncologist*, *20*(6), 576–583. doi:10.1634/theoncologist.2014-0438

DEFINITION

Behavior of person and/or caregiver that fails to coincide with a health-promoting or therapeutic plan agreed on by the person (and/or family and/or community) and health care professional. In the presence of an agreed upon, health-promoting or therapeutic plan, the person's or caregiver's behavior is fully or partly nonadherent and may lead to clinically ineffective or partially effective outcomes

DEFINING CHARACTERISTICS

- Development-related complication
- Exacerbation of symptoms
- Failure to meet outcomes
- Missing of appointments
- Nonadherence behavior

RELATED FACTORS

Health system

- Difficulty in client–provider relationship
- Inadequate access to care
- Inconvenience of care
- Ineffective communication skills of the provider
- Insufficient follow-up with provider
- Insufficient health insurance coverage
- Insufficient provider reimbursement
- Insufficient teaching skill of the provider
- Low satisfaction with care
- Perceived low credibility of provider
- Provider discontinuity

Health care plan

- Complex treatment regimen
- Financial barriers
- High-cost regimen
- Intensity of regimen
- Lengthy duration of regimen

Individual

- Cultural incongruence
- Expectations incongruent with developmental phase
- Health beliefs incongruent with plan
- Insufficient knowledge about the regimen
- Insufficient motivation
- Insufficient skills to perform regimen
- Insufficient social support

- Spiritual values incongruent with plan
- Values incongruent with plan

Network
- Insufficient involvement of members in plan
- Low social value attributed to plan
- Perception that beliefs of significant other differ from plan

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)
- Behavior
- Beliefs/values
- Coping
- Emotional status
- Knowledge
- Roles/responsibilities
- Self-perception

EXPECTED OUTCOMES

- The patient will identify factors that influence noncompliance.
- The patient will demonstrate level of compliance that maintains safety.
- The patient will contract to perform specific behaviors.
- The patient will use support systems to modify noncompliant behaviors.

SUGGESTED NOC OUTCOMES

Acceptance: Health Status; Adherence Behavior; Compliance Behavior; Symptom Control; Treatment Behavior: Illness or Injury

INTERVENTIONS AND RATIONALES

Determine: Assess patient's perception of health problem, treatment regimen and history of compliance, obstacles to compliance, financial resources, ethnicity, and religious influences. *Assessment information may help select appropriate interventions.*

Perform: Provide an environment that is nonjudgmental. *This demonstrates unconditional respect for the patient.*

Contract with the patient to practice only nonthreatening behaviors. *This involves the patient in a formal commitment and gives the patient a sense of personal control.*

Inform: Teach self-healing techniques to both the patient and family such as meditation, guided imagery, yoga, and prayer. *These techniques promote self-reliance.*

Teach principles of good nutrition for patient's specific condition. *Understanding importance of nutrition will encourage compliance.*

Inform patient about diagnosis. *Understanding essential information needed to perform skills or give self-care increases compliance.* Demonstrate

skills needed by patient to comply with treatment regimen *to reinforce patient's confidence in ability to replicate.*

Attend: Provide opportunities for the patient to discuss reasons for noncompliance. *The willingness of the nurse to listen allows the patient the ability to listen to patient's own reasoning.*

Help patient clarify patient's values about the importance of following a treatment plan *to determine appropriate interventions.*

Acknowledge patient's right to choose not to comply with prescribed regimen, *to respect autonomy. Control over patient's actions is legitimate only when dangerous to self or others.* Offer positive reinforcement.

Use support systems to reinforce negotiated behaviors. *Support from the family and friends helps foster compliance.*

Manage: When medically appropriate, support patient's cultural beliefs toward medical practices to demonstrate respect, and refer to a member of the clergy or a spiritual counselor.

Refer family to community resources and support groups *to promote compliance with modification of behavior.* If patient's situation is complicated by lack of financial resources, contact agencies that may offer help with costs of medical treatment.

SUGGESTED NIC INTERVENTIONS

Coping Enhancement; Counseling; Decision-Making Support; Health Education; Patient Contracting; Self-Modification Assistance; Self-Responsibility Facilitation

REFERENCES

JaHyun, K., Engberg, S. J., & Muto, C. A. (2014). Survey on influenza vaccination noncompliance among nursing students. *Infection Control & Hospital Epidemiology*, *35*(10), 1316–1317. doi:10.1086/678076

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344 IMBALANCED NUTRITION: LESS THAN BODY REQUIREMENTS

DEFINITION

Intake of nutrients insufficient to meet metabolic needs

DEFINING CHARACTERISTICS

- Abdominal cramping
- Abdominal pain
- Alteration in taste sensation
- Body weight 20% or more below ideal weight range
- Capillary fragility
- Diarrhea
- Excessive hair loss
- Food aversion
- Food intake less than recommended daily allowance (RDA)
- Hyperactive bowel sounds
- Insufficient information
- Insufficient interest in food
- Insufficient muscle tone
- Misinformation
- Misperception
- Pale mucous membranes
- Perceived inability to ingest food
- Satiety immediately upon ingesting food
- Sore buccal cavity
- Weakness of muscles required for mastication
- Weakness of muscles required for swallowing
- Weight loss with adequate food intake

RELATED FACTORS

- Biologic factors
- Economically disadvantaged
- Inability to absorb nutrients
- Inability to digest food
- Inability to ingest food
- Insufficient dietary intake
- Psychological disorder

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Nutrition
- Elimination
- Fluids and electrolytes
- Values/beliefs

EXPECTED OUTCOMES

- The patient will consume ____ calories daily.
- The patient will gain __ lb/week and show no further evidence of weight loss.
- The patient will communicate understanding of dietary needs.
- The patient will demonstrate ability to plan meals that will help patient gain weight.

SUGGESTED NOC OUTCOMES

Nutritional Status; Nutritional Status: Food & Fluid Intake; Nutritional Status: Nutrient Intake; Weight Gain Behavior; Weight: Body Mass; Weight Maintenance Behavior; Knowledge: Diet

INTERVENTIONS AND RATIONALES

Determine: Assess height, weight, meal preparation, serum albumen, usual dietary pattern, weight fluctuation over the last 10 years, psychosocial status, and coping behavior. *Assessment of these factors will allow the nurse to choose appropriate interventions.*

Perform: Obtain and record patient's weight every day at the same time *to ensure keeping an accurate record of weight.*

Monitor fluid intake and output every 8 hours *to provide adequate fluid replacement.*

Provide a diet prescribed for the patient's specific condition and preferences *to ensure that the patient's dietary restrictions are followed as much as possible.* Keep snacks at the bedside *to allow the patient to eat small amounts frequently.*

Approach patient in a nonjudgmental manner. *This demonstrates unconditional positive respect for the patient.* Facilitate opportunities for spiritual nourishment and growth *to address patient's holistic needs for maximal therapeutic environment.*

Inform: Teach self-healing techniques to both the patient and family such as meditation, guided imagery, yoga, and prayer. Teach patient how to incorporate the use of self-healing techniques in carrying out usual daily activities. *These techniques can be used to reduce anxiety and increase self-reliance.*

Provide patient with concise information about the diagnosis, and teach principles of good nutrition for specific condition. *Understanding encourages compliance with treatment and nutritional regimen.*

Attend: Provide opportunities for the patient to discuss reasons for not eating and to clarify values about the importance of food *in order to determine appropriate interventions.*

After obtaining patient's food preferences, attempt to obtain desired foods for the patient. Offer foods that appeal to olfactory, visual, and

tactile senses *to enhance patient's appetite.* Whenever possible, sit with patient for a predetermined time during each meal. *This inhibits patient from dawdling during the meal.*

Acknowledge patient's right to choose not to comply with prescribed regimen. *Patient's autonomy must be respected. Control over patient's actions is legitimate only when danger is posed to patient or others.*

Use support systems to reinforce negotiated behaviors. *Support from the family helps foster compliance.*

Manage: Refer patient to a dietitian or nutritional support team *for dietary management.* Refer family to community resources and support groups available *to assist patient in complying with modification of behavior.* If patient's situation is complicated by a lack of financial recourses, contact agencies *that may offer help with the cost of medical treatment.* Refer to a member of the clergy or a spiritual counselor, according to the patient's preference, *to show respect for the patient's beliefs and provide spiritual care.*

SUGGESTED NIC INTERVENTIONS

Eating Disorders Management; Fluid Monitoring; Mutual Goal-Setting; Weight Goal-Setting; Nutrition Management; Nutritional Monitoring

REFERENCES

Marik, P. E. (2014). Enteral nutrition in the critically ill: Myths and misconceptions. *Critical Care Medicine*, *42*(4), 962–969. doi:10.1097/CCM.0000000000000051

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DEFINITION

A condition in which an individual accumulates abnormal or excessive fat for age and gender that exceeds overweight

DEFINING CHARACTERISTICS

- *Adult*: BMI >30 kg/m^2
- *Child* <2 years: Term not used with children at this age
- *Child* 2 to 18 years: BMI >30 kg/m^2 or >95th percentile for age and gender

RELATED FACTORS

- Average daily physical activity is less than recommended for gender and age
- Consumption of sugar-sweetened beverages
- Disordered eating behaviors
- Disordered eating perceptions
- Economically disadvantaged
- Energy expenditure below energy intake based on standard assessment (e.g., WAVE assessment—weight, activity, variety in diet, excess)
- Excessive alcohol consumption
- Fear regarding lack of food supply
- Formula- or mixed-fed infants
- Frequent snacking
- Genetic disorder
- Heritability of interrelated factors (e.g., adipose tissue distribution, energy expenditure, lipoprotein lipase activity, lipid synthesis, lipolysis)
- High disinhibition and restraint eating behavior score
- High frequency of restaurant or fried food
- Low dietary calcium intake in children
- Maternal diabetes mellitus
- Maternal smoking
- Overweight in infancy
- Parental obesity
- Portion sizes larger than recommended
- Premature pubarche
- Rapid weight gain during childhood
- Rapid weight gain during infancy, including the first week, first 4 months, and first year
- Sedentary behavior occurring for ≥2 hours/day
- Shortened sleep time
- Sleep disorder
- Solid foods as major food source at <5 months of age

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication

- Coping
- Emotional
- Knowledge
- Nutrition
- Values and beliefs

EXPECTED OUTCOMES

- The patient will voice feelings about present weight.
- The patient will identify internal and external cues that increase food consumption.
- The patient will verbalize need to lose weight.
- The patient will set a goal of losing ____ lb a week.
- The patient will adhere to prescribed diet, and plan menus appropriate to diet.
- The patient will set target weight before discharge.
- The patient will state plan to monitor and maintain target weight.
- The patient will participate in an exercise plan ___ times per week.

SUGGESTED NOC OUTCOMES

Anxiety Level; Eating Disorder Self-Control; Exercise Participation; Nutritional Status; Weight: Body Mass

INTERVENTIONS AND RATIONALES

Determine: Assess height, weight, usual dietary patterns, food preference, understanding of risk factors, heredity influences, activity level, usual coping patterns, and body image. *Information from assessment will help identify appropriate interventions.*

Perform: Weigh patient weekly, or as ordered, *to evaluate patient's progress toward reaching goal and provide feedback.*

Help patient set realistic goal for weight loss. *Goal should be in the ideal range considering the patient's height and age, but the patient needs to be reminded that slow weight loss will help reach goal more effectively.*

Inform: Teach patient about low-calorie, nutritious foods. *This encourages patient to eat foods that provide energy without causing weight gain.*

Have patient keep a food diary *to keep track of what is actually eaten. Without this, foods are sometimes eaten and not included in daily food consumption. This will act as self-monitoring tool.*

Teach coping skills. Have patient role-play *to provide practical experience.* Provide instructional material on healthy eating habits, coping skills, self-esteem, and so forth.

Attend: Listen to patient's personal values and beliefs, but remain nonjudgmental, even if patient's values and beliefs differ from your own. *Remaining nonjudgmental, but attentive, shows your support.* Explore personal identity issues distressing to the patient *to isolate issues into small, more solvable units.*

Help patient identify patient's values, beliefs, hopes, dreams skills, and interest. *The patient's deficits may lie in a lack of self-exploration or problem-solving methods used.*

Promote choices with the most likeliness of success. *Specific instructions can help the patient gain problem-solving ability and maturity.*

Manage: Refer patient to a mental health professional for behavior modification *to help change poor eating habits and ensure permanent weight loss.*

Have a dietitian calculate the caloric intake the patient will require *to reach a desirable weight to allow for planning.*

Refer to peer support group and promote outpatient counseling and family meetings *to reinforce progress and reduce regression.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Behavior Modification; Exercise Promotion; Nutrition Management; Nutritional Therapy; Risk Identification; Teaching: Prescribed Diet; Weight Reduction Assistance

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350 RISK FOR OTHER DIRECTED VIOLENCE

DEFINITION

Vulnerable to behaviors in which an individual demonstrates that he or she can be physically, emotionally, and/or sexually harmful to others

RISK FACTORS

- Access to weapon
- Alteration in cognitive functioning
- Cruelty to animals
- Fire-setting
- History of childhood abuse (e.g., physical, psychological, sexual)
- History of substance abuse
- History of witnessing family violence
- Impulsiveness
- Motor vehicle offense (e.g., traffic violations, use of a motor vehicle to release anger)
- Negative body language (e.g., rigid posture, clenching of fists/jaw, hyperactivity, pacing, threatening stances)
- Neurologic impairment (e.g., positive EEG, head trauma, seizure disorders)
- Pathological intoxication
- Pattern of indirect violence (e.g., tearing objects off walls, urinating/defecating on floor, stamping feet, temper tantrum, throwing objects, breaking a window, slamming doors, sexual advances)
- Pattern of other-directed violence (e.g., hitting/kicking/spitting/scratching others, throwing objects/biting someone, attempted rape, rape, sexual molestation, urinating/defecating on a person)
- Pattern of threatening violence (e.g., verbal threats against property/people, social threats, cursing, threatening notes/gestures, sexual threats)
- Pattern of violent antisocial behavior (e.g., stealing, insistent borrowing, insistent demands for privileges, insistent interrupting, refusal to eat/take medication, ignoring instructions)
- Perinatal complication
- Prenatal complications
- Psychotic disorder
- Suicidal behavior

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Emotional
- Knowledge
- Neurocognition
- Risk factor management
- Self-perception

EXPECTED OUTCOMES

- The patient will maintain control over anger.
- The patient will successfully rechannel hostility into socially acceptable behaviors.
- The patient will discuss angry feelings and verbalize appropriate ways to tolerate frustration.
- The patient will express need for long-term treatment.

SUGGESTED NOC OUTCOMES

Abuse Cessation; Abusive Behavior Self-Restraint; Aggression Self-Control; Impulse Self-Control

INTERVENTIONS AND RATIONALES

Determine: Assess recent stressors; substance abuse history; previous episodes of violence; reaction of family members to episodes of violence; neurologic examination; toxicology examination and blood chemistry. *Assessment information will help identify appropriate intervention.*

Perform: Remove all objects from the environment that the patient could use to harm self, *in order to provide safety and protect potential victims of violence.*

Administer prescribed medications *to help patient control aggressive behavior and remain calm.* Monitor for effectiveness. *When used appropriately, medications will remove the need for physical restraint.*

Inform: Explain medication program to patient *to promote compliance.* Make sure that medication is swallowed, as prescribed, *to ensure compliance and produce calmness.*

Teach coping strategies and self-healing techniques to patient and family members, including meditation, guided imagery, and prayer.

Teach patient how to incorporate the use of self-healing techniques in carrying out usual daily activities. *These techniques help calm the mind and promote ability to cooperate with the difficulties associated with violent behavior.*

Attend: Explain to patient in a firm, calm voice that you will help the patient maintain control. *Communicating a willingness to help encourages the patient to take control of patient's behavior.*

Encourage patient to begin discussing hostile feelings gradually *to help patient develop more appropriate ways of dealing with hostility.*

Discuss situations that provoke feelings of anxiety, anger, and powerlessness *to identify areas of patient concern and to prevent anger from being inappropriately directed at self.*

Manage: Set limits on patient's behavior *to reinforce the expectation that the patient will act in a responsible controlled manner.*

Provide patient with telephone numbers and other information about crisis centers, hotlines, and counselors. *Alternatives may ease anxiety about the perceived threat of long-term psychotherapy.*

SUGGESTED NIC INTERVENTIONS

Anger Control Assistance; Behavior Management; Environmental Management: Violence Prevention; Impulse Control Training

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Berends, L., Ferris, J., & Laslett, A. (2014). On the nature of harms reported by those identifying a problematic drinker in the family, an exploratory study. *Journal of Family Violence*, *29*(2), 197–204. doi:10.1007/s10896-013-9570-5

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DEFINITION

A condition in which an individual accumulates abnormal or excessive fat for age and gender.

DEFINING CHARACTERISTICS

- *Adult*: BMI >25 kg/m^2
- *Child* <2 years: Weight-for-length >95th percentile
- *Child* 2 to 18 years: BMI >85th but <95th percentile, or 25 kg/m^2 (whichever is smaller)

RELATED FACTORS

- Average daily physical activity is less than recommended for gender and age
- Consumption of sugar-sweetened beverages
- Disordered eating behaviors (e.g., binge eating, extreme weight control)
- Disordered eating perceptions
- Economically disadvantaged
- Energy expenditure below energy intake based on standard assessment (e.g., WAVE assessment—weight, activity, variety in diet, excess)
- Excessive alcohol consumption
- Fear regarding lack of food supply
- Formula- or mixed-fed infants
- Frequent snacking
- Genetic disorder
- Heritability of interrelated factors (e.g., adipose tissue distribution, energy expenditure, lipoprotein lipase activity, lipid synthesis, lipolysis)
- High disinhibition and restraint eating behavior score
- High frequency of restaurant or fried food
- Low dietary calcium intake in children
- Maternal diabetes mellitus
- Maternal smoking
- Obesity in childhood
- Parental obesity
- Portion sizes larger than recommended
- Premature pubarche
- Rapid weight gain during childhood
- Rapid weight gain during infancy, including the first week, first 4 months, and first year
- Sedentary behavior occurring for 2 hours/day
- Shortened sleep time
- Sleep disorder
- Solid foods as major food source at <5 months of age

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication

- Coping
- Emotional
- Knowledge
- Nutrition
- Values and beliefs

EXPECTED OUTCOMES

- The patient will identify internal and external factors contributing to weight gain.
- The patient will state need to lose weight.
- The patient will plan to monitor weight and sustain target weight.
- The patient will express feelings regarding dietary regimen and current weight.
- The patient will identify internal and external cues that lead to increased food consumption.
- The patient will plan meals appropriate for prescribed diet.
- The patient will participate in regular physical activity

SUGGESTED NOC OUTCOMES

Anxiety Level; Eating Disorder Self-Control; Exercise Participation; Nutritional Status; Weight: Body Mass

INTERVENTIONS AND RATIONALES

Determine: Assess height, weight, usual dietary patterns, food preference, understanding of risk factors, heredity influences, activity level, usual coping patterns, and body image. *Information from assessment will help identify appropriate interventions.*

Determine patient's food preferences *to evaluate eating habits and to include preferred foods, if nutritional, in patient's diet.*

Perform: Weigh patient weekly, or as ordered, *to evaluate patient's progress toward reaching goal and provide feedback.*

Help patient set realistic goal for weight loss. *Goal should be in the ideal range considering the patient's height and age, but the patient needs to be reminded that slow weight loss will help reach goal more effectively.*

Inform: Teach patient about low-calorie, nutritious foods. *This encourages patient to eat foods that provide energy without causing weight gain.*

Have patient keep a food diary *to keep track of what is actually eaten. Without this, foods are sometimes eaten and not included in daily food consumption. This will act as self-monitoring tool.*

Teach coping skills. Have patient role-play *to provide practical experience.* Provide instructional material on healthy eating habits, coping skills, self-esteem, and so forth.

Attend: Help patient identify values, beliefs, hopes, dreams skills, and interest. *The patient's deficits may lie in a lack of self-exploration or problem-solving methods used.*

Promote choices with the most likeliness of success. *Specific instructions can help the patient gain problem-solving ability and maturity.*

Manage: Refer patient to a mental health professional for behavior modification *to help change poor eating habits and ensure permanent weight loss.*

Have a dietitian calculate the caloric intake the patient will require *to reach a desirable weight to allow for planning.*

Refer to peer support group, and promote outpatient counseling and family meetings *to reinforce progress and reduce regression.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Behavior Modification; Exercise Promotion; Nutrition Management; Nutritional Therapy; Risk Identification; Teaching: Prescribed Diet; Weight Reduction Assistance

REFERENCES

Bleich, S. N., Jones-Smith, J., Jones, H., O'Hara, M., & Rutkow, L. (2016). The voices for healthy kids campaign and US state legislation to prevent childhood obesity. *American Journal of Public Health*, *106*(3), 436–439. doi:10.2105/AJPH.2015.303002

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Subica, A. M., Grills, C. T., Douglas, J. A., & Villanueva, S. (2016). Communities of color creating healthy environments to combat childhood obesity. *American Journal of Public Health*, *106*(1), 78–86. doi:10.2105/AJPH.2015.302887

DEFINITION

Vulnerable to abnormal or excessive fat accumulation for age and gender, which may compromise health

RISK FACTORS

- *Adult*: BMI approaching 25 kg/m^2
- Average daily physical activity is less than recommended for gender and age
- *Child* <2 years: Weight-for-length approaching 95th percentile
- *Child* 2 to 18 years: BMI approaching 85th percentile, or 25 kg/m^2 (whichever is smaller)
- Children who are crossing BMI percentiles upward
- Children with high BMI percentiles
- Consumption of sugar-sweetened beverages
- Disordered eating behaviors (e.g., binge eating, extreme weight control)
- Disordered eating perceptions
- Eating in response to external cues (e.g., time of day, social situations)
- Eating in response to internal cues other than hunger (e.g., anxiety)
- Economically disadvantaged
- Energy expenditure below energy intake based on standard assessment (e.g., WAVE assessment—weight, activity, variety in diet, excess)
- Excessive alcohol consumption
- Fear regarding lack of food supply
- Formula- or mixed-fed infants
- Frequent snacking
- Genetic disorder
- Heritability of interrelated factors (e.g., adipose tissue distribution, energy expenditure, lipoprotein lipase activity, lipid synthesis, lipolysis)
- High disinhibition and restraint eating behavior score
- High frequency of restaurant or fried food
- Higher baseline weight at beginning of each pregnancy
- Low dietary calcium intake in children
- Maternal diabetes mellitus
- Maternal smoking
- Obesity in childhood
- Parental obesity
- Portion sizes larger than recommended
- Premature pubarche
- Rapid weight gain during childhood
- Rapid weight gain during infancy, including the first week, first 4 months, and first year
- Sedentary behavior occurring for >2 hours/day
- Shortened sleep time
- Sleep disorder
- Solid foods as major food source at <5 months of age

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication
- Coping
- Emotional
- Knowledge
- Nutrition
- Values and beliefs

EXPECTED OUTCOMES

- The patient will identify internal and external factors contributing to weight gain.
- The patient will state need to maintain weight.
- The patient will plan to monitor weight and sustain target weight.
- The patient will express feelings regarding dietary regimen and current weight.
- The patient will identify internal and external cues that lead to increased food consumption.
- The patient will plan meals appropriate for prescribed diet.
- The patient will participate in regular physical activity

SUGGESTED NOC OUTCOMES

Anxiety Level; Eating Disorder Self-Control; Exercise Participation; Nutritional Status; Weight: Body Mass

INTERVENTIONS AND RATIONALES

Determine: Assess height, weight, usual dietary patterns, food preference, understanding of risk factors, heredity influences, activity level, usual coping patterns, and body image. *Information from assessment will help identify appropriate interventions.*

Determine patient's food preferences *to evaluate eating habits and to include preferred foods, if nutritional, in patient's diet.*

Perform: Weigh patient monthly, or as ordered, *to evaluate patient's weight maintenance and provide feedback.*

Help patient plan a weight management program. *Ideal weight range should consider the patient's height and age.*

Inform: Teach patient about low-calorie, nutritious foods. *This encourages patient to eat foods that provide energy without causing weight gain.*

Have patient keep a food diary *to keep track of what is actually eaten. Without this, foods are sometimes eaten and not included in daily food consumption. This will act as self-monitoring tool.*

Teach coping skills. Have patient role-play *to provide practical experience.* Provide instructional material on healthy eating habits, coping skills, self-esteem, and so forth.

Attend: Promote choices with the most likeliness of success. *Specific instructions can help the patient gain problem-solving ability and maturity.*

Give patient emotional support and positive feedback for adhering to healthy diet. *This will foster compliance and help ensure adherence to the diet.*

Manage: Have a dietitian calculate the caloric intake the patient requires to maintain a healthy weight *to provide a benchmark for meal planning.*

Refer patient, as appropriate, to resources for health coaching, behavior modification, or cognitive therapy *to prevent relapse into high-risk eating behaviors.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Behavior Modification; Exercise Promotion; Nutrition Management; Nutritional Therapy; Risk Identification; Teaching: Prescribed Diet; Weight Reduction Assistance

REFERENCES

Bleich, S. N., Jones-Smith, J., Jones, H., O'Hara, M., & Rutkow, L. (2016). The voices for healthy kids campaign and US state legislation to prevent childhood obesity. *American Journal of Public Health*, *106*(3), 436–439. doi:10.2105/AJPH.2015.303002

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DEFINITION

An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (International Association for the Study of Pain); sudden or slow onset of any intensity from mild to severe with an anticipated or predictable end

DEFINING CHARACTERISTICS

- Appetite change
- Change in physiologic parameter (e.g., blood pressure, heart rate, respiratory rate, oxygen saturation, and end-tidal CO_2)
- Diaphoresis
- Distraction behavior
- Evidence of pain using standardized pain behavior checklist for those unable to communicate verbally (e.g., Neonatal Infant Pain Scale, Pain Assessment Checklist for Seniors with Limited Ability to Communicate)
- Expressive behavior (e.g., restlessness, crying, vigilance)
- Facial expression of pain (e.g., eyes lack luster, beaten look, fixed or scattered movement, grimace)
- Guarding behavior
- Hopelessness
- Narrowed focus (e.g., time perception, thought processes, interaction with people and environment)
- Positioning to ease pain
- Protective behavior
- Proxy report of pain behavior/activity changes (e.g., family member, caregiver)
- Pupil dilation
- Self-focused
- Self-report of intensity using standardized pain scale (e.g., Wong-Baker FACES scale, visual analogue scale, numeric rating scale)
- Self-report of pain characteristics using standardized pain instrument (e.g., McGill Pain Questionnaire, Brief Pain Inventory)

RELATED FACTORS

- Biologic injury agent (e.g., infection, ischemia, neoplasm)
- Chemical injury agent (e.g., burn, capsaicin, methylene chloride, mustard agent)
- Physical injury agent (e.g., abscess, amputation, burn, cut, heavy lifting, operative procedure, trauma, overtraining)

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Communication
- Coping
- Emotional

- Sleep/rest
- Values/beliefs

EXPECTED OUTCOMES

- The patient will rate pain on a scale of 1 to 10.
- The patient will articulate factors that intensify pain and will modify behaviors accordingly.
- The patient will state and carry out appropriate interventions for relief of pain.
- The patient will decrease amount and frequency of pain medication needed.
- The patient will express relief from pain within a reasonable time after intervention.
- The patient will identify specific characteristics of pain.
- The patient will help develop a plan for pain control.
- The patient will state satisfaction with pain-management regimen.
- The patient will use available resources to understand pain phenomenon and will cooperate with treatment plan.
- The patient will perform relaxation exercises at bedtime.

SUGGESTED NOC OUTCOMES

Comfort Level; Comfort Status; Pain Control; Pain: Disruptive Effects; Pain Level; Sleep; Client Satisfaction: Pain Management; Knowledge: Pain Management

INTERVENTIONS AND RATIONALES

Determine: Assess descriptive characteristics of pain, including location, quality and intensity on a scale of 1 to 10, temporal factors and sources of relief; pain tolerance; ethnicity; attitude and values. *Descriptions about the particulars of pain will help determine what goals are realistic for the patient.*

Perform: Make changes in the environment at the patient's suggestion that will promote sleep. *This allows patient to have an active role in treatment.*

Apply heat or cold, as prescribed, *to minimize or relieve pain.* Reposition patient and use pillows to splint or support painful areas, as appropriate, *to reduce muscle spasm and to redistribute pressure on body parts.* Administer analgesic medications in a collaborative mode with the patient when alternative methods are not sufficient to make the pain tolerable. *Gaining the patient's trust and involvement helps ensure compliance and reduce medication intake.*

Provide patient with sleep aids, such as pillows, bath before sleep, and reading materials. Milk and some high-protein snacks, such as cheese and nuts, contain L-tryptophan and are also sleep promoters. *Personal hygiene and prebedtime rituals promote sleep in some patients. Comfort measures act as distracters from pain, reduce muscle tension or spasm, and redistribute pressure on body parts.*

Inform: Teach patient relaxation techniques such as guided imagery, deep breathing, meditation, aromatherapy, and progressive muscle relaxation. Practice with the patient frequently and especially at bedtime. *Purposeful relaxation efforts usually help promote sleep.*

Instruct patient to eliminate or reduce caffeine and alcohol intake and to avoid foods that interfere with sleep (e.g., spicy foods). *Foods and beverages containing caffeine consumed fewer than 4 hours before bedtime may interfere with sleep. Alcohol disrupts normal sleep, especially when ingested immediately before retiring.*

Attend: Listen to patient's description of pain. Allow time for the patient to talk about patient's frustration. *Listening attentively gives the patient a feeling that the nurse is interested. It also helps determine progress in alleviating the pain.*

Ask patient each day to describe the quality of patient's sleep. *Discomfort associated with pain may prevent the patient from sleeping well.*

Encourage activities that provide distraction, such as reading, crafts, television, and visits, *to help patient focus on non-pain-related matters.*

Manage: When possible, allow patient to use alternative pain treatments common in patient's culture (such as acupuncture) as a substitute or a complement to Western treatments, *to promote nonpharmacologic pain management.*

Refer to case manager/social worker *to ensure that follow-up is provided.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Analgesic Administration; Coping Enhancement; Emotional Support; Hope Instillation; Medication Management; Pain Management; Positioning; Sleep Enhancement; Environmental Management; Guided Imagery, Aromatherapy; Massage; Relaxation Therapy; Biofeedback; Referral

REFERENCES

Gregory, J. (2014). Dealing with acute and chronic pain: Part one—Assessment. *Journal of Community Nursing*, *28*(4), 83–86.

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Whitaker, M. H. (2012). Sounds soothing: Music therapy for post-operative pain. *Nursing, 146*(4), 678–679.

DEFINITION

Unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (International Association for the Study of Pain); sudden or slow onset of any intensity from mild to severe, constant or recurring without an anticipated or predictable end and a duration of greater than three (>3) months

DEFINING CHARACTERISTICS

- Alteration in ability to continue previous activities
- Alteration in sleep pattern
- Anorexia
- Evidence of pain using standardized pain behavior checklist for those unable to communicate verbally (e.g., Neonatal Infant Pain Scale, Pain Assessment Checklist for Seniors with Limited Ability to Communicate)
- Facial expression of pain (e.g., eyes lack luster, beaten look, fixed or scattered movement, grimace)
- Proxy report of pain behavior/activity changes (e.g., family member, caregiver)
- Self-focused
- Self-report of intensity using standardized pain scale (e.g., Wong-Baker FACES scale, visual analogue scale, numeric rating scale)
- Self-report of pain characteristics using standardized pain instrument (e.g., McGill Pain Questionnaire, Brief Pain Inventory)

RELATED FACTORS

- Age >50 years
- Alteration in sleep pattern
- Chronic musculoskeletal condition
- Contusion
- Crush injury
- Damage to the nervous system
- Emotional distress
- Fatigue
- Female gender
- Fracture
- Genetic disorder
- History of abuse (e.g., physical, psychological, sexual)
- History of genital mutilation
- History of overindebtedness
- History of static work postures
- History of substance abuse
- History of vigorous exercise
- Imbalance of neurotransmitters, neuromodulators, and receptors
- Immune disorder (e.g., HIV-associated neuropathy, varicella-zoster virus)

- Impaired metabolic functioning
- Increase in body mass index
- Ineffective sexuality pattern
- Injury agent
- Ischemic condition
- Malnutrition
- Muscle injury
- Nerve compression
- Post-trauma-related condition (e.g., infection, inflammation)
- Prolonged computer use (>20 hours/week)
- Prolonged increase in cortisol level
- Repeated handling of heavy loads
- Social isolation
- Spinal cord injury
- Tumor infiltration
- Whole-body vibration

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac functioning
- Comfort
- Coping
- Emotional
- Neurocognitive functioning
- Pharmacologic function
- Respiratory functioning
- Values/beliefs

EXPECTED OUTCOMES

- The patient will identify characteristics of pain and pain behaviors.
- The patient will develop pain management program that includes activity and rest, exercise, and medication regimen that isn't pain contingent.
- The patient will carry out resocialization behaviors and activities.
- The patient will state relationship of increasing pain to stress, activity, and fatigue.
- The patient will state importance of self-care behavior or activities.

SUGGESTED NOC OUTCOMES

Comfort Status; Depression Level; Depression Self-Control; Pain Control; Pain Level; Quality of Life; Sleep; Symptom Control; Knowledge: Pain Management; Pain: Adverse Psychological Response

INTERVENTIONS AND RATIONALES

Determine: Assess descriptive characteristics of pain, including location, quality, intensity on a scale of 1 to 10, temporal factors and sources of

relief; pain tolerance; ethnicity; self-image, coping behaviors, sleep patterns, activity level, attitude, and values. Assessment will *provide information to help identify interventions for that specific patient.*

Perform: Set up a behavior-oriented plan; for instance, set up a plan to follow the activity schedule. *Behavioral–cognitive measures can help patient modify learned pain behaviors.*

Contract with patient to increase probability that the patient will follow the plan for pain management that has been developed with the patient. *A contract is an agreement that can always be referred to when the patient attempts to make decisions outside the provisions of the plan.*

Schedule self-care activities for the patient. *This reduces dependence on caregivers and others in the patient's environment.*

Administer analgesic pain medication as outlined in the plan. *When a patient requests more than the plan allows, reiterate the terms of the plan in order not to overmedicate.*

Inform: Teach patient relaxation techniques such as guided imagery, deep breathing, meditation, aromatherapy, and progressive muscle relaxation. Practice with the patient frequently and especially at bedtime. *Purposeful relaxation efforts may help promote sleep.*

Instruct patient to eliminate or reduce caffeine and alcohol intake and to avoid foods that interfere with sleep (e.g., spicy foods). *Foods and beverages containing caffeine consumed fewer than 4 hours before bedtime may interfere with sleep. Alcohol disrupts normal sleep, especially when ingested immediately before retiring.*

Attend: Work closely with staff and family *to achieve pain management goals and maximize the patient's cooperation.*

Encourage patient and family to express feelings associated with diagnosis, treatment, and recovery *to help patient and family cope with treatment.* Schedule time to spend with the patient's family. *They need time with health care providers to ask questions.*

Encourage activities that provide distraction, such as reading, crafts, television, and visits, *to help patient focus on non-pain-related matters.*

Manage: When possible, allow patient to use alternative pain treatments common in patient's culture (such as acupuncture) as a substitute or a complement to Western treatments, *to promote nonpharmacologic pain management.*

Arrange for frequent multidisciplinary/family care conference *to keep care goal-oriented.* Refer patient to support group *to help deal with pain, depression, and so forth.* Refer to social worker/case manager *for follow-up care.*

SUGGESTED NIC INTERVENTIONS

Analgesic Administration; Behavior Modification; Emotional Support; Mood Management; Pain Management; Patient Contracting; Massage; Biofeedback; Relaxation Therapy

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DEFINITION

Sensory and emotional experience that varies from pleasant to unpleasant, associated with labor and childbirth

DEFINING CHARACTERISTICS

- Alteration in blood pressure
- Alteration in heart rate
- Alteration in muscle tension
- Alteration in neuroendocrine functioning
- Alteration in respiratory rate
- Alteration in sleep pattern
- Alteration in urinary functioning
- Decrease in appetite
- Diaphoresis
- Distraction behavior
- Expressive behavior
- Facial expression of pain (e.g., eyes lack luster, beaten look, fixed or scattered movement, grimace)
- Increase in appetite
- Narrowed focus
- Nausea
- Pain
- Perineal pressure
- Positioning to ease pain
- Protective behavior
- Pupil dilation
- Self-focused
- Uterine contraction
- Vomiting

RELATED FACTORS

- Cervical dilation
- Fetal expulsion

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Comfort
- Coping
- Emotional
- Neurocognitive functioning
- Values/beliefs

EXPECTED OUTCOMES

- The patient will identify characteristics of pain and will describe factors that intensify it.
- The patient will modify behavior to decrease pain.

- The patient will express decrease in intensity of discomfort.
- The patient will experience satisfaction with pain control during labor and delivery.

SUGGESTED NOC OUTCOMES

Anxiety Level; Client Satisfaction: Pain Control; Comfort Status; Comfort Status: Physical; Nausea & Vomiting Severity; Vital Signs

INTERVENTIONS AND RATIONALES

Determine: Assess the patient's knowledge of the labor and delivery process and patient's current anxiety level *to plan supportive strategies.*

Perform: Set up a behavior-oriented plan; for instance, set up a plan to follow the activity schedule. *Behavioral–cognitive measures can help patient modify learned pain behaviors.*

Contract with patient to increase probability that the patient will follow the plan for pain management that has been developed with the patient. *A contract is an agreement that can always be referred to when the patient attempts to make decisions outside the provisions of the plan.*

Administer analgesic pain medication as outlined in the plan. *When a patient requests more than the plan allows, reiterate the terms of the plan in order not to overmedicate.*

Inform: Explain available analgesics and anesthesia to patient and support person. *Awareness of available medications will reduce anxiety.*

Explain available nonpharmacologic pain reduction strategies available to patient and support person. *Awareness of available methods will reduce anxiety.*

Attend: Assist the patient and the support person in techniques to decrease the discomfort of labor:

- Conscious relaxation. *During labor, relaxation enables the patient to use coping techniques.*
- Concentration on an internal or external focal point. *A focal point allows controlled thoughts while breathing.*
- Slow, deep chest breathing. *Deep chest breathing creates a sense of relaxation during contractions.*
- Shallow chest breathing. Slow panting like breaths. *Slow breathing avoids hyperventilation. Shallow chest breathing lifts the diaphragm from the uterus during contractions, decreasing the intensity of the contractions.*
- Effleurage. *This technique stimulates large-diameter sensory nerve fibers and interferes with the transmission of pain impulses to the brain.*

Encourage patient to rest and relax between contractions to decrease fatigue. *Fatigue worsens pain perception and decreases the patient's ability to cope with contractions.*

Manage: When possible, allow patient to use alternative pain treatments common in patient's culture (such as acupuncture) as a substitute or a

complement to Western treatments, *to promote nonpharmacologic pain management.*

SUGGESTED NIC INTERVENTIONS

Energy Management; Environmental Management: Comfort; Guided Imagery; Massage; Medication Administration; Music Therapy; Positioning; Relaxation Therapy; Vital Signs Monitoring

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DEFINITION

Recurrent or persistent pain that has lasted at least three months, and that significantly affects daily functioning or well-being

DEFINING CHARACTERISTICS

- Anxiety
- Constipation
- Deficient knowledge
- Disturbed sleep pattern
- Fatigue
- Fear
- Impaired mood regulation
- Impaired physical mobility
- Insomnia
- Obesity
- Social isolation
- Stress overload

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Comfort
- Coping
- Emotional
- Neurocognitive functioning
- Values/beliefs

EXPECTED OUTCOMES

- The patient will identify characteristics of pain and pain behaviors.
- The patient will develop pain management program that includes activity and rest, exercise, and medication regimen that isn't pain contingent.
- The patient will state relationship of increasing pain to stress, activity, and fatigue.
- The patient will state importance of self-care behavior or activities.

SUGGESTED NOC OUTCOMES

Agitation Level; Anxiety Level; Appetite; Client Satisfaction: Pain Control; Comfort Status; Depression Level; Fatigue Level; Personal Well-Being; Quality of Life

INTERVENTIONS AND RATIONALES

Determine: Assess descriptive characteristics of pain, including location, quality, intensity on a scale of 1 to 10, temporal factors and sources of relief; pain tolerance; ethnicity; self-image, coping behaviors, sleep patterns, activity level, attitude, and values. Assessment will *provide information to help identify interventions for that specific patient.*

Perform: Set up a behavior-oriented plan; for instance, set up a plan to follow the activity schedule. *Behavioral–cognitive measures can help patient modify learned pain behaviors.*

Contract with patient to increase probability that patient will follow the plan for pain management that has been developed with the patient. *A contract is an agreement that can always be referred to when the patient attempts to make decisions outside the provisions of the plan.*

Administer analgesic pain medication as outlined in the plan. *When a patient requests more than the plan allows, reiterate the terms of the plan in order not to overmedicate.*

Inform: Teach patient relaxation techniques such as guided imagery, deep breathing, meditation, aromatherapy, and progressive muscle relaxation. Practice with the patient frequently and especially at bedtime. *Purposeful relaxation efforts may help promote sleep.*

Instruct patient to eliminate or reduce caffeine and alcohol intake and to avoid foods that interfere with sleep (e.g., spicy foods). *Foods and beverages containing caffeine consumed fewer than 4 hours before bedtime may interfere with sleep. Alcohol disrupts normal sleep, especially when ingested immediately before retiring.*

Attend: Work closely with staff and family *to achieve pain management goals and maximize the patient's cooperation.*

Encourage patient and family to express feelings associated with diagnosis, treatment, and recovery *to help patient and family cope with treatment.*

Encourage activities that provide distraction, such as reading, crafts, television, and visits, *to help patient focus on non-pain-related matters.*

Manage: When possible, allow patient to use alternative pain treatments common in patient's culture (such as acupuncture) as a substitute or a complement to Western treatments, *to promote nonpharmacologic pain management.*

Refer patient to support group *to help deal with pain, depression, and so forth.*

Refer to social worker/case manager *for follow-up care.*

SUGGESTED NIC INTERVENTIONS

Analgesic Administration; Coping Enhancement; Guided Imagery; Mood management; Positioning; Relaxation Therapy

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DEFINITION

Inability of the primary caretaker to create, maintain, or regain an environment that promotes the optimum growth and development of the child

DEFINING CHARACTERISTICS

Infant or Child

- Behavior disorder (e.g., attention deficit, oppositional defiant)
- Delay in cognitive development
- Diminished separation anxiety
- Failure to thrive
- Frequent accidents
- Frequent illness
- History of abuse (e.g., physical, psychological, sexual)
- History of trauma (e.g., physical, psychological, sexual)
- Impaired social functioning
- Insufficient attachment behavior
- Low academic performance
- Runaway

Parental

- Abandonment
- Decrease in ability to manage child
- Decrease in cuddling
- Deficient parent–child interaction
- Frustration with child
- History of childhood abuse (e.g., physical, psychological, sexual)
- Hostility
- Inadequate child health maintenance
- Inappropriate care-taking skills
- Inappropriate child care arrangements
- Inappropriate stimulation (e.g., visual, tactile, auditory)
- Inconsistent behavior management
- Inconsistent care
- Inflexibility in meeting needs of child
- Neglects needs of child
- Perceived inability to meet child's needs
- Perceived role inadequacy
- Punitive
- Rejection of child
- Speaks negatively about child
- Unsafe home environment

RELATED FACTORS

- *Infant or Child:* Alteration in perceptual abilities, behavior disorder (e.g., attention deficit, oppositional defiant), chronic illness, developmental delay, difficult temperament, disabling condition, gender other than desired, multiple births, parent–child separation, prematurity, temperament conflicts with parental expectations
- *Knowledge:* Alteration in cognitive functioning, ineffective communication skills, insufficient cognitive readiness for parenting, insufficient knowledge about child development, insufficient knowledge about child health maintenance, insufficient knowledge about parenting skills, insufficient response to infant cues, low educational level, preference for physical punishment, unrealistic expectations
- *Physiological:* Physical illness
- *Psychological:* Alteration in sleep pattern, closely spaced pregnancies, depression; difficult birthing process, disabling condition, high number of pregnancies, history of mental illness, history of substance abuse, insufficient prenatal care, sleep deprivation, young parental age
- *Social:* Change in family unit, compromised home environment, conflict between partners, economically disadvantaged, father of child not involved, history of abuse (e.g., physical, psychological, sexual), history of being abusive, inability to put child's needs before own, inadequate child care arrangements, ineffective coping strategies, insufficient family cohesiveness, insufficient parental role model, insufficient problem-solving skills, insufficient resources (e.g., financial, social, knowledge), insufficient social support, insufficient transportation, insufficient valuing of parenthood, legal difficulty, low self-esteem, mother of child not involved, relocation, single parent, social isolation, stressors, unemployment, unplanned pregnancy, unwanted pregnancy, work difficulty

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Communication
- Coping
- Knowledge
- Risk management
- Roles/responsibilities
- Self-perception
- Values and beliefs

EXPECTED OUTCOMES

- The parents will make appropriate physical, verbal, and eye contact when interacting with infant or a child.

- The parents will make statements indicating satisfaction with infant or child.
- The parents will demonstrate correct feeding, bathing, and dressing techniques.
- The parents will express willingness to maintain their relationship with each other.
- The parents will bring infant for routine well-child care.

SUGGESTED NOC OUTCOMES

Coping Enhancement; Family Process Maintenance; Family Coping; Family Health Status; Family Functioning; Knowledge: Infant Care and Parenting; Parent–Infant Attachment; Parenting: Adolescent

INTERVENTIONS AND RATIONALES

Determine: Assess developmental state; interaction between parent and child; financial status; work demands; support systems; parents' knowledge of child. *Assessment of these factors will help identify appropriate interventions for this diagnosis.*

Perform: Act as a role model for parenting when caring for the child in the presence of the parents. *Lack of knowledge of routine child care practices, as well as growth and developmental norms, significantly contributes to child abuse.*

Involve parents in the care of the child immediately *to promote attachment to the child.*

Inform: Provide books and videos that will help the patient's quest for enhanced knowledge. *Supplying some materials directly may be a motivation for the parents to search further.*

Direct patient to use other sources such as libraries, Internet, or professional organizations. *An independent search results in the parents' developing confidence.* Select teaching strategies *that will enhance teaching/learning effectiveness,* such as discussion, demonstration, role-playing, and visual materials.

Teach those skills that the patient must incorporate into ability *to go much deeper into the area of interest.*

Attend: Encourage patient and family to verbalize feelings and concerns related to the knowledge and skills that parents need. *This promotes greater ease in managing challenging situations.*

Demonstrate willingness to repeat instruction and demonstrations of skills needed by parents. Be available to answer questions and correct misconceptions for parents *to enhance the effectiveness of learning.*

Manage: Refer to social and community resources *for ongoing assistance with parenting. The parents can contact these sources for additional information as needed.*

SUGGESTED NIC INTERVENTIONS

Attachment Promotion; Coping Enhancement; Family Process Maintenance; Family Support; Mutual Goal-Setting; Infant Care; Learning Enhancement; Role Enhancement; Family Integrity Promotion: Childbearing Family; Environmental Management: Attachment Process; Parent Education: Infant

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DEFINITION

Vulnerable to inability of the primary caretaker to create, maintain, or regain an environment that promotes the optimum growth and development of the child, which may compromise the well-being of the child

RISK FACTORS

- *Infant or Child:* Alteration in perceptual abilities, behavior disorder (e.g., attention deficit, oppositional defiant), developmental delay, difficult temperament, disabling condition, gender other than desired, illness, multiple births, prematurity, prolonged separation from parent, temperament conflicts with parental expectations
- *Knowledge:* Alteration in cognitive functioning, ineffective communication skills, insufficient cognitive readiness for parenting, insufficient knowledge about child development, insufficient knowledge about child health maintenance, insufficient knowledge about parenting skills, insufficient response to infant cues, low educational level, preference for physical punishment, unrealistic expectations
- *Physiological:* Physical illness
- *Psychological:* Closely spaced pregnancies, depression, difficult birthing process, disabling condition, high number of pregnancies, history of mental illness, history of substance abuse, nonrestorative sleep pattern (i.e., due to caregiver responsibilities, parenting practices, sleep partner), sleep deprivation, young parental age
- *Social:* Change in family unit, compromised home environment, conflict between partners, economically disadvantaged, father of child not involved, history of abuse (e.g., physical, psychological, sexual), history of being abusive, inadequate child care arrangements, ineffective coping strategies, insufficient access to resources, insufficient family cohesiveness, insufficient parental role model, insufficient problem-solving skills, insufficient resources (e.g., financial, social, knowledge), insufficient social support, insufficient transportation, insufficient valuing of parenthood, late-term prenatal care, legal difficulty, low self-esteem, mother of child not involved, parent–child separation, relocation, role strain, single parent, social isolation, stressors, unemployment, unplanned pregnancy, unwanted pregnancy, work difficulty

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Communication
- Roles/responsibility
- Behavioral
- Emotional
- Knowledge

EXPECTED OUTCOMES

- The parent or caregiver will establish eye, physical, and verbal contact with infant or child.
- The parent or caregiver will demonstrate correct feeding, bathing, and dressing techniques.
- The parent or caregiver will state plans to bring the infant or child to clinic for routine physical and psychological examinations.
- The parent or caregiver will express understanding of developmental norms.
- The parent or caregiver will provide age-related play activities.

SUGGESTED NOC OUTCOMES

Caregiver Emotional Health; Caregiver Physical Health; Knowledge: Health Resources; Knowledge: Parenting; Parenting Performance; Role Performance; Social Support; Caregiver Performance: Direct and Indirect Care; Family Coping; Family Functioning

INTERVENTIONS AND RATIONALES

Determine: Assess caregiver's psychosocial status, including developmental state, educational level, presence or absence of spouse or significant other, financial stressors, previous parenting. *Information of assessment factors helps identify appropriate interventions.*

Perform: Act as a role model for parenting when caring for the child in the presence of the parents. *Lack of knowledge of routine child care practices, as well as growth and developmental norms, significantly contributes to child abuse.*

Involve parents in the care of the child immediately *to promote attachment to the child.*

Inform: Teach caregiver the basics of infant and child care. *Research shows that the primary source of information about care giving is the caregiver's own family. If a caregiver lacks an effective role model, you may need to supply basic information.*

Provide written materials on environmental aspects of home maintenance. *Written materials provide a resource for parents to refer to when problems arise.*

Teach additional skills that enhance coping strategies. Help caregiver and other family members develop a program using relaxation strategies such as meditation, guided imagery, yoga, exercise, and so forth. *These strategies reduce stresses associated with parenting.*

Teach problem-solving skills.

Attend: Encourage weekly discussions about progress in parenting, *to develop family unity and allow members to address problems before they become overwhelming.*

Manage: Assist family members to contact community agencies to assist in efforts to improve parenting skills, such as self-help groups. *Community*

resources can lessen family's burden while parents learn to function independently.

SUGGESTED NIC INTERVENTIONS

Counseling; Family Integrity Promotion; Family Support; Childbearing Family; Parenting Promotion; Active Listening; Coping Enhancement

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Bello-Utu, C. F., & DeSocio, J. E. (2015). Military deployment and reintegration: A systematic review of child coping. *Journal of Child & Adolescent Psychiatric Nursing*, *28*(1), 23–34. doi:10.1111/jcap.12099

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DEFINITION

Inability to maintain an integrated and complete perception of self

DEFINING CHARACTERISTICS

- Alteration in body image
- Confusion about cultural values
- Confusion about goals
- Confusion about ideological values
- Delusional description of self
- Feeling of emptiness
- Feeling of strangeness
- Fluctuating feelings about self
- Gender confusion
- Inability to distinguish between internal and external stimuli
- Inconsistent behavior
- Ineffective coping strategies
- Ineffective relationships
- Ineffective role performance

RELATED FACTORS

- Alteration in social role
- Cult indoctrination
- Cultural incongruence
- Developmental transition
- Discrimination
- Dissociative identity disorder
- Dysfunctional family processes
- Exposure to toxic chemical
- Low self-esteem
- Manic states
- Organic brain disorder
- Perceived prejudice
- Pharmaceutical agent
- Psychiatric disorder
- Situational crisis
- Stages of growth

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Safety
- Mental status
- Self-care
- Sexual practices
- Cultural beliefs
- Relationships

EXPECTED OUTCOMES

- The patient will contract for safety.
- The patient will identify internal versus external stimuli.
- The patient will maintain adequate nutritional intake.
- The patient will identify personal goals and realistic steps toward those goals.
- The patient will compile a list of resources to call when needed.
- The patient will remain free from substance abuse.
- The patient will secure a safe place to live in.

SUGGESTED NOC OUTCOMES

Coping; Distorted Thought Self-Control; Impulse Self-Control; Self-Esteem; Risk Control

INTERVENTIONS AND RATIONALES

Determine: Assess for suicidal/homicidal ideation, self-induced cuts or burns. Assess for self-induced vomiting or restricting of food. Thorough mental status examination. *Individuals struggling with identified issues are at an increased safety risk.*

Monitor mental status daily to be able to intervene if necessary.

Monitor weight weekly *to be able to detect changes that may require further intervention.*

Perform: Contract with patient for safety. Schedule meetings with patient to process feelings and experiences. *Demonstrating care and compassion for the patient allows the patient to feel safe and promotes healing.*

Inform: Instruct patient to journal feelings and list coping strategies. *Journaling can help a patient maintain self-control and may increase insight.*

Attend: Accept patient in patient's struggle. Reinforce taking healthy risks and appropriate expression of feelings. *Appropriate expression of feelings enhances self-esteem and promotes resiliency.*

Manage: Refer patients to mental health services for medication and symptom management. *Disturbed personal identity may require ongoing mental health care.*

SUGGESTED NIC INTERVENTIONS

Coping Enhancement; Environmental Management: Safety; Role Enhancement; Self-Esteem Enhancement; Journaling

REFERENCES

Brand, B. L., Loewenstein, R. J., & Spiegel, D. (2014). Dispelling myths about dissociative identity disorder treatment: An empirically based approach. *Psychiatry: Interpersonal & Biological Processes*, *77*(2), 169–189. doi:10.1521/psyc.2014.77.2.169

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382 RISK FOR DISTURBED PERSONAL IDENTITY

DEFINITION

Vulnerable to the inability to maintain an integrated and complete perception of self, which may compromise health

RISK FACTORS

- Alteration in social role
- Cult indoctrination
- Cultural incongruence
- Developmental transition
- Discrimination
- Dissociative identity disorder
- Dysfunctional family processes
- Exposure to toxic chemical
- Low self-esteem
- Manic states
- Organic brain disorder
- Perceived prejudice
- Pharmaceutical agent
- Psychiatric disorder
- Situational crisis
- Stages of growth

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Safety
- Mental status
- Self-care
- Sexual practices
- Cultural beliefs
- Relationships

EXPECTED OUTCOMES

- The patient will actively participate in milieu therapies.
- The patient will maintain safety and report any thoughts of suicide to staff.
- The patient will perform relaxation techniques during periods of stress.
- The patient will verbalize understanding of the need for long-term therapy.

SUGGESTED NOC OUTCOMES

Coping; Distorted Thought Self-Control; Impulse Self-Control; Self-Esteem; Risk Control

INTERVENTIONS AND RATIONALES

Determine: Assess for suicidal/homicidal ideation, self-induced cuts or burns. Assess for self-induced vomiting or restricting of food. Thorough mental status examination. *Individuals struggling with identified issues are at an increased safety risk.*

Monitor mental status daily *to be able to intervene if necessary.*

Monitor weight weekly *to be able to detect changes that may require further intervention.*

Perform: Contract with patient for safety. Schedule meetings with patient to process feelings and experiences. *Demonstrating care and compassion for the patient allows the patient to feel safe and promotes healing.*

Work with patient to identify triggers that provoke anxiety. *The patient may not remember or be aware of the events that trigger the symptoms and will need assistance in identifying them.*

Inform: Instruct patient to journal feelings and list coping strategies. *Journaling can help a patient maintain self-control and may increase insight.*

Educate patient on positive coping mechanisms such as cognitive therapies and relaxation techniques, and assist the patient in applying these techniques. *Assisting the patient with relaxation therapies during times of anxiety decreases anxiety and helps assure the patient of the efficacy of these coping mechanisms.*

Attend: Accept patient in patient's struggle. Reinforce taking healthy risks and appropriate expression of feelings. *Appropriate expression of feelings enhances self-esteem and promotes resiliency.*

Manage: Refer patients to mental health services for medication and symptom management. *Disturbed personal identity may require ongoing mental health care.*

Refer patient to support groups in the community *as this will help the patient to realize that the patient is not alone and because these groups provide further anxiety prevention strategies and support.*

SUGGESTED NIC INTERVENTIONS

Coping Enhancement; Environmental Management: Safety; Role Enhancement; Self-Esteem Enhancement; Journaling

REFERENCES

Brand, B. L., Loewenstein, R. J., & Spiegel, D. (2014). Dispelling myths about dissociative identity disorder treatment: An empirically based approach. *Psychiatry: Interpersonal & Biological Processes*, *77*(2), 169–189. doi:10.1521/psyc.2014.77.2.169

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DEFINITION

Vulnerable to accidental exposure to, or ingestion of, drugs or dangerous products in sufficient doses, which may compromise health

RISK FACTORS

External

- Access to dangerous product
- Access to illicit drugs potentially contaminated by poisonous additives
- Access to large supply of pharmaceutical agents in house
- Access to pharmaceutical agent

Internal

- Alteration in cognitive function
- Emotional disturbance
- Inadequate precautions against poisoning
- Insufficient knowledge of pharmacologic agents
- Insufficient knowledge of poisoning prevention
- Occupational setting without adequate safeguards
- Reduced vision

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Neurocognition
- Risk management
- Tissue integrity

EXPECTED OUTCOMES

- The patient/family will not ingest or be exposed to dangerous products.
- The patient/family will communicate understanding of need for self-protection.
- The patient/family will explain method for safekeeping of dangerous products.

SUGGESTED NOC OUTCOMES

Risk Control: Drug Use; Risk Detection; Safe Home Environment; Knowledge: Substance Use Control

INTERVENTIONS AND RATIONALES

Determine: Observe, record, and report falls, seizures, and unsafe practices *to ensure implementation of appropriate interventions. Overdose of certain medications can cause such neurologic problems as seizures.*

Monitor and record patient's respiratory status *because certain poisons can cause respiratory depression.*

Monitor and record neurologic status *because excessive toxic exposure can cause coma. Patient may have pinpointed or dilated pupils,*

depending on the type of drug ingested and the length of time patient has been hypoxic.

Monitor vital signs, intake and output, and level of consciousness. Record and report changes. *Severe hypotension may develop following overdose. It may be related to central nervous system defect, direct myocardial depression, or vasodilation. Marked hyperthermia can occur with salicylate overdose, which affects metabolic rate. Dehydration may develop in some patients from an increased respiratory rate, sweating, vomiting, and urine losses.*

Perform: Remove dangerous or potentially dangerous products from the environment *to avoid injury.*

Check the settings on oxygen flow meters every hour on patients known to retain carbon dioxide (e.g., some patients with chronic obstructive pulmonary disease). *This avoids carbon dioxide narcosis from excessive oxygen therapy in poorly ventilated patients; if unchecked, patient may stop breathing.*

Inform: Provide patient and family members with information about such specific products as medications, oxygen, and total parenteral nutrition. Tailor instructions to a specific product and patient's ability to learn self-care. *This enables patient and family members to identify and alter environmental or lifestyle factors to achieve optimum health level.*

Attend: Encourage patient to report safety hazards and to incorporate safe behaviors in the home and work environment *to decrease the chance of poisoning.*

Manage: Refer patient to appropriate community resources (police, fire, and home health agency) for more information *to enhance safety measures.*

SUGGESTED NIC INTERVENTIONS

Home Maintenance Assistance; Medication Management; Risk Identification; Surveillance: Safety; Environmental Management: Safety; Environmental Risk Protection; Health Education

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Marcus, D. M., & Grollman, A. P. (2016). Toxicity of botanical medicines: An overlooked global health problem. *American Journal of Public Health*, *106*(1), 16–17.

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386 RISK FOR PERIOPERATIVE-POSITIONING INJURY

DEFINITION

Vulnerable to inadvertent anatomical and physical changes as a result of posture or equipment used during an invasive/surgical procedure, which may compromise health

RISK FACTORS

- Disorientation
- Edema
- Emaciation
- Immobilization
- Muscle weakness
- Obesity
- Sensoriperceptual disturbance from anesthesia

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Fluid/electrolytes
- Pharmacologic function
- Physical regulation
- Risk management

EXPECTED OUTCOMES

- The patient will maintain effective breathing patterns.
- The patient will maintain adequate cardiac output.
- The patient will have surgical positioning that facilitates gas exchange.
- The patient will not show evidence of neurologic, musculoskeletal, or vascular compromise.
- The patient will maintain tissue integrity.

SUGGESTED NOC OUTCOMES

Blood Coagulation; Circulation Status; Neurological Status; Respiratory Status: Ventilation; Thermoregulation; Tissue Integrity: Skin & Mucous Membranes; Tissue Perfusion: Peripheral

INTERVENTIONS AND RATIONALES

Determine: Document and report the results of the preoperative nursing assessment. Identify factors predisposing patient to tissue injury. *This information guides interventions.*

Perform: Use the appropriate mode of patient transportation (stretcher, patient bed, wheelchair, or crib) *to ensure patient safety.*

Make sure an adequate number of staff members assist with transferring patient—obtain at least two for moving patient onto an operating room bed and at least four for moving anesthetized patient off operating room bed. *Adequate staffing enhances safety.*

Check the operating room bed before surgery for proper functioning. *Intraoperative bed malfunction can result in increased anesthesia time and a more difficult surgical approach.*

Ensure proper positioning (follow institutional policies):

- Check patient's neck and spine for proper alignment *to avoid trauma.*
- Check that patient's legs are straight and ankles uncrossed. *Crossed ankles cause pressure on tissue, vessels, and nerves.*
- Place a safety strap 29 (5 cm) above patient's knees, tight enough to restrain without compromising superficial venous return. *Applied too tightly, the safety strap may cause venous thrombosis or compression of tibial, peroneal, or sciatic nerves.*
- Secure patient's arms at patient's sides with a draw sheet, with palms down, making sure that no part of the arm or hand extends over the mattress. *Hyperextension can cause injury to the brachial plexus. Supination of palms minimizes pressure.*

Apply eye pads if patient's eyelids don't remain closed or if surgery is being performed on head, neck, or chest. *If allowed to remain open, the eyes may dry out and become infected. Corneal abrasions may result from drapes and other foreign material rubbing against the eyes.*

If surgery is expected to last more than 2 hours or if patient is predisposed to a pressure injury, place padding under occiput, scapulae, olecranon, sacrum, coccyx, and calcaneus *to protect potential pressure points.* Apply a padded footboard *to support patient's feet.* Avoid plantar flexion, and prevent stretching of the tibial nerve and subsequent foot drop.

Assess patient position following each positional change *to ensure proper body alignment and adequate padding and support.*

Inform: Tell patient about positioning measures planned, *to reduce preoperative anxiety.*

Attend: Assure patient that careful positioning of the body will be carried *to reduce worry about possible injury.*

Manage: Consult with a physical or occupational therapist if special protective equipment is needed *to ensure safety for the patient.*

SUGGESTED NIC INTERVENTIONS

Circulatory Care: Mechanical Assist Device, Circulatory Care: Arterial Insufficiency; Circulatory Care: Venous Insufficiency; Circulatory Precautions; Infection Control: Intraoperative; Positioning: Intraoperative; Skin Surveillance; Surgical Precautions; Temperature Regulation: Intraoperative; Surgical Precautions

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Spruce, L., & Van Wicklin, S. A. (2014). Back to basics: Positioning the patient. *AORN Journal*, *100*(3), 298–305. doi:10.1016/j.aorn.2014.06.004

DEFINITION

Sustained maladaptive response to a traumatic, overwhelming event

DEFINING CHARACTERISTICS

- Aggression
- Alienation
- Alteration in concentration
- Alteration in mood
- Anger
- Anxiety
- Avoidance behavior
- Denial
- Depression
- Dissociative amnesia
- Enuresis
- Exaggerated startle response
- Fear
- Flashbacks
- Gastrointestinal irritation
- Grieving
- Guilt
- Headache
- Heart palpitations
- History of detachment
- Hopelessness
- Horror
- Hypervigilance
- Intrusive dreams
- Intrusive thoughts
- Irritability
- Neurosensory irritability
- Nightmares
- Panic attacks
- Rage
- Reports of feeling numb
- Repression
- Shame
- Substance abuse

RELATED FACTORS

- Destruction of one's home
- Event outside the range of usual human experience
- Exposure to disaster (natural or man-made)
- Exposure to epidemic

- Exposure to event involving multiple deaths
- Exposure to war
- History of abuse (e.g., physical, psychological, sexual)
- History of being a prisoner of war
- History of criminal victimization
- History of torture
- Self-injurious behavior
- Serious accident (e.g., industrial, motor vehicle)
- Serious injury to loved one
- Serious threat to loved one
- Serious threat to self
- Witnessing mutilation
- Witnessing violent death

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Emotional
- Neurocognition
- Risk management
- Self-perception

EXPECTED OUTCOMES

- The patient will recover or be rehabilitated from physical injuries to the extent possible.
- The patient will state feelings and fears related to traumatic event.
- The patient will express feelings of safety.
- The patient will use available support systems.
- The patient will use effective coping mechanisms to reduce fear.
- The patient will maintain or reestablish adaptive social interactions with family members.

SUGGESTED NOC OUTCOMES

Anxiety Self-Control; Body Image; Coping; Depression Level; Fear Self-Control; Hope; Impulse Self-Control; Quality of Life; Self-Esteem; Stress Level; Abuse Protection; Abuse Recovery: Physical, Emotional, and Financial

INTERVENTIONS AND RATIONALES

Determine: Assess factors in patient's culture that may affect patient's response to trauma; remain supportive and nonjudgmental *to show patient that you support and accept patient's response to trauma.*

Perform: Follow medical regimen to manage physical injuries. *Attention to physical needs remains primary, according to Maslow's hierarchy.*

Inform: Instruct patient about at least one fear-reducing behavior such as seeking support from others when frightened. *As patient learns to reduce fears, coping skills will increase.*

Attend: Provide emotional support:

- Visit patient frequently to reduce the fear of being alone.
- Be available to listen *to respond empathetically to patient's feelings.*
- Accept and encourage the statement of patient's feelings *to reassure patient that feelings are appropriate and valid.*
- Assure patient of safety, and take the measures needed to ensure it. *Frequent nightmares or flashbacks may cause patient to question the safety of patient's environment.*
- Avoid care-related activities or environmental stimuli that may intensify symptoms associated with trauma (loud noises, bright lights, abrupt entrances to patient's room, or painful procedures or treatment). *Environmental stimuli can easily intensify flashbacks to a traumatic event.*

Reorient patient to surroundings and reality as frequently as necessary. *Posttrauma psychic numbing impairs orientation, memory, and reality perception.*

Support patient's family members by providing time for them to express feelings and helping them understand patient's reactions. *This reduces their anxiety and gives them a chance to help patient.*

Manage: Offer referrals to other support persons or groups, including clergy, mental health professionals, and trauma support groups. *Referrals help patient regain a sense of universality, reduce isolation, share fears, and deal constructively with feelings.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Anxiety Reduction; Coping Enhancement; Counseling; Forgiveness Facilitation; Mood Management; Security Enhancement; Socialization Enhancement; Support Group; Referral; Culture Brokerage; Support System Enhancement

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Bloch, F., Blandin, M., Ranerison, R., Claessens, Y., Rigaud, A., & Kemoun, G. (2014). Anxiety after a fall in elderly subjects and subsequent risk of developing post traumatic stress disorder at two months. A pilot study. *Journal of Nutrition, Health & Aging*, *18*(3), 303–306. doi:10.1007/s12603-013-0415-y

Rock, L. F. (2014). Sedation and its association with posttraumatic stress disorder after intensive care. *Critical Care Nurse*, *34*(1), 30–39. doi:10.4037/ccn2014209

Warlan, H., & Howland, L. (2015). Posttraumatic stress syndrome associated with stays in the intensive care unit: Importance of nurses' involvement. *Critical Care Nurse*, *35*(3), 44–54. doi:10.4037/ccn2015758

392 RISK FOR POST-TRAUMA SYNDROME

DEFINITION

Vulnerable to sustained maladaptive response to traumatic, overwhelming event, which may compromise health

RISK FACTORS

- Diminished ego strength
- Displacement for home
- Duration of traumatic event
- Environment not conducive to needs
- Exaggerated sense of responsibility
- Human service occupations (e.g., police, fire, rescue, corrections, emergency room, mental health)
- Insufficient social support
- Perceives event as traumatic
- Survivor role

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication
- Coping
- Emotional status
- Self-perception

EXPECTED OUTCOMES

- The patient will be free from chronic posttrauma response, substance abuse, or other mental health disorders.
- The patient will express understanding of posttrauma response.
- The patient will express feelings of safety.
- The patient will employ effective coping skills and reach out to appropriate sources of support to reduce fear.

SUGGESTED NOC OUTCOMES

Coping; Depression Level; Depression Self-Control; Risk Detection; Social Support; Spiritual Health; Stress Level; Abuse Protection

INTERVENTIONS AND RATIONALES

Determine: Assess nature of the trauma; losses that occurred from the traumatic event; effect of the trauma on social interactions; patient's perception of what has occurred; coping responses; mental status; use of chemicals, for example, alcohol, drugs; available support systems. *Information from assessment factors will help identify appropriate interventions.*

Perform: Structure time to build a trusting relationship with the patient. *The patient will likely talk about fears and be open to ideas about ways to reduce stress only from someone who is trusted.*

Inform: Teach self-healing techniques to both the patient and the family, such as meditation, guided imagery, yoga, and prayer, *to prevent anxiety and aid in keeping patient in a frame of mind to make positive decisions.*

Teach patient how to incorporate the use of self-healing techniques in carrying out usual daily activities, *in an effort to prevent the development of posttraumatic stress disorder.*

Demonstrate procedures and encourage participation in patient's care. *Have patient participate to whatever level possible without increasing stress level.*

Provide patient with concise information about decision-making skills. *This will produce benefits that can reinforce health-seeking behaviors.*

Attend: Listen attentively to patient's statements about the power in caring for self. Provide encouragement to boost self-confidence of the patient *to encourage a trusting relationship and open discussion.*

Facilitate opportunities for spiritual nourishment and growth *to address patient's holistic needs for maximal therapeutic environment.*

Reinforce the family's efforts to care for the patient. *Let them know they are doing well to ease adaptation to new caregiver roles.*

Encourage family to support patient's independence. *Family members may be inclined to make decisions and do things to protect the patient.*

Encourage patient's cooperation as you continue with healing techniques, such as therapeutic touch. *Some patients may resist being touched.*

Caution patient before you touch. Avoid approaching patient from behind, *to avoid actions that may be misinterpreted and may trigger flashback of the traumatic event.*

Assist patient to be aware of persons, places, and things that act as triggers or reduce the traumatic response, *to encourage active participation in treatment.*

Provide emotional support to the family to be available to answer questions. *Members of the family may have difficulty coping with the risks the patient faces.*

Manage: Schedule time to meet with family and patient *to listen to ways in which they plan to enhance their coping skills in the present situation.* Refer family to community resources and support groups available *to assist in managing patient's illness and providing emotional and financial assistance to caregivers.*

Refer to a member of the clergy or a spiritual counselor, according to the patient's preference, *to show respect for the patient's beliefs and provide spiritual care.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Coping Enhancement; Hope Instillation; Mood Management; Self-Awareness Enhancement Support System Enhancement

REFERENCES

Bloch, F., Blandin, M., Ranerison, R., Claessens, Y., Rigaud, A., & Kemoun, G. (2014). Anxiety after a fall in elderly subjects and subsequent risk of developing post traumatic stress disorder at two months. A pilot study. *Journal of Nutrition, Health & Aging*, *18*(3), 303–306. doi:10.1007/s12603-013-0415-y

Rock, L. F. (2014). Sedation and its association with posttraumatic stress disorder after intensive care. *Critical Care Nurse*, *34*(1), 30–39. doi:10.4037/ccn2014209

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DEFINITION

The lived experience of lack of control over a situation, including a perception that one's actions do not significantly affect an outcome

DEFINING CHARACTERISTICS

- Alienation
- Dependency
- Depression
- Doubt about role performance
- Frustration about inability to perform previous activities
- Inadequate participation in care
- Insufficient sense of control
- Shame

RELATED FACTORS

- Complex treatment regimen
- Dysfunctional institutional environment
- Insufficient interpersonal interactions

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Communication
- Coping
- Knowledge
- Roles/responsibilities
- Values and beliefs

EXPECTED OUTCOMES

- The patient will acknowledge fears, feelings, and concerns about current situation.
- The patient will make decisions regarding course of treatment.
- The patient will decrease level of anxiety by changing response to stressors.
- The patient will participate in self-care activities.
- The patient will express feeling of regained control.
- The patient will accept and adapt to lifestyle changes.

SUGGESTED NOC OUTCOMES

Depression Self-Control; Family Participation in Professional Care; Health Beliefs; Health Beliefs: Perceived Ability to Perform; Participation in Healthcare Decisions

INTERVENTIONS AND RATIONALES

Determine: Assess mobility; behavioral responses; coping strategies; past experiences with illness; knowledge; environment, including equipment and supplies, health care professionals and personnel, lighting, noise, privacy, number and types of stressors; social factors; spiritual beliefs. *Information gained from assessment will help identify appropriate interventions.*

Perform: Work with the patient to identify specific issues in which the patient feels powerless. *Understanding several areas will help the patient focus on setting goals.*

Help the patient develop focused goals. *Having goals will give the patient confidence that patient's efforts will produce results.*

Inform: Teach coping strategies to patient and family members. Have patient practice role-playing *to increase the confidence in patient's ability to handle difficult situation in the health care system.* Teach self-healing techniques to both the patient and the family, such as meditation, guided imagery, yoga, and prayer. Teach patient how to incorporate the use of self-healing techniques in carrying out usual daily activities. *The more routine the use of these techniques becomes, the greater will be the effectiveness.*

Attend: Help patient identify values, beliefs, hopes, dreams, skills, and interest. *The patient's deficits may lie in a lack of self-exploration, problem-solving methods used, or separation issues with parents.*

Promote choices with the most likeliness of success. *Specific instructions can help the patient gain problem-solving ability and maturity.*

Listen to patient's personal values and beliefs, but remain nonjudgmental, even if patient's values and beliefs differ from your own. *Remaining nonjudgmental, but attentive, shows your support. Explore personal identity issues distressing to the patient to isolate issues into small, more solvable units.*

Accept patient's feelings of powerlessness as normal. *This indicates respect for the patient and enhances feelings of self-respect.*

Encourage patient to take an active role as a health team member and in self-care. *Active participation will promote self-reliance.*

Manage: Organize family conferences to explore potential reactions to the patient's choices, and promote support for the patient's independent decision making. *Meetings can help the patient and family members ventilate true feelings in a safe environment.*

SUGGESTED NIC INTERVENTIONS

Cognitive Restructuring; Decision-Making Support; Emotional Support; Health Education; Mood Management; Presence; Self-Assistance; Self-Responsibility Facilitation; Values Clarification; Coping Enhancement

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Sheridan, N. F., Kenealy, T. W., Kidd, J. D., Schmidt-Busby, J. G., Hand, J. E., Raphael, D. L., . . . Rea, H. H. (2015). Patients' engagement in primary care: Powerlessness and compounding jeopardy. A qualitative study. *Health Expectations*, *18*(1), 32–43. doi:10.1111/hex.12006

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DEFINITION

Vulnerable to the lived experience of lack of control over a situation, including apperception that one's actions do not significantly affect the outcome, which may compromise health

RISK FACTORS

- Anxiety
- Caregiver role
- Economically disadvantaged
- Illness
- Ineffective coping strategies
- Insufficient knowledge to manage a situation
- Insufficient social support
- Low self-esteem
- Pain
- Progressive illness
- Social marginalization
- Stigmatization
- Unpredictability of illness trajectory

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Health care system
- Self-perception
- Knowledge
- Coping

EXPECTED OUTCOMES

- The patient will make decisions regarding course of action.
- The patient will decrease level of anxiety by changing response to stressors.
- The patient will participate in self-care activities.
- The patient will describe modifications or adjustments to the environment that allows feelings of control.
- The patient will discuss factors in the illness-related regimen over which control can be maintained.
- The patient will demonstrate ability to plan for controllable factors.
- The patient will express feeling of maintaining control.
- The patient will accept and adapt to lifestyle.

SUGGESTED NOC OUTCOMES

Anxiety Level; Body Image; Coping; Endurance; Information Processing; Personal Autonomy; Risk Control; Social Support

INTERVENTIONS AND RATIONALES

Determine: Assess for high-risk behaviors; health-promoting activities; coping skills; activities of daily living, including rest and sleep; sensory

perception; decision-making skills; sexuality patterns. *Assessment information helps identify appropriate interventions.*

Perform: Modify environment when possible *to meet patient's self-care needs to promote sense of control over the environment.*

Orient patient to space by walking with patient around space and assisting to place personal belongings.

Inform: Teach patient about risk factors and other aspects of the patient's medical condition, *to help patient feel in control of patient's care.*

Attend: Be present when patient is facing situations in which the patient feels powerlessness, *to help patient cope.*

Encourage patient to express concerns. Set aside time for discussions with the patient about daily events. *This helps the patient feel into focus vaguely understood emotions.* Discuss situations that provoke feelings of anxiety, anger, and powerlessness, *to identify areas of patient concern and to prevent anger from being inappropriately directed at self.*

Encourage participation in self-care. Provide patient with as many decisions as possible with regard to self-care (such as positioning, choosing an injection site, and receiving visitors), *to communicate respect for patient and enhance feelings of independence.*

Provide positive environment for patient's activities. Encourage patient to take an active role as a member of health care team. *This enhances patient's sense of control and reduces passive and dependent behavior.*

Encourage family members to support patient without taking control, *to increase patient's feelings of self-worth.*

Manage: Arrange to accommodate patient's spiritual needs. *Spiritual assistance may help patient gain courage and resist despair.*

Refer to mental health professional *for additional assistance with coping.* Refer patient to community resources *that may offer assistance to the patient when needed.*

Offer written information that can be referred to when needed.

SUGGESTED NIC INTERVENTIONS

Decision-Making Support; Risk Control; Presence; Self-Assistance

REFERENCES

Sheridan, N. F., Kenealy, T. W., Kidd, J. D., Schmidt-Busby, J. G., Hand, J. E., Raphael, D. L., . . . Rea, H. H. (2015). Patients' engagement in primary care: Powerlessness and compounding jeopardy. A qualitative study. *Health Expectations*, *18*(1), 32–43. doi:10.1111/hex.12006

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400 RISK FOR PRESSURE ULCER

DEFINITION

Vulnerable to localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear (NPUAP, 2007)

RISK FACTORS

- ADULT: Braden Scale score of < 18
- Alteration in cognitive functioning
- Alteration in sensation
- American Society of Anesthesiologists (ASA) Physical Status classification score ≥ 2
- Anemia
- Cardiovascular disease
- CHILD: Braden Q Scale of ≤ 16
- Decrease in mobility
- Decrease in serum albumin level
- Decrease in tissue oxygenation
- Decrease in tissue perfusion
- Dehydration
- Dry skin
- Edema
- Elevated skin temperature by 1° C to 2° C
- Extended period of immobility on hard surface (e.g., surgical procedure ≥ 2 hours)
- Extremes of age
- Extremes of weight
- Female gender
- Hip fracture
- History of cerebral vascular accident
- History of pressure ulcer
- History of trauma
- Hyperthermia
- Impaired circulation
- Inadequate nutrition
- Incontinence
- Insufficient caregiver knowledge of pressure ulcer prevention
- Low score on Risk Assessment Pressure Sore (RAPS) scale
- Lymphopenia
- New York Heart Association (NYHA) Functional Classification ≥ 2
- Nonblanchable erythema
- Pharmaceutical agents (e.g., general anesthesia, vasopressors, antidepressant, norepinephrine)
- Physical immobilization

- Pressure over bony prominence
- Reduced triceps skin fold thickness
- Scaly skin
- Self-care deficit
- Shearing forces
- Skin moisture
- Smoking
- Surface friction
- Use of linen with insufficient moisture wicking property

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Knowledge
- Nutrition
- Tissue integrity

EXPECTED OUTCOMES

- The patient will not experience a pressure ulcer.
- The patient will experience adequate nutrition.
- The patient will maintain adequate circulation to skin.
- The patient will explain skin care regimen.
- The patient will demonstrate skin care regimen.

SUGGESTED NOC OUTCOMES

Circulation Status; Fluid Balance; Immobility Consequences: Physiological; Neurological Status: Peripheral; Nutritional Status; Physical Aging; Tissue Perfusion: Peripheral; Wound Healing: Primary Intention; Wound Healing: Secondary Intention

INTERVENTIONS AND RATIONALES

Determine: Inspect skin every shift. Describe and document skin condition, and report changes. *These measures provide evidence of the effectiveness of the skin care regimen.*

Monitor frequency of turning and skin condition *to reduce pressure, promote circulation, and minimize skin breakdown.*

Use a risk assessment tool such as the Braden scale to continually assess risk as patient condition changes. *Systematic monitoring helps to identify problems early.*

Perform: Use pressure redirecting devices, as needed. Position patient for comfort and minimal pressure on bony prominences. Change the position of patient at least every 2 hours. Keep patient's skin clean and dry; lubricate, as needed. *These measures reduce pressure, promote circulation, and minimize skin breakdown.*

Inform: Explain the importance of practicing preventive skin care measures *to encourage compliance with skin care regimen.*

Instruct patient and family members in a skin care regimen *to encourage compliance.* Supervise patient and family members in skin care management. Provide feedback *to improve skill in managing skin care.*

Attend: Allow patient to express feelings about skin problem. *Verbalization of feelings helps allay anxiety and develops coping skills.*

Manage: Provide a referral to a psychiatric liaison nurse, social service, or support group, as appropriate, *to provide additional support for patient and family.*

SUGGESTED NIC INTERVENTIONS

Bathing; Circulatory Precautions; Electrolyte Monitoring; Fluid Management; Infection Protection; Positioning; Pressure Management; Pressure Ulcer Care; Pressure Ulcer Prevention; Skin Care: Topical Treatments; Skin Surveillance; Wound Care

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DEFINITION

Decrease in the ability to guard self from internal or external threats such as illness or injury

DEFINING CHARACTERISTICS

- Alteration in clotting
- Alteration in perspiration
- Anorexia
- Chilling
- Coughing
- Deficient immunity
- Disorientation
- Dyspnea
- Fatigue
- Immobility
- Insomnia
- Itching
- Maladaptive stress response
- Neurosensory impairment
- Pressure ulcers
- Restlessness
- Weakness

RELATED FACTORS

- Abnormal blood profile
- Cancer
- Extremes of age
- Immune disorder (e.g., HIV-associated neuropathy, varicella-zoster virus)
- Inadequate nutrition
- Pharmaceutical agent
- Substance abuse
- Treatment regimen

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Fluids and electrolytes
- Pharmacologic function
- Physical regulation
- Respiratory function
- Risk management

EXPECTED OUTCOMES

- The patient will not experience chills, fever, or other signs and symptoms.

- The patient will demonstrate use of protective measures, including conservation of energy, maintenance of balanced diet, and attainment of adequate rest.
- The patient will demonstrate effective coping skills.
- The patient will Demonstrate personal cleanliness and maintain clean environment.
- The patient will maintain safe environment.
- The patient will demonstrate increased strength and resistance.
- The patient will exhibit improved immune system as evidenced by normal WBC, CBC and differential, normal sedimentation rate, and immunoelectrophoresis.
- The patient will express desire for additional health information.

SUGGESTED NOC OUTCOMES

Abuse Protection; Immune Status; Immunization Behavior; Knowledge: Infection Control; Energy Conservation; Sleep

INTERVENTIONS AND RATIONALES

Determine: Assess vital signs; high-risk behaviors, knowledge of present condition; coping skills; comfort level; activities of daily living; cardiac, respiratory, and neurologic status; protective mechanisms; CBC and differential, sedimentation rate, immunoelectrolytes, immunoelectrophoresis, blood cultures, wound exudate, sputum, urine. *Assessment information helps identify appropriate interventions.*

Perform: Take vital signs every 4 hours. *This allows for early detection of complications.*

Administer medications, as ordered, for symptoms. *Discomfort interferes with rest, interferes with nutritional intake, and places added stress on the patient.*

Inform: Teach protective measures, including the need to conserve energy, obtain adequate rest, and eat a balanced diet. *Adequate sleep and nutrition enhance immune function. Energy conservation can help decrease the weakness caused by anemia.*

Teach coping strategies, including stress management and relaxation techniques. *Relaxation and decreased stress can increase function, thereby improving strength and resistance.*

Teach patient to guard against falls, cuts, abrasions, and other types of accidents to prevent infections. Provide written instruction for the patient so patient has it to review when needed.

Attend: Promote personal and environmental cleanliness *to decrease threat from microorganisms.*

Manage: Order nutritious foods with supplements for the patient. Encourage to eat *to prevent further complications.* Offer to have dietitian visit patient to assist with this.

If patient has new insights on patient's own condition or treatment, encourage to share this information with patient's oncologist *to foster a sense of responsibility for obtaining health care*. Suggest that patient present practitioner with a summary of findings in advance of patient's appointment, *to allow the practitioner time to review the information.*

SUGGESTED NIC INTERVENTIONS

Coping Enhancement: Environmental; Management: Safety; Infection Control; Knowledge: Personal Safety Health

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Al-Jabri, A., Youssef, R., Hasson, S., Balkhair, A., Al-Belushi, M., Al-Saadoon, M., . . . Idris, M. (2014). Knowledge, attitudes and intended behaviors towards HIV testing and self-protection: A survey of Omani pregnant women. *Eastern Mediterranean Health Journal*, *20*(10), 614–622.

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DEFINITION

Sustained maladaptive response to a forced, violent, sexual penetration against the victim's will and consent

DEFINING CHARACTERISTICS

- Aggression
- Agitation
- Alteration in sleep pattern
- Anger
- Anxiety
- Change in relationship(s)
- Confusion
- Denial
- Dependency
- Depression
- Disorganization
- Dissociative identity disorder
- Embarrassment
- Fear
- Guilt
- Helplessness
- History of suicide attempt
- Humiliation
- Hyperalertness
- Impaired decision making
- Low self-esteem
- Mood swings
- Muscle spasm
- Muscle tension
- Nightmares
- Paranoia
- Perceived vulnerability
- Phobias
- Physical trauma
- Self-blame
- Sexual dysfunction
- Shame
- Shock
- Substance abuse
- Thoughts of revenge

RELATED FACTORS

- Rape

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Emotional
- Values/beliefs

EXPECTED OUTCOMES

- The patient will recover from physical injuries to the fullest possible extent.
- The patient will express feelings and fears.
- The patient will make contact with appropriate sources of support.

SUGGESTED NOC OUTCOMES

Abuse Protection; Abuse Recovery: Emotional; Coping; Abuse Recovery: Sexual

INTERVENTIONS AND RATIONALES

Determine: Assess history of traumatic event; physical injuries sustained at the time of the trauma; emotional reactions to the event; support systems available to the patient; coping; problem-solving strategies. *Assessment information will help establish realistic goals and identify appropriate interventions.*

Perform: Explain assessment procedures to the patient, *to reduce the level of fear associated with data gathering following a rape.*

Inform: Teach patient relaxation techniques such as guided imagery, deep breathing, meditation, aromatherapy, and progressive muscle relaxation. Practice with the patient at bedtime. *Purposeful relaxation efforts usually help promote sleep.*

Educate patient about various emotional responses to trauma. *Rape-trauma syndrome is a variant of posttraumatic distress disorder. Responses such as suicidal ideation, disorientation, confusion, extreme detachment, nightmares, guilt, depression, and flashbacks are common. The patient may believe that the emotional turmoil she experiences after rape is abnormal. Pointing out that others have gone through the same experience may lessen the patient's isolation, help her talk about the symptoms, and motivate her to seek follow-up care.*

Teach a variety of techniques that will help the woman cope. *Patient may believe that the emotional turmoil one experiences after rape is abnormal.*

Attend: Provide emotional support. Be available to listen, and accept the patient's feelings *to let her know her feelings are valid and acceptable.*

Approach patient in a warm, caring manner *to cultivate her trust and cooperation.* Assure patient of her safety, and take all necessary measures to ensure it.

Manage: Offer referral to other support groups or professionals, such as clergy, a crisis center, mental health professionals, rape counselors, and

Women Organized Against Rape. *This will help the patient express her feelings and develop coping skills.*

SUGGESTED NIC INTERVENTIONS

Abuse Protection Support; Active Listening; Anxiety Reduction; Crisis Intervention; Rape-Trauma Treatment; Self-Esteem Enhancement; Referral

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DEFINITION

A pattern of mutual partnership that is insufficient to provide for each other's needs

DEFINING CHARACTERISTICS

- Delay in meeting of developmental goals appropriate for family life-cycle stage
- Dissatisfaction with complementary relationship between partners
- Dissatisfaction with emotional need fulfillment between partners
- Dissatisfaction with idea sharing between partners
- Dissatisfaction with information sharing between partners
- Dissatisfaction with physical need fulfillment between partners
- Inadequate understanding of partner's compromised functioning (e.g., physical psychological, social)
- Insufficient balance in autonomy between partners
- Insufficient balance in collaboration between partners
- Insufficient mutual respect between partners
- Insufficient mutual support in daily activities between partners
- Partner not identified as support person
- Unsatisfying communication with partner

RELATED FACTORS

- Alteration in cognitive functioning in one partner
- Developmental crisis
- History of domestic violence
- Incarceration of one partner
- Ineffective communication skills
- Stressors
- Substance abuse
- Unrealistic expectations

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Emotional
- Knowledge
- Roles/relationships
- Sexuality

EXPECTED OUTCOMES

- The patient will actively participate in activities that help build cohesion with partner/family.
- The patient will express understanding of patient's role as an individual, a partner, and/or member of the family.

- The patient will identify negative behaviors that contribute to the dysfunction of patient's relationship(s) and desire to change them.
- The patient will verbalize positive aspects of patient's relationship(s).

SUGGESTED NOC OUTCOMES

Abusive Behavior Self-Control; Coping; Family Functioning; Role Performance; Psychosocial Adjustment: Social Support; Substance Addiction Consequences

INTERVENTIONS AND RATIONALES

Determine: Assess patient and partner/family *since the partner/family can provide additional information/perspectives that the patient may not be aware of.*

Assess the patient and family for signs of addiction or abuse, *as both can contribute negatively to the physiologic and psychological status of the patient and partner/family and the status of their relationship.*

Perform: Assist the patient and partner/family to identify positive activities that they can participate in together *to help build cohesion.*

Assist patient with cognitive therapies and stress reduction techniques. *Positive coping skills can help foster self-confidence and a positive attitude and positive behaviors toward personal relationships.*

Inform: Educate the patient and partner/family regarding importance of everyone following through with the treatment plan, as joint participation is necessary to facilitate a successful outcome.

Attend: Provide a safe environment and assist patient and partner/family in communicating openly *to help facilitate a positive interaction.*

Manage: Work with the patient and partner/family to set up a treatment plan. *Encouraging the patient to work with partner/family helps to create cohesiveness and mutual support in implementing the treatment plan.*

Work with outside agencies/programs if abuse or addiction is a factor, *to ensure patient and partner/family safety.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Abuse Protection Support; Coping Enhancement; Complex Relationship Building; Family Support; Role Enhancement; Sexual Counseling; Substance Use Treatment; Support Group

REFERENCES

Coy, J. S., & Miller, M. M. (2014). Intimate partners who struggle with formal commitments: Attachment styles, major challenges, and clinical implications. *American Journal of Family Therapy*, *42*(3), 232–242. doi:10.1080/01926187.2013.808138

Grant, M. (2014). Resolving communication challenges in the intensive care unit. *AACN Advanced Critical Care, 26*(2), 123–130. doi:10.1097/NCI.0000000000000076

Snelling, P. C. (2015). Who can blame who for what and how in responsibility for health? *Nursing Philosophy, 16*(1), 3–18. doi:10.1111/nup.12061

DEFINITION

Vulnerable to developing a pattern that is insufficient for providing a mutual partnership to provide for each other's needs

RISK FACTORS

- Alteration in cognitive functioning in one partner
- Developmental crisis
- History of domestic violence
- Incarceration of one partner
- Ineffective communication skills
- Stressor
- Substance abuse
- Unrealistic expectations

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Emotional
- Knowledge
- Roles/relationships
- Sexuality

EXPECTED OUTCOMES

- The patient will actively participate in activities that help build cohesion with partner/family.
- The patient will express understanding of patient's role as an individual, a partner, and/or member of the family.
- The patient will identify healthy coping mechanisms that will support the patient as an individual, a partner, and/or family member.
- The patient will verbalize desire to work with partner/family in developing healthy communication skills.

SUGGESTED NOC OUTCOMES

Family Functioning; Family Integrity; Role Performance; Psychosocial Adjustment; Life Change; Social Interaction Skills; Social Support

INTERVENTIONS AND RATIONALES

Determine: Assess patient and partner/family *since the partner/family can provide additional information/perspectives that the patient may not be aware of.*

Assess support system and availability. *Partner may travel frequently, and immediate family may not live in proximity to the patient, which can cause emotional strain.*

Perform: Assist the patient and partner/family to identify positive activities that they can participate in together *to help build cohesion.*

Assist patient with cognitive therapies and stress reduction techniques. *Positive coping skills can help foster self-confidence and a positive attitude and positive behaviors toward personal relationships.*

Inform: Educate patient and partner/family regarding the need for family treatment, *as the partner/family is also affected by the status of the relationship, and only together can they begin to repair the relationship.*

Attend: Provide a safe environment, and assist patient and partner/family in communicating openly, *to help facilitate a positive interaction.*

Manage: Work with patient and partner/family to ensure that the treatment plan is sensitive to their cultural practices and developmental needs, *to help build unity and confidence in their ability to follow through with the treatment plan.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Abuse Protection Support; Complex Relationship Building; Family Support; Role Enhancement; Sexual Counseling; Substance Use Treatment; Support Group

REFERENCES

Harvey, P., & Ahmann, E. (2016). Validation: A family-centered communication skill. *Nephrology Nursing Journal*, *43*(1), 61–66.

Laursen, J. (2015). Spouses needs for professional support: The spouses' perspective on communication. *MEDSURG Nursing*, *24*(5), 325–362.

Snelling, P. C. (2015). Who can blame who for what and how in responsibility for health? *Nursing Philosophy, 16*(1), 3–18. doi:10.1111/nup.12061

DEFINITION

Impaired ability to exercise reliance on beliefs and/or participate in rituals of a particular faith tradition

DEFINING CHARACTERISTICS

- Desire to reconnect with previous belief pattern
- Desire to reconnect with previous customs
- Difficulty adhering to prescribed religious beliefs
- Difficulty adhering to prescribed religious rituals (e.g., ceremonies, regulations, clothing, prayer, services, holiday observances)
- Distress about separation from faith community
- Questioning of religious belief patterns
- Questioning of religious customs

RELATED FACTORS

- *Developmental and Situational:* Aging, end-stage life crisis, life transition
- *Physical:* Illness, pain
- *Psychological:* Anxiety, fear of death, history of religious manipulation, ineffective coping strategies, insecurity, insufficient social support, personal crisis
- *Sociocultural:* Cultural barrier to practicing religion, environmental barrier to practicing religion, insufficient social integration, insufficient sociocultural interaction
- *Spiritual:* Spiritual crises, suffering

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Values/beliefs

EXPECTED OUTCOMES

- The patient will describe conflicts with patient's religious beliefs and the effects of illness on these beliefs.
- The patient will accept counsel of a person trained in spirituality.
- The patient will engage in religious practices to the extent that it is therapeutic.
- The patient will begin differentiating between delusional thinking and reality arterial blood gas levels.

SUGGESTED NOC OUTCOMES

Hope; Motivation; Quality of Life; Spiritual Health

INTERVENTIONS AND RATIONALES

Determine: Assess spiritual or religious beliefs; religious affiliation; importance of religion in daily life; religious involvement of family; religious dietary restrictions; importance of religion in helping with usual coping. *Assessment information helps identify appropriate interventions.*

Attend: Approach patient in a nonjudgmental way when the patient is discussing religious beliefs or spiritual needs. *The nurse's beliefs may*

differ radically, but it is a professional responsibility to assist the patient in an ethically sensitive way.

Help patient list the religious practices most important to the patient, *to determine what is possible to provide in the hospital.*

Acquire simple-to-obtain items, such as books, pictures, CD, cross, *to provide comfort to the patient.*

Confirm that patient's spiritual needs are being satisfied *so that modifications can be made in the plan.*

Involve family members in helping meet patient's spiritual needs if the patient agrees. *If family members have strong spiritual beliefs, they can be a help to one another in times of pain and difficulty.*

Encourage patient and family to express feelings associated with diagnosis, treatment, and recovery. *Expression of feelings helps patient and family cope with treatment.*

Schedule time to spend with the family. They need time with health care providers to ask questions.

Manage: Suggest a referral to a clergy person or faith community nurse *so that the person can discuss deeper spiritual issues.*

SUGGESTED NIC INTERVENTIONS

Acid–Base Management; Bedside Laboratory Testing; Active Listening; Spiritual Growth; Spiritual Support

REFERENCES

Ellington, L., Reblin, M., Ferrell, B., Puchalski, C., Otis-Green, S., Handzo, G., . . . Clayton, M. F. (2015). The religion of "I Don't Know" naturalistic pilot observations of spiritual conversations occurring during cancer home hospice nurse visits. *Omega: Journal of Death & Dying*, *72*(1), 3–19. doi:10.1177/0030222815574689

ter Kuile, H., & Ehring, T. (2014). Predictors of changes in religiosity after trauma: Trauma, religiosity, and posttraumatic stress disorder. *Psychological Trauma: Theory, Research, Practice & Policy*, *6*(4), 353–360. doi:10.1037/a0034880

Quinlivan, M. (2014). Supporting the delivery of effective pastoral care. *British Journal of School Nursing*, *9*(8), 405–406.

DEFINITION

Vulnerable to an impaired ability to exercise reliance on religious beliefs and/or participate in rituals of a particular faith tradition, which may compromise health

RISK FACTORS

- *Developmental:* Life transition
- *Environmental:* Barrier to practicing religion, insufficient transportation
- *Physical:* Hospitalization, illness, pain
- *Psychological:* Depression, ineffective caregiving, ineffective coping strategies, insecurity, insufficient social support
- *Sociocultural:* Cultural barrier to practicing religion, insufficient social interaction
- *Spiritual:* Suffering

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Communication
- Values/beliefs
- Knowledge

EXPECTED OUTCOMES

- The patient will articulate those religious practices that are important to the patient.
- The patient will decide what changes to patient's practices are realistic and acceptable.
- The patient will cope with the limitations placed on self by current circumstances.
- The patient will make use of the available spiritual resources.
- The patient will express satisfaction with ability to practice patient's religion.

SUGGESTED NOC OUTCOMES

Health Beliefs; Health-Promoting Behavior; Hope; Motivation; Quality of Life; Spiritual Health

INTERVENTIONS AND RATIONALES

Determine: Assess religious affiliation; degree of active participation in religious activities; support/coping systems; social interaction; present living circumstances. *Assessment information helps identify appropriate interventions.*

Inform: Teach patient about the resources that are available to the patient as a preparation for developing a realistic plan. *The plan will be more meaningful to the patient if the patient has already lined up possible resources.*

Attend: Encourage patient to talk about the religious practices that are important to the patient, *to provide focus for appropriate interventions.*

Help patient explore modifications to patient's activities without compromising spiritual comfort. *Decision making promotes feelings of independence and control.*

Have patient list options for participation in religious activities, *to promote optimism or acceptance in present situations.*

Manage: Involve family, friends, and clergy, *to provide appropriate spiritual support.*

Check daily or weekly with the patient *to evaluate the effectiveness of the patient's plan.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Emotional Support; Hope Instillation; Presence; Religious Ritual Enhancement; Spiritual Growth Facilitation; Spiritual Support; Values Clarification

REFERENCES

Kleebauer, A. (2014). Nurses agree religion has a place in care. *Nursing Standard*, *29*(14), 13. doi:10.7748/ns.29.14.13.s15

Mendes, A. (2015). Culture and religion in nursing: Providing culturally sensitive care. *British Journal of Nursing*, *24*(8), 459–459. doi:10.12968/bjon.2015.24.8.459

Quinlivan, M. (2014). Supporting the delivery of effective pastoral care. *British Journal of School Nursing*, *9*(8), 405–406.

DEFINITION

Physiological and/or psychosocial disturbance following transfer from one environment to another

DEFINING CHARACTERISTICS

- Alienation
- Aloneness
- Alteration in sleep pattern
- Anger
- Anxiety
- Concern over relocation
- Dependency
- Depression
- Fear
- Frustration
- Increase in illness
- Increase in physical symptoms
- Increase in verbalization of needs
- Insecurity
- Loneliness
- Loss of identity
- Loss of self-worth
- Low self-esteem
- Pessimism
- Unwillingness to move
- Withdrawal
- Worried

RELATED FACTORS

- Compromised health status
- History of loss
- Impaired psychosocial functioning
- Ineffective coping strategies
- Insufficient predeparture counseling
- Insufficient support system
- Language barrier
- Move from one environment to another
- Powerlessness
- Social isolation
- Unpredictability of experience

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameter.*)

- Activity/exercise
- Coping

- Emotional
- Knowledge
- Neurocognition
- Risk management
- Roles/relationships

EXPECTED OUTCOMES

- The patient will request information about new environment.
- The patient will communicate understanding of relocation.
- The patient will take steps to prepare for relocation.
- The patient will use available resources.
- The patient will express satisfaction with adjustment to new environment.

SUGGESTED NOC OUTCOMES

Loneliness Severity; Psychosocial Adjustment: Life Change; Quality of Life; Stress Level

INTERVENTIONS AND RATIONALES

Determine: Assess patient's needs for additional health care services before relocation, *to ensure receipt of appropriate care in the new environment.*

Perform: Assign a primary nurse to patient *to provide a consistent, caring, and accepting environment that enhances patient's adjustment and well-being.*

Help patient and family members prepare for relocation. Conduct group discussions, provide pictures of the new setting, and communicate any additional information that will ease transition, *to help patient cope with a new environment.*

If possible, allow patient and family members to visit the new location and provide introductions to the new staff. *The more familiar the environment, the less stress patient will experience during relocation.*

Inform: Educate family members about relocation stress syndrome and its potential effects *to encourage family members to provide needed emotional support throughout the transition period.*

Attend: Encourage patient to express emotions associated with relocation, *to provide opportunity to correct misconceptions, answer questions, and reduce anxiety.*

Reassure patient that family members and friends know patient's new location and will continue to visit, *to reduce feelings of abandonment and anxiety.*

Manage: Communicate all aspects of patient's discharge plan to appropriate staff members at the new location *to ensure continuity of care.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Coping Enhancement; Self-Responsibility Facilitation

REFERENCES

McGrath, P. (2015). Findings on family issues during relocation for hematology care. *Oncology Nursing Forum*, *42,* E250–E256. doi:10.1188/15.ONF.E250-E256

Oh, H., Lee, S., Kim, J., Lee, E., Min, H., Cho, O., & Seo, W. (2015). Clinical validity of a relocation stress scale for the families of patients transferred from intensive care units. *Journal of Clinical Nursing*, *24*(13/14), 1805–1814. doi:10.1111/jocn.12778

Yueh-Ying, Y., Shu-Ming, C., Chien-Lin, K., & Hsin-Ju, L. (2014). Exploring relocation stress and diabetes control in the elderly residents of long-term care facilities. *Journal of Nursing*, *61*(6), 57–65. doi:10.6224/JN.61.6.57

420 RISK FOR RELOCATION STRESS SYNDROME

DEFINITION

Vulnerable to physiological and/or psychosocial disturbance following transfer from one environment to another that may compromise health

RISK FACTORS

- Compromised health status
- Deficient mental competence
- History of loss
- Ineffective coping strategies
- Insufficient predeparture counseling
- Insufficient support system
- Move from one environment to another
- Powerlessness
- Significant environmental change
- Unpredictability of experience

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Coping
- Emotional
- Knowledge
- Neurocognition
- Risk management
- Roles/relationships

EXPECTED OUTCOMES

- The patient will request information about the new environment.
- The patient will participate in decision making regarding relocation.
- The patient will communicate understanding of need for relocation.
- The patient will express satisfaction with adjustment to new environment.
- The patient will take steps to prepare for relocation along with family members or partner.

SUGGESTED NOC OUTCOMES

Loneliness Severity; Psychosocial Adjustment: Life Change; Quality of Life; Stress Level

INTERVENTIONS AND RATIONALES

Determine: Assess patient's needs for additional health care services before relocation *to ensure that patient receives appropriate care in the new environment.*

Perform: Assign a primary nurse to patient *to provide a consistent, caring, and accepting environment that enhances patient's adjustment and well-being.*

If possible, include patient in the decision-making process regarding potential location, dates, and circumstances of relocation, *to promote a feeling of participation in choices, which will allow feeling of control.*

If possible, allow patient and family members to visit the new location and provide introductions to the new staff. *The more familiar the environment, the less stress patient will experience during relocation.*

Inform: Educate family members about relocation stress syndrome and its potential effects *to encourage family members to provide needed emotional support throughout the transition period.*

Attend: Help patient and family members prepare for relocation. Conduct group discussions, provide pictures of setting, and communicate any information that will ease transition, *to help patient with the new environment.*

Encourage patient to express emotions associated with relocation or provide an opportunity to correct misconceptions and answer questions. *This helps reduce anxiety about relocation.*

Manage: Communicate all aspects of patient's discharge plan to appropriate staff members at the new location *to ensure continuity of care.*

Reassure patient that family members and friends know patient's new location and will continue to visit, *to reduce feelings of abandonment.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Coping Enhancement; Self-Responsibility Facilitation

REFERENCES

McGrath, P. (2015). Findings on family issues during relocation for hematology care. *Oncology Nursing Forum*, *42,* E250–E256. doi:10.1188/15.ONF.E250-E256

Oh, H., Lee, S., Kim, J., Lee, E., Min, H., Cho, O., & Seo, W. (2015). Clinical validity of a relocation stress scale for the families of patients transferred from intensive care units. *Journal of Clinical Nursing*, *24*(13/14), 1805–1814. doi:10.1111/jocn.12778

Yueh-Ying, Y., Shu-Ming, C., Chien-Lin, K., & Hsin-Ju, L. (2014). Exploring relocation stress and diabetes control in the elderly residents of long-term care facilities. *Journal of Nursing*, *61*(6), 57–65. doi:10.6224/JN.61.6.57

422 RISK FOR INEFFECTIVE RENAL PERFUSION

DEFINITION

Vulnerable to a decrease in blood circulation to the kidney, which may compromise health

RISK FACTORS

- Abdominal compartment syndrome
- Alteration in metabolism
- Bilateral cortical necrosis
- Burns
- Cardiac surgery
- Cardiopulmonary bypass
- Diabetes mellitus
- Exposure to nephrotoxin
- Extremes of age
- Female gender
- Glomerulonephritis
- Hypertension
- Hypovolemia
- Hypoxemia
- Hypoxia
- Infection
- Interstitial nephritis
- Malignancy
- Malignant hypertension
- Polynephritis
- Renal disease (e.g., polycystic kidney, renal artery stenosis, failure)
- Smoking
- Substance abuse
- Systemic inflammatory response syndrome (SIRS)
- Trauma
- Treatment regimen
- Vascular embolism
- Vasculitis

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Elimination
- Fluid and electrolytes

EXPECTED OUTCOMES

- The patient will identify risk factors that contribute to risk for decreased renal perfusion.

- The patient will make appropriate lifestyle changes to minimize risks, including careful management of chronic health conditions.
- The patient will verbalize signs and symptoms of possible renal dysfunction related to impaired perfusion.
- The patient will maintain fluid balance.

SUGGESTED NOC OUTCOMES

Cardiac Pump Effectiveness; Electrolyte & Acid/Base Balance; Kidney Function; Knowledge: Health Promotion

INTERVENTIONS AND RATIONALES

Determine: Assess patient current management of preexisting health conditions that increase the risk of decreased renal perfusion. *Effective management of chronic health conditions will help preserve kidney function.*

Monitor intake and output to evaluate need for fluid replacement.

Perform: Collect and evaluate laboratory and urine data that may indicate renal damage. *Serum creatinine levels and urine protein and creatinine are sensitive indicators of renal function.*

Maintain mean arterial pressure of at least 60 to 70, *to provide continuous perfusion needed for optimal renal function.*

Inform: Provide patient teaching regarding the need to control modifiable risk factors and the signs and symptoms that indicate renal dysfunction. *Prevention and early intervention are essential in maintaining renal function.*

Attend: Provide patient and family with encouragement and psychological support *to reinforce positive health behaviors.*

Manage: Collaborate with other members of the health care team to develop an individualized plan of care to reduce risk factors. *A multidisciplinary approach results in positive patient outcomes.*

SUGGESTED NIC INTERVENTIONS

Electrolyte Monitoring; Hemodynamic Regulation; Fluid Management; Urinary Elimination Management

REFERENCES

Sarnak, M. J. (2014). A patient with heart failure and worsening kidney function. *Clinical Journal of the American Society of Nephrology*, *9*(10), 1790–1798. doi:10.2215/CJN.11601113

Textor, S. C., & McKusick, M. M. (2016). Renal artery stenosis: If and when to intervene. (2016). *Current Opinion in Nephrology & Hypertension*, *25*(2), 144–151. doi:10.1097/MNH.0000000000000202

Wong, B. T., Chan, M. J., Glassford, N. J., Mårtensson, J., Bion, V., Chai, S. Y., . . . Bellomo, R. (2015). Mean arterial pressure and mean perfusion pressure deficit in septic acute kidney injury. *Journal of Critical Care*, *30*(5), 975–981. doi:10.1016/jjcrc.2015.05.003

424 IMPAIRED RESILIENCE

DEFINITION

Decreased ability to sustain a pattern of positive responses to an adverse situation or crisis

DEFINING CHARACTERISTICS

- Decreased interest in academic activities
- Decreased interest in vocational activities
- Depression
- Guilt
- Impaired health status
- Ineffective coping strategies
- Low self-esteem
- Renewed elevation of distress
- Shame
- Social isolation

RELATED FACTORS

- Community violence
- Demographics that increase chance of maladjustment
- Economically disadvantaged
- Ethnic minority status
- Exposure to violence
- Female gender
- Inconsistent parenting
- Insufficient impulse control
- Large family size
- Low intellectual ability
- Low maternal educational level
- Parental mental illness
- Perceived vulnerability
- Psychological disorder
- Substance abuse

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Support systems
- Substance use
- Self-care
- Depression
- Safety
- Decision making
- Anxiety
- Spiritual needs

EXPECTED OUTCOMES

- The patient will remain free from harming self or others.
- The patient will avoid abusing substances.
- The patient will identify personal strengths.
- The patient will engage in activities that promote health.
- The patient will identify strategies that have been successful in previous times of stress.

SUGGESTED NOC OUTCOMES

Role Performance; Knowledge: Health Behavior; Risk Control; Stress Level; Symptom Control; Personal Resiliency

INTERVENTIONS AND RATIONALES

Determine: Explore with patients what maladaptive behaviors they are exhibiting because of impaired individual resilience. *The patient must take ownership of behaviors before change can occur.*

Monitor responses to change *to assess their effect on patient.*

Perform: Assist patient in making a list of strengths and resources with contact information and the parameters for contacting those resources. *Planning for needs decreases anxiety and increases self-care.*

Inform: Instruct patient to engage in positive health behaviors. *Adequate sleep, nutritional intake, and activity improve decision making.*

Attend: Encourage patient to wait to make life-changing decisions until the current crisis is over. *Decision making is impaired during times of crisis.*

Manage: Refer patients to mental health resources in the event of maladaptive coping or safety risk. *Individuals with impaired individual resilience face an increased risk of physical and mental illness.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Coping Enhancement; Decision-Making Support; Spiritual Support; Risk Identification; Resiliency Promotion

REFERENCES

Baker, A. Z., & Procter, N. G. (2014). Losses related to everyday occupations for adults affected by mental illness. *Scandinavian Journal of Occupational Therapy*, *21*(4), 287–294. doi:10.3109/11038128.2014.894571

Laursen, J. (2015). Spouses needs for professional support: The spouses' perspective on communication. *MEDSURG Nursing*, *24*(5), 325–362.

Zalonis, R., & Slota, M. (2014). The use of palliative care to promote autonomy in decision making. *Clinical Journal of Oncology Nursing*, *18*(6), 707–711. doi:10.1188/14.CJON.707-711

DEFINITION

Vulnerable to decreased ability to sustain a pattern of positive response to an adverse situation or crisis, which may compromise health

RISK FACTORS

- Chronicity of existing crises
- Multiple coexisting adverse situations
- New crisis (e.g., unplanned pregnancy, loss of housing, death of family member)

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Support systems
- Comfort
- Self-care
- Autonomic system
- Physical regulation
- Decision making
- Coping
- Spiritual needs

EXPECTED OUTCOMES

- The patient will identify available support systems to maintain resilience.
- The patient will identify healthy coping strategies.
- The patient will verbalize belief in self to withstand current situation.
- The patient will engage in activities that promote health.
- The patient will identify strategies that have been successful in previous times of stress.

SUGGESTED NOC OUTCOMES

Coping; Health Promoting Behavior; Role Performance; Personal Resiliency; Stress Level; Knowledge: Health Behavior

INTERVENTIONS AND RATIONALES

Determine: Evaluate previous mechanisms of effective coping in difficult situations. *Assimilating current situation to previous successes enhances resilience.*

Perform: Assist patient in making a list of strengths and resources. Be knowledgeable of cultural aspects of resilience. *Cultural relevance is critical to all aspects of patient care.*

Inform: Instruct patient to engage in positive self-talk: "I can handle this," "I will accomplish one thing today and celebrate it." *A positive outlook increases endorphins and enhances self-efficacy.*

Attend: Encourage patient to maintain activities of health promotion including adequate sleep, nutritious eating, and activity. *Maintaining adequate self-care enhances resilience.*

Manage: Refer patients to mental health resources in the event of maladaptive coping or safety risk. *Risk of compromised resilience may lead to actual compromised resilience.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Coping Enhancement; Decision-Making Support; Spiritual Support; Culture Brokerage; Self-Awareness Enhancement; Resiliency Promotion

REFERENCES

Baker, A. Z., & Procter, N. G. (2014). Losses related to everyday occupations for adults affected by mental illness. *Scandinavian Journal of Occupational Therapy*, *21*(4), 287–294. doi:10.3109/11038128.2014.894571

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DEFINITION

Parental experience of role confusion and conflict in response to crisis

DEFINING CHARACTERISTICS

- Anxiety
- Concern about change in parental role
- Concern about family (e.g., functioning, communication, health)
- Disruption in caregiver routine
- Fear
- Frustration
- Guilt
- Perceived inadequacy to provide for child's needs (e.g., physical, emotional)
- Perceived loss of control over decisions relating to child
- Reluctance to participate in usual caregiving activities

RELATED FACTORS

- Change in marital status
- Home care of a child with special needs
- Interruptions in family life due to home care regimen (e.g., treatments, caregivers, lack of respite)
- Intimidated by invasive modalities (e.g., intubation)
- Intimidated by restrictive modalities (e.g., isolation)
- Living in nontraditional setting (e.g., foster, group, or institutional care)
- Parent–child separation

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication
- Coping
- Roles/relationships
- Self-perception

EXPECTED OUTCOMES

- The parents will communicate feelings about present situation.
- The parents will participate in their child's daily care.
- The parents will express feelings of greater control and ability to contribute more to the child's well-being.
- The parents will express knowledge of child's developmental needs.
- The parents will hold, touch, and convey warmth and affection to child.
- The parents will use available support systems or agencies to assist with coping.

SUGGESTED NOC OUTCOMES

Caregiver Adaptation to Patient Institutionalization; Caregiver Performance: Direct and Indirect Care; Coping: Family

INTERVENTIONS AND RATIONALES

Determine: Assess the child's special needs; age and maturity of parents; roles within the family; available support systems for parents; parent–child relationship; and presence of conflict between family's lifestyle and child's needs. *Assessment information will be useful in establishing appropriate interventions.*

Perform: Make changes in the environment with child-friendly pictures, and so forth, *to foster enhanced communication between parents and child.*

Provide family-centered care by involving the parents in the child's care. *Parents are responsible for decisions about the child's care.*

Inform: Provide information on informed consent *because parents will be making decisions for child's care.*

Teach parents about normal growth and development and advocate that they provide as much normalcy for the child with special needs as possible. *Treating them differently will retard progress in socialization.*

Teach patient and caregiver the skills necessary to manage care adequately. *Teaching will encourage compliance and adjustment to optimum wellness.*

Teach parents how to find areas in activities of living in which it is possible to maintain control, *to avoid feelings of powerless.*

Teach parents to assist child with self-care activities in a way that maximizes the child's potential. *This enables caregivers to participate in child's care while supporting child's independence.*

Attend: Encourage visit by friends to promote socialization.

Encourage parents to pay attention to needs of siblings at home, and to discuss with siblings their feelings about having a sister or brother with special needs. *The goal is to have siblings be supportive but feel important in their own rights.*

Provide respite care *to promote emotional well-being of parents.* Encourage parents to spend time away from child *to enhance their marital relationship.*

Manage: Act as a liaison between family and multidisciplinary health care team *to provide support to the patients as they reach out for help.*

Refer parents to home care agencies, and ensure that an appropriate assessment is done, *to encourage long-term support.*

Refer parents to a mental health specialist *to enable support for the family members as they continue coping with the child's special needs.*

Arrange for parents to meet with parents who are coping positively with the same kinds of issues. *Peer support will help parents cope with their child's issues.*

SUGGESTED NIC INTERVENTIONS

Family Process Maintenance; Limit Setting; Mutual Goal-Setting; Parenting Promotion; Role Enhancement; Family Presence Facilitation

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DEFINITION

A pattern of behavior and self-expression that do not match the environmental context, norms, and expectations

DEFINING CHARACTERISTICS

- Alteration in role perception
- Anxiety
- Change in capacity to resume role
- Change in others' perception of role
- Change in self-perception of role
- Change in usual pattern of responsibility
- Depression
- Discrimination
- Domestic violence
- Harassment
- Inappropriate developmental expectations
- Ineffective adaptation to change
- Ineffective coping strategies
- Ineffective role performance
- Insufficient confidence
- Insufficient external support for role enactment
- Insufficient knowledge of role requirements
- Insufficient motivation
- Insufficient opportunity for role enactment
- Insufficient self-management
- Insufficient skills
- Pessimism
- Powerlessness
- Role ambivalence
- Role conflict
- Role confusion
- Role denial
- Role dissatisfaction
- Role strain
- System conflict
- Uncertainty

RELATED FACTORS

- *Knowledge:* Insufficient role model, insufficient role preparation (e.g., role transition skill rehearsal, validation), low educational level, unrealistic role expectations
- *Physiological:* Alteration in body image, depression, fatigue, low self-esteem, mental health issue (e.g., depression, psychosis, personality

disorder, substance abuse), neurologic defect, pain, physical illness, substance abuse
- *Social:* Conflict, developmental level inappropriate for role expectation, domestic violence, economically disadvantaged, high demands of job schedule, inappropriate linkage with the health care system, insufficient resources (e.g., financial, social, knowledge), insufficient rewards, insufficient role socialization, insufficient support system, stressors, young age

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)
- Coping
- Emotional
- Knowledge
- Roles/relationships

EXPECTED OUTCOMES

- The patient/family will express feelings about diminished ability to perform usual roles.
- The patient/family will recognize and state feelings about limitations imposed by illness.
- The patient/family will make decisions about course of treatment and management of illness.
- The patient/family will continue to function in usual roles as much as possible.
- The patient/family will express feelings of making productive contribution to self-care, to others, or to environment.

SUGGESTED NOC OUTCOMES

Caregiver Lifestyle Disruption; Psychosocial Adjustment: Life Change; Role Performance; Coping; Psychomotor Energy

INTERVENTIONS AND RATIONALES

Determine: Assess patient's knowledge of illness *to establish baseline data.*
Perform: If possible, assign the same nurse to patient each shift *to establish rapport and foster development of a therapeutic relationship.*

Spend ample time with patient each shift to *foster a sense of safety and decrease loneliness.* If possible, assign the same nurse to patient each shift to *establish rapport and promote a therapeutic relationship.*

Encourage patient to express thoughts and feelings *to identify life affects of altered role performance.*

Express belief in ability of patient to develop coping skills, *to help patient gain confidence.*

Be aware of patient's emotional vulnerability, and allow open expression of all emotions. *An accepting attitude will help patient deal with the effects of chronic illness and loss of functioning.*

Provide opportunities for patient to make decisions. *Showing respect for patient's decision-making ability enhances feelings of independence.*
Inform: Educate patient and family members about redefining *roles to promote optimal functioning. Through education, family members may become resources in patient's care.*

Offer patient and family members a realistic assessment of patient's illness, and communicate hope for the immediate future. *Education helps promote patient safety and security and helps family members plan for future health care requirements.*
Attend: Encourage patient to participate in self-care activities, keeping in mind patient's physical and emotional limitations. *Involvement in self-care promotes optimal functioning.*

Help patient recognize and use personal strengths *to maintain optimal functioning and promote a healthy self-image.*

Encourage patient to continue to fulfill life roles within the constraints posed by illness. *This will help patient maintain a sense of purpose and preserve connections with other people.*

Encourage patient to participate in care as an active member of the health care team. *This will help establish mutually accepted goals between patient and caregivers. Patient who participates in care is more likely to take an active role in other aspects of life.*
Manage: Help family members identify their feelings about patient's decreased role functioning. *Encourage participation in a support group. Relatives of patient may need social support, information, and an outlet for ventilating feelings.*

SUGGESTED NIC INTERVENTIONS

Caregiver Support; Family Process Maintenance; Role Enhancement; Family Mobilization

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DEFINITION

Difficulty in performing family/significant other caregiver role

DEFINING CHARACTERISTICS

- *Caregiving Activities:* Apprehensiveness about future ability to provide care, apprehensiveness about future health of care receiver, apprehensiveness about potential institutionalization of care receiver, apprehensiveness about well-being of care receiver if unable to provide care, difficulty completing required tasks, difficulty performing required tasks, dysfunctional change to caregiving activities, preoccupation with care routine
- *Caregiver Health Status: Physiological*—cardiovascular disease, diabetes mellitus, fatigue, gastrointestinal distress, headache, hypertension, rash, weight change
- *Caregiver Health Status: Emotional*—alteration in sleep pattern, anger, depression, emotional vacillation, frustration, impatience, ineffective coping strategies, insufficient time to meet personal needs, nervousness, somatization, stressors
- *Caregiver Health Status: Socioeconomic*—change in leisure activities, low work productivity, refusal of career advancement, social isolation
- *Caregiver–Care Receiver Relationship:* Difficulty watching care receiver with illness, grieving of changes in relationship with care receiver, uncertainty about changes in relationship with care receiver
- *Family Processes:* Concern about family member(s), family conflict

RELATED FACTORS

- *Care Receiver Health Status:* Alteration in cognitive functioning, chronic illness, codependency, dependency, illness severity, increase in care needs
- *Caregiver Health Status:* Alteration in cognitive functioning, codependency, ineffective coping strategies, insufficient fulfillment of others' expectations, insufficient fulfillment of self-expectations, physical conditions, substance abuse, unrealistic self-expectations
- *Caregiver–Care Receiver Relationship:* Abusive relationship, care receiver's condition inhibits conversation, pattern of ineffective relationships, unrealistic care receiver expectations, violent relationship
- *Caregiving Activities:* Around-the-clock care responsibilities, change in nature of care activities, complexity of care activities, duration of caregiving, excessive caregiving activities, recent discharge home with significant care needs, unpredictability of care situation
- *Family Process:* Pattern of family dysfunction, pattern of ineffective family coping
- *Resources:* Caregiver not developmentally ready for caregiver role, difficulty accessing assistance, difficulty accessing community resources, difficulty accessing support, financial crisis (e.g., debt, insufficient finances), inexperience with caregiving, insufficient assistance,

insufficient caregiver privacy, insufficient community resources (e.g., respite, recreation, social support), insufficient emotional resilience, insufficient energy, insufficient equipment for providing care, insufficient knowledge about community resources, insufficient physical environment for providing care, insufficient social support, insufficient time, insufficient transportation
- *Socioeconomic:* Alienation, competing role commitments, insufficient recreation, social isolation

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)
- Behavior
- Neurocognition
- Coping
- Role/relationships
- Emotional
- Support systems
- Home environment

EXPECTED OUTCOMES

- The caregiver will describe current stressors.
- The caregiver will identify stressors that can and can't be controlled.
- The caregiver will identify formal and informal sources of support.
- The caregiver will show evidence of using support systems.
- The caregiver will report increased ability to cope with stress.

SUGGESTED NOC OUTCOMES

Caregiver Emotional Health; Caregiver Lifestyle Disruption; Caregiver Stressors; Caregiver Well-Being; Caregiver Role Endurance; Caregiver Adaptation to Patient Institutionalization; Caregiver Home Care Readiness

INTERVENTIONS AND RATIONALES

Determine: Help caregivers identify current stressors *to evaluate the causes of role strain.*

Perform: Provide care, as indicated, *to give caregivers respite.*

Inform: Suggest ways for caregivers to use time more efficiently. For example, caregiver may save time by filling out insurance forms while visiting and chatting with care recipient. *Better time management may help caregiver reduce stress.*

Attend: Using a nonjudgmental approach, help caregiver evaluate which stressors are controllable and which aren't, *to begin to develop strategies to reduce stress.*

Encourage caregiver to discuss coping skills used to overcome similar stressful situations in the past, *to build confidence for managing the current situation.*

Encourage caregiver to participate in a support group. Provide information on organizations such as Alzheimer's Association, Children of Aging Parents, or the referral service of the community-acquired immunodeficiency syndrome task force *to foster mutual support and provide an opportunity for caregiver to discuss personal feelings with empathetic listeners.*

Help caregiver identify informal sources of support, such as family members, friends, church groups, and community volunteers, *to provide resources for obtaining an occasional or regularly scheduled respite.*

Help caregiver identify available formal support services, such as home health agencies, municipal or county social services, hospital social workers, physicians, clinics, and day-care centers, *to enhance coping by providing a reliable structure for support.*

If caregiver seems overly anxious or distraught, gently point out facts about care recipient's mental and physical condition. *Many times, especially when care recipient is a family member, caregiver's perspective is clouded by a long history of emotional involvement. Your input may help caregiver view the situation more objectively.*

Manage: If you believe that excessive emotional involvement is hindering caregiver's ability to function, consider recommending Co-Dependents Anonymous, a support group for people whose preoccupation with a relationship leads to chronic suffering and diminished effectiveness, *to provide support.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Caregiver Support; Coping Enhancement; Counseling; Role Enhancement; Support Group

REFERENCES

Campbell, C. L., McCoy, S., Hoffman, N., & O'Neil, P. (2014). Decreasing role strain for caregivers of veterans with dependence in performing activities of daily living. *Health & Social Work, 39*(1), 55–62.

Ching-Tzu, Y., Hsin-Yun, L., & Yea-Ing Lotus, S. (2014). Dyadic relational resources and role strain in family caregivers of persons living with dementia at home: A cross-sectional survey. *International Journal of Nursing Studies, 51*(4), 593–602. doi:10.1016/j.ijnurstu.2013.09.001

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DEFINITION

Vulnerable to difficulty in performing the family/significant other caregiver role, which may compromise health

RISK FACTORS

- Alteration in cognitive functioning in care receiver
- Care receiver discharged home with significant needs
- Care receiver exhibits bizarre behavior
- Care receiver exhibits deviant behavior
- Caregiver health impairment
- Caregiver isolation
- Caregiver not developmentally ready for caregiver role
- Caregiver's competing role commitments
- Caregiving task complexity
- Codependency
- Congenital disorder
- Developmental delay
- Developmental delay of caregiver
- Excessive caregiving activities
- Exposure to violence
- Extended duration of caregiving required
- Family isolation
- Female caregiver
- Illness severity of care receiver
- Inadequate physical environment for providing care
- Ineffective caregiver coping pattern
- Ineffective family adaptation
- Inexperience with caregiving
- Instability in care receiver's health
- Insufficient caregiver recreation
- Insufficient respite for caregiver
- Partner as caregiver
- Pattern of family dysfunction prior to the caregiving situation
- Pattern of ineffective relationship between caregiver and care receiver
- Prematurity
- Presence of abuse (e.g., physical, psychological, sexual)
- Psychological disorder in caregiver
- Psychological disorder in care receiver
- Stressors
- Substance abuse
- Unpredictability of illness trajectory

RISK FOR CAREGIVER ROLE STRAIN

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Knowledge
- Neurocognition
- Role/relationships

EXPECTED OUTCOMES

- The caregiver will identify current stressors.
- The caregiver will identify appropriate coping strategies and will state plans to incorporate strategies into daily routine.
- The caregiver will state intention to contact formal and informal sources of support.
- The caregiver will state intention to incorporate recreational activities into daily routine.
- The caregiver will report satisfaction with ability to cope with stress caused by caregiving responsibilities.

SUGGESTED NOC OUTCOMES

Caregiver Emotional Health; Caregiver Home Care Readiness; Caregiver Lifestyle Disruption; Caregiver-Patient Relationship; Caregiver Physical Health; Caregiver Stressors; Caregiver Role Endurance

INTERVENTIONS AND RATIONALES

Determine: Help caregiver identify current stressors. Ask whether stress is likely to increase or decrease in the future, *to evaluate the risk of caregiver role strain.*

Attend: Encourage caregiver to discuss coping skills used to overcome similar stressful situations in the past, *to bolster caregiver's confidence in ability to manage current situation and explore ways to apply coping strategies before caregiver becomes overwhelmed.*

Help caregiver identify formal and informal sources of support, such as home health agencies, municipal or county social services, hospital social workers, physicians, clinics and day care centers, family members, friends, church groups, and community volunteers, *to plan for an occasional or regularly scheduled respite.*

Encourage caregiver to discuss hobbies or diversional activities. *Incorporating enjoyable activities into the daily or weekly schedule will discipline caregiver to take needed breaks from caregiving responsibilities and thereby diminish stress.*

Encourage caregiver to participate in a support group. Provide information on organizations such as Alzheimer's Association and Children

of Aging Parents *to foster mutual support and provide an outlet for expressing feelings before frustration becomes overwhelming.*

If caregiver seems overly anxious or distraught, gently point out facts about care recipient's mental and physical condition. *Many times a caregiver's perspective is clouded by a long history of emotional involvement. Your input may help caregiver view the situation more objectively.* Suggest ways for caregiver to use time efficiently. *Better time management may help caregiver reduce stress.*

Manage: If you believe that excessive emotional involvement is hindering caregiver's ability to function, consider recommending Co-Dependents Anonymous, *to provide support.*

SUGGESTED NIC INTERVENTIONS

Caregiver Support; Home Maintenance Assistance; Referral; Respite Care; Role Enhancement; Support Group

REFERENCES

Campbell, C. L., McCoy, S., Hoffman, N., & O'Neil, P. (2014). Decreasing role strain for caregivers of veterans with dependence in performing activities of daily living. *Health & Social Work, 39*(1), 55–62.

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440 BATHING SELF-CARE DEFICIT

DEFINITION

Impaired ability to perform or complete bathing activities for self

DEFINING CHARACTERISTICS

- Impaired ability to dry body
- Impaired ability to access bathroom
- Impaired ability to access water
- Impaired ability to gather bathing supplies
- Impaired ability to regulate bath water
- Impaired ability to wash body

RELATED FACTORS

- Alteration in cognitive functioning
- Anxiety
- Decrease in motivation
- Environmental barrier
- Impaired ability to perceive body part
- Impaired ability to perceive spatial relationships
- Musculoskeletal impairment
- Neuromuscular impairment
- Pain
- Perceptual impairment
- Weakness

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Coping
- Self-care
- Self-perception

EXPECTED OUTCOMES

- The patient will have self-care needs met.
- The patient will have few, if any, complications.
- The patient will communicate feelings about limitations.
- The patient will demonstrate correct use of assistive devices.
- The patient will carry out bathing and hygiene program daily.

SUGGESTED NOC OUTCOMES

Adaptation to Physical Disability; Energy Conservation; Self-Care: Activities of Daily Living (ADLs); Self-Care: Bathing; Self-Care: Hygiene

INTERVENTIONS AND RATIONALES

Determine: Observe patient's functional level every shift; document and report any changes. *Careful observation helps you adjust nursing actions to meet patient's needs.*

Monitor the completion of bathing and hygiene daily. Praise patient's accomplishments. *Reinforcement and rewards may encourage renewed effort.*
Perform: Perform the prescribed treatment for underlying musculoskeletal impairment. Monitor patient's progress, reporting favorable and adverse responses to treatment. *Applying therapy consistently aids patient's independence.*

Provide assistive devices, such as a long-handled toothbrush, for bathing and hygiene; instruct patient on use. *Appropriate assistive devices encourage independence.*

Assist with or perform bathing and hygiene daily. Assist only when patient has difficulty, *to promote feeling of independence.*
Inform: Instruct patient and family members in bathing and hygiene techniques (you can give family members written instructions). Have patient and family members demonstrate bathing and hygiene under supervision. *Return demonstration identifies problem areas and increases patients' and family members' self-confidence.*
Attend: Encourage patient to voice feelings and concerns about self-care deficits, *to help patient achieve the highest functional level possible.*
Manage: As needed, refer patient to a psychiatric liaison nurse, support group, or home health care agency. *These extra resources will reinforce activities planned to meet patient's needs.*

SUGGESTED NIC INTERVENTIONS

Behavior Modification; Discharge Planning; Bathing; Ear Care; Foot Care; Hair Care; Nail Care; Self-Care Assistance; Self-Care Assistance: Bathing/Hygiene

REFERENCES

Akin, S., Mendi, B., Ozturk, B., Cinper, C., & Durna, Z. (2014). Assessment of relationship between self-care and fatigue and loneliness in hemodialysis patients. *Journal of Clinical Nursing*, *23*(5/6), 856–864. doi:10.1111/jocn.12248

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442 DRESSING SELF-CARE DEFICIT

DEFINITION

Impaired ability to perform or complete dressing activities for self

DEFINING CHARACTERISTICS

- Decrease in motivation
- Discomfort
- Environmental barrier
- Fatigue
- Impaired ability to fasten clothing
- Impaired ability to gather clothing
- Impaired ability to maintain appearance
- Impaired ability to pick up clothing
- Impaired ability to put clothing on lower body
- Impaired ability to put clothing on upper body
- Impaired ability to put on various items of clothing (e.g., shirt, socks, shoes)
- Impaired ability to remove clothing item (e.g., shirt, socks, shoes)
- Impaired ability to use assistive device
- Impaired ability to use zipper
- Musculoskeletal impairment
- Neuromuscular impairment
- Pain

RELATED FACTORS

- Alteration in cognitive functioning
- Anxiety
- Perceptual impairment
- Weakness

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Coping
- Self-care
- Self-perception

EXPECTED OUTCOMES

- The patient will have self-care needs met.
- The patient will have few, if any, complications.
- The patient will communicate feelings about limitations.
- The patient will demonstrate the correct use of assistive devices.
- The patient will carry out dressing and grooming program daily.

SUGGESTED NOC OUTCOMES

Self-Care: Activities of Daily Living (ADLs); Self-Care: Dressing; Caregiver Performance: Direct Care

INTERVENTIONS AND RATIONALES

Determine: Observe patient's functional level every shift; document and report any changes. *Careful observation helps you adjust nursing actions to meet patient's needs.*

Monitor patient's abilities to dress and groom daily. *This identifies problem areas before they become sources of frustration.*

Perform: Perform the prescribed treatment for underlying musculoskeletal impairment. Monitor patient's progress, reporting favorable and adverse responses to treatment. *Applying therapy consistently aids patient's independence.*

Provide enough time for patient to perform dressing and grooming. *Rushing creates unnecessary stress and promotes failure.*

Provide necessary assistive devices, such as a long-handled shoehorn and zipper pull, as needed. Instruct patient on use. *Appropriate assistive devices encourage independence.*

Assist with or perform dressing activities: fasten clothes, comb hair, and clean nails. Provide help only when patient has difficulty, *to promote feeling of independence.*

Inform: Instruct patient and family members on dressing techniques (you can give family members written instructions). Have patient and family members demonstrate dressing and grooming techniques under supervision. *Return demonstration reveals problem areas and increases self-confidence.*

Attend: Encourage patient to voice feelings and concerns about self-care deficits, *to help patient achieve the highest functional level possible.*

Encourage family members to provide clothing patient can easily manage. Patient may benefit from clothing slightly larger than regular size and Velcro straps. *Such clothing makes independent dressing easier.*

Manage: As needed, refer patient to a psychiatric liaison nurse, support group, or home health care agency. *These extra resources will reinforce activities planned to meet patient's needs.*

SUGGESTED NIC INTERVENTIONS

Self-Care Assistance: Dressing/Grooming; Dressing

REFERENCES

Akin, S., Mendi, B., Ozturk, B., Cinper, C., & Durna, Z. (2014). Assessment of relationship between self-care and fatigue and loneliness in hemodialysis patients. *Journal of Clinical Nursing*, *23*(5/6), 856–864. doi:10.1111/jocn.12248

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444 FEEDING SELF-CARE DEFICIT

DEFINITION

Impaired ability to perform or complete self-feeding activities

DEFINING CHARACTERISTICS

- Impaired ability to bring food to the mouth
- Impaired ability to chew food
- Impaired ability to get food onto utensil
- Impaired ability to handle utensils
- Impaired ability to manipulate food in mouth
- Impaired ability to open containers
- Impaired ability to pick up cup
- Impaired ability to prepare food
- Impaired ability to self-feed a complete meal
- Impaired ability to self-feed in an acceptable manner
- Impaired ability to swallow food
- Impaired ability to swallow sufficient amount of food
- Impaired ability to use assistive device

RELATED FACTORS

- Alteration in cognitive functioning
- Anxiety
- Decrease in motivation
- Discomfort
- Environmental barrier
- Fatigue
- Musculoskeletal impairment
- Neuromuscular impairment
- Pain
- Perceptual impairment
- Weakness

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Coping
- Self-care
- Self-perception

EXPECTED OUTCOMES

- The patient will express feelings about feeding limitations.
- The patient will maintain weight at ___ lb.
- The patient will have no evidence of aspiration.
- The patient will consume ___ % of diet.
- The patient will demonstrate the correct use of assistive devices.
- The patient will carry out feeding program daily.

SUGGESTED NOC OUTCOMES

Aspiration Prevention; Nutritional Status; Self-Care: Activities of Daily Living (ADLs); Self-Care: Eating; Swallowing Status

INTERVENTIONS AND RATIONALES

Determine: Observe patient's functional level every shift; document and report any changes. *Careful observation helps you adjust nursing actions to meet patient's needs.*

Monitor and record breath sounds every 4 hours *to check for aspiration of food.* Report crackles, wheezes, or rhonchi.

Perform: Perform the prescribed treatment of underlying musculoskeletal impairment. Monitor patient's progress, reporting favorable and adverse responses to treatment. *Applying therapy consistently aids patient's independence.*

Weigh patient weekly and record weight. Report a change of more than 1 lb/week *to ensure adequate nutrition and fluid balance.*

Initiate an ordered feeding program:

- Determine the types of food best handled by patient, *to encourage patient's feelings of independence.*
- Place patient in high Fowler's position to feed, *to aid swallowing and digestion.* Support weakened extremities, and wash patient's face and hands before meals *to promote a sense of well-being and safety.*
- Provide assistive devices such as plate guard and rocker knife, *to allow more independence*; instruct patient on their use *to promote independence.*
- Supervise or assist at each meal; for example, cut food into small pieces. *This aids chewing, swallowing, and digestion, and reduces the risk of choking or aspiration.*
- Feed patient slowly. *Rushing causes stress, reducing digestive activity and causing intestinal spasms.*
- Keep suction equipment at the bedside *to remove aspirated foods, if necessary.*
- Record the percentage of food consumed *to ensure adequate nutrition.*

Inform: Instruct patient and family members on feeding techniques and equipment. *This aids understanding and encourages compliance.*

Return demonstration reveals problem areas and increases self-confidence.

Attend: Encourage patient to express feelings and concerns about feeding deficits, *to help patient achieve the highest functional level.*

Encourage patient to carry out the aspects of feeding according to patient's abilities. *This gives patient a sense of achievement and control.*

Manage: Refer patient to a psychiatric liaison nurse, support group, or community agencies such as Visiting Nurse Association and Meals on Wheels. *Additional resources reinforce activities planned to meet patient's needs.*

SUGGESTED NIC INTERVENTIONS

Aspiration Precautions; Fluid Management; Nutrition Management; Nutritional Monitoring; Self-Care Assistance: Feeding; Swallowing Therapy

REFERENCES

Akin, S., Mendi, B., Ozturk, B., Cinper, C., & Durna, Z. (2014). Assessment of relationship between self-care and fatigue and loneliness in hemodialysis patients. *Journal of Clinical Nursing*, *23*(5/6), 856–864. doi:10.1111/jocn.12248

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DEFINITION

Impaired ability to perform or complete self-toileting activities

DEFINING CHARACTERISTICS

- Impaired ability to complete toilet hygiene
- Impaired ability to flush toilet
- Impaired ability to manipulate clothing for toileting
- Impaired ability to reach toilet
- Impaired ability to rise from toilet
- Impaired ability to sit on toilet

RELATED FACTORS

- Alteration in cognitive functioning
- Anxiety
- Decrease in motivation
- Environmental barrier
- Fatigue
- Impaired ability to transfer
- Impaired mobility
- Musculoskeletal impairment
- Neuromuscular impairment
- Pain
- Perceptual impairment
- Weakness

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Coping
- Self-care
- Self-perception

EXPECTED OUTCOMES

- The patient will have self-care needs met.
- The patient will have few, if any, complications.
- The patient will communicate feelings about limitations.
- The patient will maintain continence.
- The patient will demonstrate the correct use of assistive devices.
- The patient will carry out toileting program daily.

SUGGESTED NOC OUTCOMES

Urinary Continence; Bowel Continence; Self-Care: Activities of Daily Living (ADLs); Self-Care: Hygiene; Self-Care: Toileting

INTERVENTIONS AND RATIONALES

Determine: Observe patient's functional level every shift; document and report any changes. *Careful observation helps you adjust nursing actions to meet patient's needs.*

Monitor intake and output and skin condition; record episodes of incontinence. *Accurate intake and output records can identify potential imbalances.*

Perform: Perform the prescribed treatment of underlying musculoskeletal impairment. Monitor patient's progress, reporting favorable and adverse responses to treatment. *Applying therapy consistently aids patient's independence.*

Use assistive devices, as needed, such as an external catheter at night, a bedpan or urinal every 2 hours during the day, and adaptive equipment for bowel care. Instruct on use. As control improves, reduce the use of assistive devices. *Assisting at an appropriate level helps maintain patient's self-esteem.*

Assist with toileting only if needed. Allow patient to perform independently as much as possible *to promote independence.*

Perform urinary and bowel care, if needed. Follow urinary or bowel elimination plans. *Monitoring success or failure of toileting plans helps identify and resolve problem areas.*

Inform: Instruct patient and family members in toileting routine (you can give family members written instructions). Have patient and family members demonstrate toileting routine under supervision. *Return demonstration identifies problem areas and increases patient's self-confidence.*

Attend: Encourage patient to voice feelings and concerns about patient's self-care deficits, *to help patient achieve the highest functional level possible.*

Manage: As needed, refer patient to a psychiatric liaison nurse, support group, or home health care agency. *Additional resources reinforce activities planned to meet patient's needs.*

SUGGESTED NIC INTERVENTIONS

Bowel Training; Self-Care Assistance: Toileting; Urinary Elimination Management; Urinary Bladder Training; Urinary Incontinence Care; Bowel Incontinence Care

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Basak, T., Unver, V., & Demirkaya, S. (2015). Activities of daily living and self-care agency in patients with multiple sclerosis for the first 10 years. *Rehabilitation Nursing*, *40*(1), 60–65. doi:10.1002/rnj.153

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Talley, K. C., Wyman, J. F., Bronas, U. G., Olson-Kellogg, B. J., McCarthy, T. C., & Hong, Z. (2014). Factors associated with toileting disability in older adults without dementia living in residential care facilities. *Nursing Research*, *63*(2), 94–104. doi:10.1097/NNR.0000000000000017

DEFINITION

Vulnerable to behaviors in which an individual demonstrates that he or she can be physically, emotionally, and/or sexually harmful to self

RISK FACTORS

- Age ≥45 years
- Age 15 to 19 years
- Behavioral cues (e.g., writing forlorn love notes, directing angry messages at a significant other who has rejected the person, giving away personal items, taking out a large life insurance policy)
- Conflict about sexual orientation
- Conflict in interpersonal relationship(s)
- Employment concern (e.g., unemployed, recent job loss/failure)
- Engaged in autoerotic sexual acts
- History of multiple suicide attempts
- Insufficient personal resources (e.g., achievement, insight, affect unavailable and poorly controlled)
- Marital status (e.g., single, widowed, divorced)
- Mental health issue (e.g., depression, psychosis, personality disorder, substance abuse)
- Occupation (e.g., executive, administrator/owner of business, professional, semiskilled worker)
- Pattern of difficulties in family background (e.g., chaotic or conflictual, history of suicide)
- Physical health issue
- Psychological disorder
- Social isolation
- Suicidal ideation
- Suicidal plan
- Verbal cues (e.g., talking about death, "better off without me," asking about lethal dosage of medication)

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Emotional
- Risk management
- Self-perception
- Values/belief

EXPECTED OUTCOMES

- The patient will maintain environment that is free from potential suicidal weapons.

- The patient will recover from suicidal episode.
- The patient will discuss feelings that precipitated suicide attempt.
- The patient will consult mental health professional.
- The patient will describe available resources for crisis prevention and management.
- The patient will verbalize noticed improvement in self-worth.

SUGGESTED NOC OUTCOMES

Impulse Self-Control; Self-Mutilation Restraint; Suicide Self-Restraint

INTERVENTIONS AND RATIONALES

Determine: Assess life situation; recent stressors; available support systems; history of suicidal attempts; history of substance/alcohol abuse; history of violence against person or property; history of antisocial behavior. *Assessment information will help identify appropriate intervention for this diagnosis.*

Perform: Remove all objects from the environment that the patient could use to harm self, *to provide safety and protect potential victims of violence to self.*

Administer prescribed medications *to help patient control aggressive behavior and remain calm.* Monitor for effectiveness. *When used appropriately, medications will help reduce suicidal ideations.*

Inform: Explain medication program to patient *to promote compliance.* Make sure that the medication is swallowed, as prescribed, *to ensure compliance and produce calmness.*

Teach coping strategies and self-healing techniques to patient and family members, including meditation, guided imagery, and prayer.

Teach patient how to incorporate the use of self-healing techniques in carrying out usual daily activities. *These techniques help calm the mind and promote ability to cooperate with the difficulties associated with suicidal behavior.*

Attend: Use a warm, caring nonjudgmental manner *to show unconditional positive regard.*

Demonstrate understanding, but don't reinforce denial of the present situation, *because denial can mask the roots of suicidal feelings.*

Listen carefully to the patient and do not challenge patient *to communicate caring and support.*

Manage: Make a short-term contract with the patient that the patient will not harm self during a specific period. Continue negotiating until no evidence of suicidal ideation exists. *A contract gets the subject of suicide out in the open, places some responsibility to the patient, and conveys acceptance of the patient as a person.*

Provide patient with telephone numbers and other information about crisis centers, hotlines, and counselors. *Alternatives may ease anxiety about the perceived threat of long-term psychotherapy.*

SUGGESTED NIC INTERVENTIONS

Behavior Management: Self-Harm; Environmental Management: Violence Prevention; Impulse Control Training; Suicide Prevention; Crisis Intervention

REFERENCES

Kaess, M., Durkee, T., Brunner, R., Carli, V., Parzer, P., Wasserman, C., . . . Kahn, J. (2014). Pathological internet use among European adolescents: Psychopathology and self-destructive behaviours. *European Child & Adolescent Psychiatry*, *23*(11), 1093–1102.

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452 CHRONIC LOW SELF-ESTEEM

DEFINITION

Longstanding negative self-evaluation/feelings about self or self-capabilities

DEFINING CHARACTERISTICS

- Dependent on other's opinions
- Exaggerates negative feedback about self
- Excessive seeking of reassurance
- Guilt
- Hesitant to try new experiences
- Expressions of shame
- Indecisive behavior
- Nonassertive behavior
- Overly conforming
- Passivity
- Poor eye contact
- Rejection of positive feedback
- Repeatedly unsuccessful in life events
- Shame
- Underestimates ability to deal with situation

RELATED FACTORS

- Cultural incongruence
- Exposure to traumatic situation
- Inadequate belonging
- Inadequate respect from others
- Ineffective coping with loss
- Insufficient group membership
- Psychiatric disorder
- Receiving insufficient affection
- Receiving insufficient approval from others
- Repeated failures
- Repeated negative reinforcement
- Spiritual incongruence

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Emotional
- Role/responsibilities
- Self-perception

EXPECTED OUTCOMES

- The patient will voice feelings related to current situation and its effect on self-esteem.
- The patient will report feeling safe in agency environment.

- The patient will make a verbal contract not to harm self while in the facility.
- The patient will gradually join in self-care and decision-making process.
- The patient will decrease number of negative self-defeating comments.
- The patient will accept positive and negative feedback without exaggeration.

SUGGESTED NOC OUTCOMES

Body Image; Depression Self-Control; Mood Equilibrium; Motivation; Personal Autonomy; Quality of Life; Self-Esteem; Risk Detection; Decision-Making; Suicide Self-Restraint

INTERVENTIONS AND RATIONALES

Determine: Assess reason for hospitalization; perception of self; and cognitive ability. *Information gained from the assessment will assist to identify appropriate goals and interventions.*

Perform: Provide for a specific amount of uninterrupted time each day to engage the patient in conversation. *This will allow the patient time for self-exploration, which promotes future change.*

When appropriate, institute suicide precaution according to protocol. *Patient needs supervision until the patient demonstrates adequate self-control to ensure patient's own safety.*

Provide the patient with a simple structured daily routine. *Structured activity limits the patient's anxious behavior.*

Encourage discussion of problems patient considers important. Have patient make a list of three most critical issues. *This creates opportunity for patient to identify problems and begin setting realistic goals to build self-confidence.*

Encourage bathing, grooming, and other hygiene functions for the patient every day, as needed. Encourage patient to do as much as possible for self. *Greater independence will help strengthen self-esteem.*

Inform: Teach self-healing techniques to patient and family, such as meditation, guided imagery, yoga, and prayer, *to prevent anxiety and encourage a positive frame of mind.*

Provide patient with concise information about decision-making skills, *to produce benefits that can reinforce health-seeking behaviors.*

Attend: Provide patient with positive feedback for verbal reports or behaviors that indicate a return to positive self-appraisal. *This gives patient feelings of significance, approval, and competence, which can help cope effectively with stressful situations.*

Encourage social interaction. *Disturbed interpersonal relationships may be an outward expression of self-hate.*

Facilitate opportunities for spiritual nourishment and growth *to address patient's holistic needs for maximal therapeutic environment.*

Be available to answer any questions patient's family may have, *to provide accurate information and emotional support.*

Manage: Assist patient to seek assistance when discharged, *to help replace maladaptive coping behaviors with more adaptive ones.*

Schedule time to meet with family and patient to listen to ways in which they plan to enhance their coping skills in the present situation. *This better ensures success in meeting established goals.*

Refer family to community resources and support groups available *to assist in managing patient's illness and providing emotional and financial assistance to caregivers.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Body Image Enhancement; Coping Enhancement; Decision-Making Support; Hope Instillation; Self-Esteem Enhancement; Support Group; Suicide Prevention

REFERENCES

Guerrero-Escobedo, P., Tamez-Rivera, O., Amieva, H., & Avila-Funes, J. A. (2014). Frailty is associated with low self-esteem in elderly adults. *Journal of the American Geriatrics Society*, *62*(2), 396–398. doi:10.1111/jgs.12679

Noordenbos, G., Aliakbari, N., & Campbell, R. (2014). The relationship among critical inner voices, low self-esteem, and self-criticism in eating disorders. *Eating Disorders*, *22*(4), 337–351. doi:10.1080/10640266.2014.898983

Sowislo, J. F., Orth, U., & Meier, L. L. (2014). What constitutes vulnerable self-esteem? Comparing the prospective effects of low, unstable, and contingent self-esteem on depressive symptoms. *Journal of Abnormal Psychology*, *123*(4), 737–753. doi:10.1037/a0037770

DEFINITION

Vulnerable to longstanding negative self-evaluating/feelings about self or self-capabilities, which may compromise health

RISK FACTORS

- Cultural incongruence
- Exposure to traumatic situation
- Inadequate affection received
- Inadequate group membership
- Inadequate respect from others
- Ineffective coping with loss
- Insufficient feeling of belonging
- Psychiatric disorder
- Repeated failures
- Repeated negative reinforcement
- Spiritual incongruence

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Emotional
- Roles/relationships
- Self-perception

EXPECTED OUTCOMES

- The patient will attend milieu therapies and interact with peers.
- The patient will use cognitive therapies to modify negative thoughts about self.
- The patient will maintain safety and report any thoughts of self-harm to staff.
- The patient will report decrease in feelings of anger, fear, guilt, and self-doubt.
- The patient will verbalize positive self characteristics and accomplishments.

SUGGESTED NOC OUTCOMES

Anxiety Control; Body Image; Coping; Depression Level; Mood Equilibrium; Risk Control; Self-Esteem; Social Interaction Skills

INTERVENTIONS AND RATIONALES

Determine: Assess patient's mental status per unit protocols. *Recurring assessments will aid in identifying interventions and expected outcomes and allow for modifications based on patient's progress.*

Obtain thorough history upon admission *to determine whether patient's history has additional risk factors for low self-esteem.*

Perform: Assist patient in applying cognitive therapies and positive self-talk, *to identify and modify negative actions and thoughts that lead to feelings of anger, fear, guilt, and self-doubt.*

Work with patient to set a daily schedule that promotes self-care and attendance at milieu therapies, and give sincere praise when patient follows through. *Independence and positive feedback from peers and staff will aid in developing self-confidence and increasing self-esteem.*

Inform: Educate patient on the importance of being assertive and reinforce by having the patient state particular needs or preferences for the day, *as this will help build independence and self-confidence, and decrease fear of rejection.*

Educate patient regarding the importance of setting realistic treatment goals *to continue to build self-confidence and self-esteem.*

Educate patient regarding resources available in the community such as support groups and *their positive impact on building self-esteem.*

Attend: Dedicate quality time to patient in a therapeutic and consistent manner *to help patient feel safe, allow time for open expression of feelings, and allow for the development of a trusting relationship.*

Manage: Work together with patient to develop a treatment plan and schedule appointments. *This will help to build the patient's independence, confidence, social skills, and self-esteem.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Body Image Enhancement; Cognitive Restructuring; Coping Enhancement; Self-Esteem Enhancement; Support Group

REFERENCES

Baker, A. Z., & Procter, N. G. (2014). Losses related to everyday occupations for adults affected by mental illness. *Scandinavian Journal of Occupational Therapy*, *21*(4), 287–294. doi:10.3109/11038128.2014.894571

Kitzinger, C., & Kitzinger, J. (2014). Grief, anger and despair in relatives of severely brain injured patients: Responding without pathologising. *Clinical Rehabilitation*, *28*(7), 627–631. doi:10.1177/0269215514527844

Zalonis, R., & Slota, M. (2014). The use of palliative care to promote autonomy in decision making. *Clinical Journal of Oncology Nursing*, *18*(6), 707–711. doi:10.1188/14.CJON.707-711

DEFINITION

Development of a negative perception of self-worth in response to a current situation

DEFINING CHARACTERISTICS

- Helplessness
- Indecisive behavior
- Nonassertive behavior
- Purposelessness
- Self-negating verbalizations
- Situational challenge to self-worth
- Underestimates ability to deal with situation

RELATED FACTORS

- Alteration in body image
- Alteration in social role
- Behavior inconsistent with values
- Developmental transition
- Functional impairment
- History of loss
- History of rejection
- Inadequate recognition
- Pattern of failure

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Emotional
- Role/responsibilities
- Self-perception

EXPECTED OUTCOMES

- The patient will voice feelings related to current situation and its effect on self-esteem.
- The patient will verbally appraise self before and during current health problems.
- The patient will participate in decisions related to care and therapies.
- The patient will report a sense of control over life events.
- The patient will articulate return to previous positive feelings about self.

SUGGESTED NOC OUTCOMES

Decision-Making; Psychosocial Adjustment: Life Change; Self-Esteem; Suffering Severity

INTERVENTIONS AND RATIONALES

Determine: Assess health history, including mental status (affect, general appearance, and mood) and cognitive ability, as well as unhealthy coping

and environmental factors. *Information gained from the assessment will assist to identify appropriate interventions.*

Perform: Spend time alone with patient listening to the problems that are important to the patient at this time. Have patient make a list of the three most critical issues the patient has now, *to help patient identify own strengths and begin setting some realistic goals to build self-confidence.*

Encourage bathing, grooming, and other hygiene functions for the patient every day, as needed. Encourage patient to do as much as possible for self. *Greater independence will help strengthen self-esteem.*

Inform: Teach self-healing techniques to both the patient and family, such as meditation, guided imagery, yoga, and prayer, *to prevent anxiety and aid in keeping patient in a frame of mind to make positive decisions.*

Provide patient with concise information about decision-making skills. *This will produce benefits that can reinforce health-seeking behaviors.*

Attend: Encourage patient to express feelings about self (past and present). *Self-exploration encourages patient to consider future change.*

Provide patient with positive feedback for verbal reports or behaviors that indicate a return to positive self-appraisal. *This gives patient feelings of significance, approval, and competence, which can help cope effectively with stressful situations.*

Provide a specific amount of noncore time to engage patient in conversation. *Such discussions help patient assume responsibility for coping responses.*

Facilitate opportunities for spiritual nourishment and growth *to address patient's holistic needs for maximal therapeutic environment.*

Reinforce the family's efforts to care for the patient and support patient's independence. Let them know they are doing well, *to ease adaptation to new caregiver roles.* Provide emotional support to family by being available to answer questions. *Accurate information will help family cope with current situation.*

Manage: Schedule time to meet with family and patient to listen to ways in which they plan to enhance their coping skills in the present situation. *Helping patient and/or family develop a realistic plan will better ensure success in meeting established goals.*

Refer family to community resources and support groups available *to assist in managing patient's illness and providing emotional and financial assistance to caregivers.*

Refer to a member of the clergy or a spiritual counselor, according to the patient's preference, *to show respect for the patient's beliefs and provide spiritual care.*

SUGGESTED NIC INTERVENTIONS

Anticipatory Guidance; Decision-Making Support; Self-Esteem Enhancement; Behavior Management; Relaxation Therapy

REFERENCES

Ahmann, E. (2014). Encouraging positive behavior in 'challenging' children: The nurtured heart approach™. *Pediatric Nursing*, *40*(1), 38–42.

Altınta, A., Aşçı, F. H., Kin-İşler, A., Güven-Karahan, B., Kelecek, S., Özkan, A., . . . Kara, F. M. (2014). The role of physical activity, body mass index and maturity status in body-related perceptions and self-esteem of adolescents. *Annals of Human Biology*, *41*(5), 395–402. doi: 10.3109/03014460.2013.857721

Greenleaf, C., Petrie, T. A., & Martin, S. B. (2014). Relationship of weight-based teasing and adolescents' psychological well-being and physical health. *Journal of School Health*, *84*(1), 49–55. doi:10.1111/josh.12118

460 RISK FOR SITUATIONAL LOW SELF-ESTEEM

DEFINITION

Vulnerable to developing a negative perception of self-worth in response to a current situation, which may compromise health

RISK FACTORS

- Alteration in body image
- Alteration in social role
- Behavior inconsistent with values
- Decrease in control over environment
- Developmental transition
- Functional impairment
- History of abandonment
- History of abuse (e.g., physical, psychological, sexual)
- History of loss
- History of neglect
- Inadequate recognition
- Pattern of failure
- Pattern of helplessness
- Physical illness
- Unrealistic self-expectations

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Emotional

EXPECTED OUTCOMES

- The patient will participate in decisions related to care and therapy.
- The patient will maintain eye contact and initiate conversation.
- The patient will maintain an open and upright posture.
- The patient will verbally assess feelings about current situation and health problems and impact on lifestyle.
- The patient will express positive feelings about self (verbally or through behaviors), indicating acceptance of changes caused by health problems or situation.
- The patient will perform hygiene and self-care activities indicating attention to appearance.
- The patient will express interest in talking to others who have successfully overcome the problem of low self-esteem.

SUGGESTED NOC OUTCOMES

Self-Esteem; Life Changes; Decision Making; Perceived Control; Psychosocial Adjustment

INTERVENTIONS AND RATIONALES

Determine: Assess developmental stage; family system; role in family; sibling position; health history; mental status, including affect, general appearance, mood; cognitive ability; support systems; patient's ability to identify choices; readiness for change to occur; level of knowledge for positive decision making, coping mechanisms, environmental factors. *Information from assessment will assist the nurse to identify appropriate interventions.*

Perform: Encourage bathing, grooming, and other hygiene functions for the patient every day, as needed. Encourage patient to do as much as possible for self. *Greater independence will help strengthen self-esteem.*

Inform: Keep patient informed about what to expect and when to expect it. *Accurate information reduces anxiety.*

Teach self-healing techniques to both the patient and family, such as meditation, guided imagery, yoga, and prayer. Teach patient how to incorporate the use of self-healing techniques in carrying out usual daily activities. *These techniques help calm the mind and promote ability to cooperate with the difficulties associated with low self-esteem.*

Attend: Encourage patient to talk about personal assets and accomplishments and about improvements in condition no matter how small they may seem. Give positive feedback. *Conversation assists you to evaluate the patient's self-concept and adaptive abilities.*

Direct the patient's focus beyond the present state. *As long as a patient focuses only on the present state, patient will have difficulty planning activities that will move patient forward.*

Manage: Help patient involve the family, community, clergy, and friends with changes to the care plan, *to increase the potential of the patient's control over self-care outcomes.*

Refer patient and family to other professional caregivers, for example, dietitian, social worker, clergy, and mental health professional. *Support groups such as Ostomy clubs, I Can Cope, and Reach for Recovery can provide physical, material, financial, and emotional resources to patient and the family during the recovery period.*

Assist patient to utilize appropriate resources by contacting family and scheduling follow-up appointments. *This helps give the patient a sense of direction and control over future care.*

SUGGESTED NIC INTERVENTIONS

Assertiveness Training; Coping Enhancement; Self-Modification Assistance; Self-Responsibility Facilitation; Referral

REFERENCES

Garofalo, C., Holden, C. J., Zeigler-Hill, V., & Velotti, P. (2016). Understanding the connection between self-esteem and aggression: The mediating role of emotion dysregulation. *Aggressive Behavior*, *42*(1), 3–15. doi:10.1002/ab.21601

La Mela, C., Maglietta, M., Caini, S., Casu, G. P., Lucarelli, S., Mori, S., & Ruggiero, G. M. (2015). Perfectionism, weight and shape concerns, and low self-esteem: Testing a model to predict bulimic symptoms. *Eating Behaviors*, *19,* 155–158. doi:10.1016/j.eatbeh.2015.09.002

Noser, A., & Zeigler-Hill, V. (2014). Investing in the ideal: Does objectified body consciousness mediate the association between appearance contingent self-worth and appearance self-esteem in women? *Body Image*, *11*(2), 119–125. doi:10.1016/j.bodyim.2013.11.006

DEFINITION

Deliberate self-injurious behavior causing tissue damage with the intent of causing nonfatal injury to attain relief of tension

DEFINING CHARACTERISTICS

- Abrading
- Biting
- Constricting a body part
- Cuts on body
- Hitting
- Ingestion of harmful substance
- Inhalation of harmful substance
- Insertion of object into body orifice
- Picking at wound
- Scratches on body
- Self-inflicted burn
- Severing of a body part

RELATED FACTORS

- Absence of family confidant
- Adolescence
- Alteration in body image
- Autism
- Borderline personality disorder
- Character disorder
- Childhood illness
- Childhood surgery
- Depersonalization
- Developmental delay
- Dissociation
- Disturbance in interpersonal relationships
- Eating disorder
- Emotional disorder
- Family divorce
- Family history of self-destructive behavior
- Family substance abuse
- Feeling threatened with loss of significant relationship
- History of childhood abuse (e.g., physical, psychological, sexual)
- History of self-directed violence
- Impaired self-esteem
- Impulsiveness
- Inability to express tension verbally
- Incarceration
- Ineffective communication between parent and adolescent
- Ineffective coping strategies
- Irresistible urge for self-directed violence
- Irresistible urge to cut self
- Isolation from peers
- Labile behavior
- Living in nontraditional setting (e.g., foster, group, or institutional care)
- Low self-esteem
- Mounting tension that is intolerable
- Negative feeling (e.g., depression, rejection, self-hatred, separation anxiety, guilt, depersonalization)
- Pattern of inability to plan solutions
- Pattern of inability to see long-term consequences
- Peers who self-mutilate
- Perfectionism
- Psychotic disorder

- Requires rapid stress reduction
- Sexual identity crisis
- Substance abuse
- Use of manipulation to obtain nurturing relationship with others
- Violence between parental figures

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Communication
- Coping
- Emotional
- Knowledge
- Roles/responsibilities

EXPECTED OUTCOMES

- The patient will refrain from harming self while in the hospital.
- The patient will express an increased sense of security.
- The patient will report being able to cope better with disorganization, aggressive impulses, anxiety, and hallucinations.
- The patient will verbalize absence of or fewer dissociative states.
- The patient will participate in therapeutic milieu.
- The patient will describe community resources that can provide assistance when feeling out of control.

SUGGESTED NOC OUTCOMES

Impulse Self-Control; Risk Control; Self-Mutilation Restraint

INTERVENTIONS AND RATIONALES

Determine: Assess behavioral responses; coping strategies; number and types of stressors; social factors; and spiritual beliefs. *Assessment information will assist in identifying appropriate goal and interventions.*

Perform: Move patient to a quiet room *to reduce stimuli if the patient is in a dissociative state.* Remove all dangerous objects from patient's room *to prevent injury.* Place patient under observation *to provide protection and increase patient's sense of security.*

Administer psychotropic medications, as prescribed, *to reduce tension, impulse behavior, hallucinations, and panic.*

Inform: Teach patient's coping strategies to family members. *Family members and friends can help patient practice adaptive methods of coping with self-destructive feelings.*

Have patient and family members practice role-playing *to increase the confidence in the patient's ability to handle difficult situations.*

Teach self-healing techniques to both patient and family, such as meditation, guided imagery, yoga, and prayer. Teach patient how to incorporate the use of self-healing techniques in carrying out usual daily activities. *These techniques can reduce the anxiety that comes from attempting to cope with patient's disease.*

Teach additional skills that enhance coping and relaxation strategies for the patient and family (i.e., meditation, guided imagery, yoga, exercise). *Self-healing gives the patient a better sense of control over regaining independence.*

Attend: Limit the number of staff members who interact with patient, *to provide continuity of care and enhance a sense of security.*

If patient is participating in a therapeutic milieu, discuss patient's risk of self-harm with community members, *to provide patient with enhanced protection and psychological support.*

If patient causes harm to self, provide care in a calm, nonjudgmental manner. *Encourage discussion of feelings that caused self-mutilation to help patient connect self-destructive behavior to feelings that preceded it, and provide an opportunity to explore alternative ways of dealing with negative feelings.*

Accept patient's feelings of powerlessness as normal. *This indicates respect for the patient and enhances feelings of self-respect.*

Encourage patient to take an active role in self-care *to promote a sense of control.*

Manage: Organize frequent staff meetings *to ensure patient care is consistent with current behavior.*

Organize family conferences to allow opportunities for the family to discuss their particular frustrations and hopes in relation to the patient's current situation. *Family conferences can help the patient and family members ventilate true feelings in a safe environment.*

SUGGESTED NIC INTERVENTIONS

Area Restriction; Self-Harm; Environmental Management; Impulse Control; Coping Behaviors; Guided Imagery; Meditation Facilitation

REFERENCES

Klonsky, E. D., Victor, S. E., & Saffer, B. Y. (2014). Nonsuicidal self-injury: What we know, and what we need to know. *Canadian Journal of Psychiatry*, *59*(11), 565–568.

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DEFINITION

Vulnerable to deliberate self-injurious behavior causing tissue damage with the intent of causing nonfatal injury to attain relief of tension

RISK FACTORS

- Adolescence
- Alteration in body image
- Autism
- Battered child
- Borderline personality disorder
- Character disorder
- Childhood illness
- Childhood surgery
- Depersonalization
- Developmental delay
- Dissociation
- Disturbance in interpersonal relationships
- Eating disorder
- Emotional disorder
- Family divorce
- Family history of self-destructive behavior
- Family substance abuse
- Feeling threatened with loss of significant relationship
- History of childhood abuse (e.g., physical, psychological, sexual)
- History of self-directed violence
- Impaired self-esteem
- Impulsiveness
- Inability to express tension verbally
- Incarceration
- Ineffective coping strategies
- Irresistible urge for self-directed violence
- Isolation from peers
- Living in nontraditional setting (e.g., foster group, or institutional care)
- Loss of control over problem-solving situation
- Loss of significant relationship(s)
- Low self-esteem
- Mounting tension that is intolerable
- Negative feelings (e.g., depression, rejection, self-hatred, separation anxiety, guilt, depersonalization)
- Pattern of inability to plan solutions
- Pattern of inability to see long-term consequences
- Peers who self-mutilate
- Perfectionism

- Psychotic disorder
- Requires rapid stress reduction
- Sexual identity crisis
- Substance abuse
- Use of manipulation to obtain nurturing relationship with others
- Violence between parental figures

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Emotional
- Self-perception
- Values/beliefs

EXPECTED OUTCOMES

- The patient will refrain from harming self.
- The patient will express increased feelings of security.
- The patient will report improved ability to cope with self-destructive feelings.
- The patient will experience no episodes of dissociation.
- The patient will participate in therapeutic milieu.
- The patient will report suicidal ideations to staff.

SUGGESTED NOC OUTCOMES

Abuse Recovery Status; Anxiety Level; Impulse Self-Control; Risk Control; Self-Mutilation Restraint

INTERVENTIONS AND RATIONALES

Determine: Assess high-risk behaviors; health-promoting activities; coping skills; activities of daily living, including rest and sleep; sensory perception; decision-making skills; and sexuality patterns. *Information from the assessment will help establish outcomes to be developed.*

Perform: Administer psychotropic medications, as prescribed, *to reduce tension, impulsive behavior, hallucinations, and panic.*

Remove all dangerous objects from the environment *to enhance security.*

Move patient to a quiet room *to reduce stimuli if the patient is in a dissociative state.*

Place patient under observation *to provide protection and increase patient's sense of security.*

Inform: Teach patient about risk factors and other aspects of patient's medical condition *to help patient feel in control of patient's care.*

Teach patient's coping strategies to family members *so they can help patient practice adaptive methods of coping with self-destructive feelings.*

Have patient and family members practice role-playing *to increase the confidence in the patient's ability to handle difficult situations.*

Teach self-healing techniques to both the patient and family such as meditation, guided imagery, yoga, and prayer. *These techniques can reduce the anxiety that comes from attempting to cope with patient's disease.*

Attend: Make short-term verbal contracts with patient in which the patient states he or she will not harm himself or herself. *This makes patient aware that he or she is ultimately responsible for his or her own safety and he or she can guarantee it.*

Ask patient directly whether the patient is thinking about suicide and if so, what plan the patient has. *A self-destructive patient may become suicidal and may require additional precautions.*

If patient harms self, care for the patient in a calm, nonjudgmental manner. Encourage patient to talk about feelings that prompted the self-mutilation. *Discussion of the event may help the patient connect self-destructive behavior to feelings that preceded it. Discussion may also provide patient with an opportunity to explore alternative ways of dealing with negative thoughts and feelings.*

Manage: Organize frequent staff meetings to ensure consistency in managing the patient's care that is consistent with patient's current behavior.

Organize family conferences to allow opportunities for the family to discuss their particular frustrations and hopes in relation to the patient's current situation. *Family conferences can help the patient and family members ventilate true feelings in a safe environment.*

SUGGESTED NIC INTERVENTIONS

Area Restriction; Behavior Management: Self-Harm; Environmental Management: Violence Prevention; Impulse Control Training; Coping Enhancement

REFERENCES

Klonsky, E. D., Victor, S. E., & Saffer, B. Y. (2014). Nonsuicidal self-injury: What we know, and what we need to know. *Canadian Journal of Psychiatry*, *59*(11), 565–568.

Larkin, C., Corcoran, P., Perry, I., & Arensman, E. (2014). Severity of hospital-treated self-cutting and risk of future self-harm: A national registry study. *Journal of Mental Health*, *23*(3), 115–119. doi:10.3109/09638237.2013.841867

Morales, Y. M., & Guarnero, P. A. (2014). Non-suicidal self-injury among adult males in a correctional setting. *Issues in Mental Health Nursing*, *35*(8), 628–634. doi:10.3109/01612840.2014.927943

DEFINITION

A constellation of culturally framed behaviors involving one or more self-care activities in which there is a failure to maintain a socially accepted standard of health and well-being (Gibbons, Lauder, & Ludwick, 2006 as cited in Herdman & Kamitsuru, 2014)

DEFINING CHARACTERISTICS

- Insufficient environmental hygiene
- Insufficient personal hygiene
- Nonadherence to health activity

RELATED FACTORS

- Alteration in cognitive functioning
- Capgras syndrome
- Deficient executive function
- Fear of institutionalization
- Frontal lobe dysfunction
- Functional impairment
- Inability to maintain control
- Learning disability
- Lifestyle choice
- Malingering
- Psychiatric disorder
- Psychotic disorder
- Stressors
- Substance abuse

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Self-care
- Neurocognition
- Behavior

EXPECTED OUTCOMES

- The patient will demonstrate improved cognitive, functional, and mental health status.
- The patient will adhere to prescribed health activities.
- The patient will experience increased safety.
- The patient will demonstrate improved coping with complex health circumstances including personal and environmental hygiene, nutrition, and fitness.
- The patient will have fewer acute hospitalizations and emergency room visits.

SUGGESTED NOC OUTCOMES

Adherence Behavior; Compliance Behavior; Coping; Decision-Making; Health Orientation; Motivation; Personal Well-Being; Risk Control; Self-Care Status

INTERVENTIONS AND RATIONALES

Determine: Assess patient with complex health issues for adequate coping abilities, *because poor coping skills may lead to unintentional self-neglect.*

Assess patient with failing self-care for changes in cognitive function, *because neglected self-care may be the first noticeable sign of diminishing cognitive function.*

Perform: Involve patient's family in care activities as appropriate *to improve the chance that the patient will incorporate recommended regimens into lifestyle as long-term choice.*

Inform: Teach strategies to enhance adherence to medication and other health regimens. *Some instances of self-neglect occur because the patient has not been able to incorporate recommended regimens into lifestyle.*

Attend: Encourage patient to identify internally motivating factors for adhering to health regimens. *Persons who intentionally neglect self-care as a lifestyle choice (i.e., fail to comply with medication and treatment regimens) will fare better if the decision to improve self-care is theirs.*

Manage: Refer patient demonstrating a significant decline in self-care abilities (i.e., posing a threat to self and/or community) for competency evaluation, *because unintentional self-neglect may indicate diminished competency.*

SUGGESTED NIC INTERVENTIONS

Behavior Management; Counseling; Exercise Promotion; Limit Setting; Mutual Goal Setting; Self-Care Assistance; Self-Efficacy Enhancement; Self-Responsibility Facilitation

REFERENCES

Braye, S., Orr, D., & Preston-Shoot, M. (2015). Serious case review findings on the challenges of self-neglect: Indicators for good practice. *Journal of Adult Protection*, *17*(2), 75–87. doi:10.1108/JAP-05-2014-0015

Rathbone-McCuan, E. (2014). An improved approach to treating elder self-neglect: The self-care framework. *Generations*, *38*(3), 80–85.

Wilkins, S. S., Horning, S., Castle, S., Leff, A., Hahn, T. J., & Chodosh, J. (2014). Challenges and management of self-neglect in older adults with cognitive impairment. *Annals of Long Term Care*, *22*(12), 30–34.

DEFINITION

A state in which an individual experiences a change in sexual function during the sexual response phases of desire, excitation, and/or orgasm, which is viewed as unsatisfying, unrewarding, or inadequate

DEFINING CHARACTERISTICS

- Alteration in sexual activity
- Alteration in sexual excitation
- Alteration in sexual satisfaction
- Change in interest toward others
- Change in self-interest
- Change in sexual role
- Decrease in sexual desire
- Perceived sexual limitation
- Seeks confirmation of desirability
- Undesired change in sexual function

RELATED FACTORS

- Absence of privacy
- Absence of significant other
- Alteration in body function (due to anomaly, disease, medication, pregnancy, radiation, surgery, trauma, etc.)
- Inadequate role model
- Insufficient knowledge about sexual function
- Misinformation about sexual function
- Presence of abuse (e.g., physical, psychological, sexual)
- Psychosocial abuse (e.g., controlling manipulation, verbal abuse)
- Value conflict
- Vulnerability

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Emotional
- Knowledge
- Pharmacologic function
- Self-perception

EXPECTED OUTCOMES

- The patient will acknowledge problems or potential problems in sexual function.
- The patient will voice feelings about changes in sexual identity.
- The patient will express understanding of reason for sexual dysfunction.
- The patient will express willingness to obtain counseling.
- The patient will reestablish sexual activity at pre-illness level.

SUGGESTED NOC OUTCOMES

Adaptation to Physical Disability; Body Image; Fear Level; Physical Aging; Role Performance; Sexual Functioning; Sexual Identity; Stress Level

INTERVENTIONS AND RATIONALES

Determine: Assess marital status, sexual patterns, living arrangements, usual sexual patterns, attitudes toward modifying sexual patterns, and knowledge about appropriate options available, anxiety, and loss. *In combination with a general assessment, these factors will help establish realistic outcomes for a plan.*

Perform: Arrange for patient and partner to have periods of privacy for sexual expression by closing the door, using a privacy sign, and arranging with the staff to refrain from entering the room for a predetermined period of time. *Hospital routines allow too few opportunities for a patient to have private time. Sexual expression will not occur where privacy does not exist.*

Inform: Teach patient and partner about alternative methods of intimacy and expression of affection. *This can raise patient's self-esteem until impotence is evaluated.*

Teach coping strategies, including stress management and relaxation techniques. *Relaxation and decreased stress can increase function, thereby improving strength and resistance.*

Attend: Encourage patient to ask questions about personal sexuality. *A nonthreatening atmosphere encourages patients to ask questions specifically related to the particular situation.*

Provide support for the partner. Supportive interventions (such as active listening) *communicate concern, interest, and acceptance.*

Suggest patient discuss concerns with partner. *Open discussion fosters sharing of concerns and strengthens relationship.*

Manage: Suggest referral to a sex counselor or other appropriate professional for future guidance, *to provide patient with a resource for postdischarge support.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Emotional Support; Role Enhancement; Sexual Counseling; Coping Enhancement; Environmental Management; Self-Awareness Enhancement; Self-Esteem Enhancement

REFERENCES

Celik, S., Golbası, Z., Kelleci, M., & Satman, I. (2015). Sexual dysfunction and sexual quality of life in women with diabetes: The study based on a diabetic center. *Sexuality & Disability*, *33*(2), 233–241. doi:10.1007/s11195-014-9383-3

Mills, L. (2015). Sexual dysfunction in men with diabetes. *Journal of Diabetes Nursing*, *19*(9), 332–338.

Steinke, E. E., Mosack, V., & Hill, T. J. (2015). Change in sexual activity after a cardiac event: The role of medications, comorbidity, and psychosocial factors. *Applied Nursing Research*, *28*(3), 244–250. doi:10.1016/j.apnr.2015.04.011

DEFINITION

Expressions of concern regarding own sexuality

DEFINING CHARACTERISTICS

- Alteration in relationship with significant other
- Alteration in sexual activity
- Alteration in sexual behavior
- Change in sexual role
- Difficulty with sexual activity
- Difficulty with sexual behavior
- Value conflict

RELATED FACTORS

- Absence of privacy
- Absence of significant other
- Conflict about sexual orientation
- Conflict about variant preference
- Fear of pregnancy
- Fear of sexually transmitted infection
- Impaired relationship with a significant other
- Inadequate role model
- Insufficient knowledge about alternatives related to sexuality
- Skill deficit about alternatives related to sexuality

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Emotional
- Knowledge
- Values/beliefs

EXPECTED OUTCOMES

- The patient will voice feelings about reported changes in sexual activity.
- The patient will express concern about self-concept, self-esteem, and body image.
- The patient will state at least one effect of illness or treatment on sexual behavior.
- The patient and partner will resume effective communication patterns.
- The patient and partner will use available counseling referrals or support.

SUGGESTED NOC OUTCOMES

Anxiety Level; Body Image; Role Performance; Sexual Identity; Stress Level Sexual Functioning

INTERVENTIONS AND RATIONALES

Determine: Assess for current treatment/medication regimen, marital status and family members, perception of sexual identity and role, and perception

of changes in sexual activities resulting from illness or treatment. *Assessment information may help discover reasons for the problem and will assist to identify desirable outcomes and interventions.*

Perform: Arrange to spend time each shift with the patient to develop a trusting relationship. *The patient may need to discuss his or her difficulty but is more inclined to do that with a person he or she trusts.*

Inform: Teach patient relaxation techniques such as guided imagery, deep breathing, meditation, aromatherapy, and progressive muscle relaxation. Practice with the patient at bedtime. *Purposeful relaxation efforts usually help reduce anxiety.*

Educate patient and partner about the illness and treatment. Answer questions that might clarify any misconceptions they may have. *This may help them focus on specific concerns, encourage questions, and avoid misunderstandings.*

Attend: Provide time for privacy *to allow the patient and partner to discuss feelings about sexuality and to engage in alternatives for intimacy while the patient is in the hospital.*

Be available to listen; accept patient's feelings to let the patient know that the feelings are valid and acceptable. *A nonjudgmental approach demonstrates unconditional positive regard for the patient and patient's feelings.*

Manage: Offer referral to counselors or support persons such as mental health professional, sex counselor, and illness-related support group *to provide postdischarge support.*

SUGGESTED NIC INTERVENTIONS

Anticipatory Guidance; Body Image Enhancement; Coping Enhancement; Sexual Counseling; Emotional Support; Self-Awareness Enhancement; Support Group; Guided Imagery; Teaching: Sexuality; Teaching: Disease Process

REFERENCES

Erden, S., & Kaya, H. (2015). Sexual dysfunction and anxiety levels of type 2 male diabetics. *Applied Nursing Research*, *28*(3), 239–243. doi:10.1016/j.apnr.2015.04.014

Perz, J., Ussher, J. M., & Gilbert, E. (2014). Feeling well and talking about sex: Psycho-social predictors of sexual functioning after cancer. *BMC Cancer*, *14*(1), 228–228. doi:10.1186/1471-2407-14-228

Villaamil, F. (2014). Shared embarrassment: (Not) Talking about sex in HIV-related doctor-patient encounters. *Medical Anthropology*, *33*(4), 335–350. doi:10.1080/01459740.2013.826215

DEFINITION

Vulnerable to an inadequate blood flow to the body's tissues that may lead to life-threatening cellular dysfunction, which may compromise health

RISK FACTORS

- Hypotension
- Hypovolemia
- Hypoxemia
- Hypoxia
- Infection
- Sepsis
- Systemic inflammatory response syndrome (SIRS)

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Physical regulation

EXPECTED OUTCOMES

- The patient will maintain adequate blood pressure to provide tissue perfusion.
- The patient will not experience hemodynamic complications from underlying medical condition.
- The patient will understand the need for aggressive management of underlying medical condition in an effort to prevent shock.
- The patient will verbalize reportable signs and symptoms of possible hypotension and hypoperfusion.

SUGGESTED NOC OUTCOMES

Tissue Perfusion: Cerebral; Hydration; Fluid Balance; Vital Signs; Circulation Status; Electrolyte & Acid/Base Balance

INTERVENTIONS AND RATIONALES

Determine: Monitor hemodynamic status frequently, including blood pressure, heart rate, and oxygen saturation. *Trending of vital signs will provide database for early intervention and treatment.*

Assess level of consciousness (LOC) with each vital sign check. *Change in LOC is an early indicator of cerebral hypoperfusion.*

Perform: Administer intravenous fluids, oxygen, and medications, as prescribed, *to maintain fluid volume and organ perfusion.*

Collect and evaluate serum laboratory specimens *to provide data to effectively treat underlying medical condition and avoid complication of shock.*

Inform: Educate patient and family of reportable signs and symptoms of inadequate perfusion, for example, dizziness, confusion, restlessness, and dyspnea. *Early intervention and treatment is essential in preventing permanent organ damage.*

Attend: Encourage patient and family to express concerns and fears *to reduce anxiety*.
Manage: Collaborate with other members of the health care team *to effectively manage underlying medical condition and prevent complications.*

SUGGESTED NIC INTERVENTIONS

Acid–Base Management; Acid–Base Monitoring; Fluid/Electrolyte Management; Hypovolemia Management; Shock Management; Laboratory Data Interpretation

REFERENCES

Gallimore, E. (2015). Clinical features and management of hemorrhagic shock. *Nursing Standard*, *30*(1), 51–58. doi:10.7748/ns.30.1.51.e9955

Hsiao, C. Y., Yang, H. Y., Chang, C. H., Lin, H. L., Wu, C. Y., Hsiao, M. C., . . . Yen, T. H. (2015). Risk factors for development of septic shock in patients with urinary tract infection. *BioMed Research International*, *2015,* 1–7. doi:10.1155/2015/717094

Soleimanpour, H., Safari, S., Rahmani, F., Nejabatian, A., & Alavian, S. M. (2015). Hepatic shock differential diagnosis and risk factors: A review article. *Hepatitis Monthly*, *15*(10), 9–14. doi:10.5812/hepatmon.27063

DEFINITION

Limitation of ability to independently and purposefully attain and/or maintain a rest position that is supported by the buttocks and thighs, in which the torso is upright

DEFINING CHARACTERISTICS

- Impaired ability to adjust position of one or both lower limbs on uneven surface
- Impaired ability to attain a balanced position of the torso
- Impaired ability to flex or move both hips
- Impaired ability to flex or move both knees
- Impaired ability to maintain the torso in balanced position
- Impaired ability to stress torso with body weight
- Insufficient muscle strength

RELATED FACTORS

- Alteration in cognitive functioning
- Impaired metabolic functioning
- Insufficient endurance
- Insufficient energy
- Malnutrition
- Neurologic disorder
- Orthopedic surgery
- Pain
- Prescribed posture
- Psychological disorder
- Sarcopenia
- Self-imposed relief posture

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Comfort
- Knowledge
- Sensation/perception

EXPECTED OUTCOMES

- The patient will achieve highest level of independence possible when sitting.
- The patient will achieve highest level of joint ROM when sitting.
- The patient will show no evidence of complications.
- The patient will achieve balance while sitting.
- The patient will maintain muscle strength.

SUGGESTED NOC OUTCOMES

Activity Tolerance; Endurance; Joint Movement: Hip; Joint Movement: Spine; Neurological Status: Central Motor Control; Neurological Status: Spinal Sensory/Motor Function; Physical Fitness; Skeletal Function

INTERVENTIONS AND RATIONALES

Determine: Identify level of functioning using a functional mobility scale. Communicate patient's skill level to all staff members *to provide continuity and preserve identified level of independence.*

Monitor and record daily any evidence of immobility complications, *as they may be more prone to develop complications.*

Perform: Perform ROM exercises to joints, unless contraindicated, at least once every shift *to prevent joint contractures and muscular atrophy.*

Place items within reach of the unaffected side if patient has one-sided weakness or paralysis, *to promote patient's independence.*

Carry out medical regimen to manage or prevent complications (e.g., administer prophylactic heparin for venous thrombosis). *This promotes patient's health and well-being.*

Provide progressive mobilization to the limits of patient's condition (bed mobility to chair mobility to ambulation) *to maintain muscle tone and prevent complications of immobility.*

Use a transfer belt, if necessary, *to support patient and prevent staff injury.*

Inform: Instruct patient and family members on ROM exercises, transfers, skin inspection, and mobility regimen *to help prepare for discharge and promote continuity of care.* Request return demonstration *to ensure use of proper technique.*

Instruct patient to call before attempting to stand without assistance. *Ensure patient safety from falls.*

Attend: Encourage independence by helping patient to use assistive devices. *This increases muscle tone and patient's self-esteem.*

Manage: Refer patient to a physical therapist for development of sitting regimen *to help rehabilitate musculoskeletal deficits.*

SUGGESTED NIC INTERVENTIONS

Body Mechanics Promotion; Exercise Therapy: Balance; Exercise Therapy: Muscle Control; Positioning; Self-Care Assistance

REFERENCES

Cabanas-Valdés, R., Cuchi, G. U., & Bagur-Calafat, C. (2013). Trunk training exercises approaches for improving trunk performance and functional sitting balance in patients with stroke: A systematic review. *Neurorehabilitation*, *33*(4), 575–592. doi:10.3233/NRE-130996

Iyengar, Y., Vijayakumar, K., Abraham, J., Misri, Z., Suresh, B., & Unnikrishnan, B. (2014). Relationship between postural alignment in sitting by photogrammetry and seated postural control in post-stroke subjects. *Neurorehabilitation*, *35*(2), 181–190. doi:10.3233/NRE-141118

Tsang, W. W., Gao, K. L., Chan, K. M., Purves, S., Macfarlane, D. J., & Fong, S. S. (2015). Sitting Tai Chi improves the balance control and muscle strength of community-dwelling persons with spinal cord injuries: A pilot study. *Evidence-based Complementary & Alternative Medicine (eCAM)*, *2015*, 1–9. doi:10.1155/2015/523852

DEFINITION

Altered epidermis and/or dermis

DEFINING CHARACTERISTICS

- Alteration in skin integrity
- Foreign matter piercing skin

RELATED FACTORS

- *External:* Chemical injury agent (e.g., burn, capsaicin, methylene chloride, mustard agent), extremes of age, humidity, hyperthermia, hypothermia, mechanical factor (e.g., shearing forces, pressure, physical immobility), moisture, pharmaceutical agent, radiation therapy
- *Internal:* Alteration in fluid volume, alteration in metabolism, alteration in pigmentation, alteration in sensation (resulting from spinal cord injury, diabetes mellitus, etc.), alteration in skin turgor, hormonal change, immunodeficiency, impaired circulation, inadequate nutrition, pressure over bony prominence

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Knowledge
- Nutrition
- Tissue integrity

EXPECTED OUTCOMES

- The patient will show no evidence of skin breakdown.
- The patient will show normal skin turgor.
- The patient will regain skin integrity (specify); for example, pressure ulcer will decrease in size.
- The patient will have a healed surgical wound.
- The patient will communicate understanding of skin protection measures.
- The patient will demonstrate skill in care of wound, burn, or incision.
- The patient will demonstrate skin inspection technique.
- The patient will perform skin care routine.
- The patient will communicate feelings about change in body image.

SUGGESTED NOC OUTCOMES

Immobility Consequences: Physiological; Tissue Integrity: Skin & Mucous Membranes; Tissue Perfusion: Peripheral; Wound Healing: Primary Intention; Wound Healing: Secondary Intention; Body Image

INTERVENTIONS AND RATIONALES

Determine: Inspect skin every shift. Describe and document skin condition, and report changes. *These measures provide evidence of the effectiveness of the skin care regimen.*

Monitor frequency of turning and skin condition *to reduce pressure, promote circulation, and minimize skin breakdown.*

Perform: Perform prescribed treatment regimen for the skin condition involved and monitor progress. Report responses to the treatment regimen *to maintain or modify current therapy.*

Provide supportive measures, as indicated:

- Assist with general hygiene and comfort measures *to promote comfort and sense of well-being.*
- Administer pain medication and monitor its effectiveness. *Patient needs pain relief to maintain health.*
- Maintain proper environmental conditions *to promote patient's sense of well-being.*
- Use a foam mattress, bed cradle, or other devices *to minimize skin breakdown.*
- Warn against tampering with the wound or dressings *to reduce potential for infection.*
- Maintain infection control standards *to reduce the risk of spreading disease.*

Position patient for comfort and minimal pressure on bony prominences. Change patient's position at least every 2 hours. *These measures reduce pressure, promote circulation, and minimize skin breakdown.*

Inform: Explain the therapy to patient and family members *to encourage compliance.*

Instruct patient and family members in a skin care regimen *to encourage compliance.* Supervise patient and family members in skin care management. Provide feedback *to improve skill in managing skin care.*

Attend: Allow patient to express feelings about skin problem. *Verbalization of feelings helps allay anxiety and develops coping skills.*

Manage: Provide a referral to a psychiatric liaison nurse, social service, or support group, as appropriate, *to provide additional support for patient and family.*

SUGGESTED NIC INTERVENTIONS

Fluid Management; Infection Protection; Positioning; Pressure Management; Pressure Ulcer Care; Pressure Ulcer Prevention; Skin Surveillance; Wound Care; Body Image Enhancement

REFERENCES

Coyer, F., Gardner, A., Doubrovsky, A., Cole, R., Ryan, F. M., Allen, C., & McNamara, G. (2015). Reducing pressure injuries in critically ill patients by using a patient skin integrity care bundle (INSPIRE). *American Journal of Critical Care*, *24*(3), 199–210. doi:10.4037/ajcc2015930

Flanagan, M. (2013). Wound healing and skin integrity: Principles and practice. *Wound Practice & Research*, *23*(1), 46–47.

Moncrieff, G., Van Onselen, J., & Young, T. (2015). The role of emollients in maintaining skin integrity. *Wounds UK*, *11*(1), 68–74.

482 RISK FOR IMPAIRED SKIN INTEGRITY

DEFINITION

Vulnerable to alteration in epidermis and/or dermis, which may compromise health

RISK FACTORS

- *External:* Chemical injury agent (e.g., burn, capsaicin, methylene chloride, mustard agent), excretions, extremes of age, humidity, hyperthermia, hypothermia, mechanical factor (e.g., shearing forces, pressure, physical immobility), moisture, radiation therapy, secretions
- *Internal:* Alteration in metabolism, alteration in pigmentation, alteration in sensation (resulting from spinal cord injury; diabetes mellitus, etc.), alteration in skin turgor, hormonal change, immunodeficiency, impaired circulation, inadequate nutrition, pharmaceutical agent, pressure over bony prominence, psychogenetic factor

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Knowledge
- Nutrition
- Tissue integrity

EXPECTED OUTCOMES

- The patient will experience no skin breakdown.
- The patient will maintain muscle strength and joint range of motion (ROM).
- The patient will sustain adequate food and fluid intake.
- The patient will have intact mucous membranes.
- The patient will maintain adequate skin circulation.
- The patient will communicate understanding of preventive skin care measures.
- The patient will demonstrate preventive skin care measures.
- The patient will correlate risk factors and preventive measures.

SUGGESTED NOC OUTCOMES

Immobility Consequences: Physiological; Nutritional Status; Physical Aging; Risk Control; Risk Detection; Tissue Integrity: Skin & Mucous Membranes; Joint Movement

INTERVENTIONS AND RATIONALES

Determine: Inspect skin every shift. Describe and document skin condition and report changes. *These measures provide evidence of the effectiveness of the skin care regimen.*

Monitor nutritional intake and maintain adequate hydration. *Anemia* (<10 mg hemoglobin) *and low serum albumin concentrations* (<2 mg)

are associated with the development of pressure ulcers. Hydration helps maintain skin integrity.

Perform: Change patient's position at least every 2 hours following turning schedule posted at bedside. Monitor frequency of turning. *These measures reduce pressure on tissues, promote circulation, and help prevent skin breakdown.*

Use preventive skin care devices, as needed, such as a foam mattress, alternating pressure mattress, sheepskin, pillows, and padding, *to avoid discomfort and skin breakdown.*

Keep patient's skin clean and dry and lubricate, as needed. Avoid the use of irritating soap, and rinse skin well. *These measures alleviate skin dryness, promote comfort, and reduce the risk of irritation and skin breakdown.*

Protect bony prominences with foam padding. *Prominences have little subcutaneous fat and are prone to breakdown; using foam padding may help promote skin integrity.*

Lift patient's body when moving the patient, using a lifting sheet, if needed. Avoid shearing force. *Shearing force results when tissues slide against each other; a lifting sheet reduces sliding.*

Keep linen dry, clean, and free from wrinkles or crumbs. Change wet bed linens and incontinence pads immediately. *Dry, smooth linens help prevent excoriation and skin breakdown.*

Inform: Educate patient and family on preventive skin care ways to maintain good personal hygiene, including using nonirritating (nonalkaline) soap; patting rather than rubbing skin dry; inspecting skin regularly; avoiding prolonged exposure to water, sun, cold, and wind; avoiding rubber rings; recognizing the beginning of skin breakdown (redness, blisters, and discoloration); and reporting signs and symptoms. *These measures explain the importance of practicing preventive skin care measures to encourage compliance with skin care regimen.*

Supervise patient and family in preventive skin care measures, and provide constructive feedback. Practice helps improve skill in managing the skin care regimen and encourages compliance.

Attend: Encourage ambulation or perform or assist with active ROM exercises at least every 4 hours while patient is awake. *Exercises prevent muscle atrophy and contracture. Ambulation promotes circulation and relieves pressure.*

Manage: Indicate the risk factor potential on patient's chart and care plan and reevaluate weekly, using an accepted form such as the Braden Scale. *The risk factor score helps evaluate treatment progress.*

SUGGESTED NIC INTERVENTIONS

Circulatory Precautions; Infection Prevention; Positioning; Pressure Management; Pressure Ulcer Prevention; Skin Surveillance; Splinting

REFERENCES

Cowdell, F., & Garrett, D. (2014). Older people and skin: Challenging perceptions. *British Journal of Nursing*, *23,* S4–S8.

Cowdell, F., & Radley, K. (2014). What do we know about skin-hygiene care for patients with bariatric needs? Implications for nursing practice. *Journal of Advanced Nursing*, *70*(3), 543–552. doi:10.1111/jan.12208

Yamaguti, W. P., Moderno, E. V., Yamashita, S. Y., Gomes, T. C., Maida, A. V., Kondo, C. S., . . . de Brito, C. M. (2014). Treatment-related risk factors for development of skin breakdown in subjects with acute respiratory failure undergoing noninvasive ventilation or CPAP. *Respiratory Care*, *59*(10), 1530–1536. doi:10.4187/respcare.02942

DEFINITION

Prolonged periods of time without sleep (sustained natural, periodic suspension of relative consciousness)

DEFINING CHARACTERISTICS

- Agitation
- Alteration in concentration
- Anxiety
- Apathy
- Combativeness
- Confusion
- Decrease in functional ability
- Decrease in reaction time
- Drowsiness
- Fatigue
- Fleeting nystagmus
- Hallucinations
- Hand tremors
- Heightened sensitivity to pain
- Irritability
- Lethargy
- Listlessness
- Malaise
- Perceptual disorders
- Restlessness
- Transient paranoia

RELATED FACTORS

- Age-related sleep stage shifts
- Average daily physical activity is less than recommended for gender and age
- Conditions with periodic limb movement (e.g., restless leg syndrome, nocturnal myoclonus)
- Dementia
- Environmental barrier
- Familial sleep paralysis
- Idiopathic central nervous system hypersomnolence
- Narcolepsy
- Nightmares
- Nonrestorative sleep pattern (i.e., due to caregiver responsibilities, parenting practices, sleep partner)
- Overstimulating environment
- Prolonged discomfort (e.g., physical, psychological)
- Sleep apnea
- Sleep terror

- Sleep walking
- Sleep-related enuresis
- Sleep-related painful erections
- Sundowner's syndrome
- Sustained circadian asynchrony
- Sustained inadequate sleep hygiene
- Treatment regimen

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Comfort
- Coping
- Emotional
- Knowledge
- Pharmacologic function
- Sleep/rest

EXPECTED OUTCOMES

- The patient will identify factors that prevent or disrupt sleep.
- The patient will achieve uninterrupted sleep for ____ hour(s).
- The patient will express feelings of being well rested.
- The patient will show no signs of physical sleep deprivation.
- The patient will alter diet and habits to promote sleep.
- The patient will not exhibit sleep-related behavioral symptoms, such as irritability, lethargy, listlessness, restlessness, anxiety, worry, or depression.
- The patient will perform relaxation exercises at bedtime.

SUGGESTED NOC OUTCOMES

Concentration; Endurance; Energy Conservation; Mood Equilibrium; Rest; Sleep; Stress Level; Symptom Severity

INTERVENTIONS AND RATIONALES

Determine: Assess usual sleep patterns, daytime activity and work patterns, recent life changes, sleep environment, activities that promote sleep, and dietary and drug history. *Information gained during the assessment will assist in identifying outcomes and interventions.*

Perform: Offer interventions to promote sleep, such as a warm bath, back rub, comfortable positioning, additional pillows, and food or drink. *Personal hygiene routine precedes sleep for many individuals. Milk and some high-protein snacks like cheese or nuts contain L-tryptophan and are sleep promoters.*

Inform: Teach patient relaxation techniques such as guided imagery, meditation, and progressive muscle relaxation. Practice them with patient at bedtime. *Purposeful relaxation efforts commonly promote sleep.*

Instruct patient to limit alcohol and caffeine intake. Avoid foods and beverages with caffeine 4 to 5 hours before bedtime. *Dietary changes may help promote restful sleep.*

Advise patient to avoid daytime naps, *to promote restful nocturnal sleep.*

Attend: Encourage patient to discuss factors in the environment that make sleeping difficult. *A strange or new environment may affect rapid eye movement and non–rapid eye movement sleep.*

Ask patient what changes would help promote sleep (such as reducing noise, changing medication or treatment schedule, or changing lighting), *to encourage patient to play an active role in care.* Make immediate changes to accommodate patient.

Avoid quick, unanticipated movements when turning and positioning patients with neuromuscular dysfunction, *to prevent spasticity, which may interrupt sleep.*

Manage: Suggest a referral to sleep disorder center especially if daily activities are affected or sleep apnea occurs. *A specialist may be required to assist in treatment.*

Help patients with chronic illnesses or disabilities find resources for addressing psychosocial issues. *Fears and concerns about future prevent restful sleep.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Energy Management; Comfort; Progressive Muscle Relaxation; Sleep Enhancement; Guided Imagery; Meditation Facilitation; Relaxation Therapy

REFERENCES

Das, S., Deepa, O. V., Pradhan, J., & Kumari, S. (2015). Factors of sleep disturbances among hospitalized patients, jeopardizing the prognosis. *Asian Journal of Nursing Education & Research*, *5*(2), 302–304.

Kohansieh, M., & Makaryus, A. N. (2015). Sleep deficiency and deprivation leading to cardiovascular disease. *International Journal of Hypertension*, *2015,* 1–5. doi:10.1155/2015/615681

Podgorski, T., & Wise, C. (2015). EB146 Sleep deprivation in the intensive care unit: Promoting sleep in the patients who need it most. *Critical Care Nurse*, *35*(2), e73–e74.

DEFINITION

Time-limited interruptions of sleep amount and quality due to external factors

DEFINING CHARACTERISTICS

- Alteration in sleep pattern
- Difficulty in daily functioning
- Difficulty initiating sleep
- Dissatisfaction with sleep
- Feeling unrested
- Unintentional awakening

RELATED FACTORS

- Disruption caused by sleep partner
- Environmental barrier (e.g., ambient noise, daylight/darkness exposure, ambient temperature/humidity, unfamiliar setting)
- Immobilization
- Insufficient privacy
- Nonrestorative sleep pattern (i.e., due to caregiver responsibilities, parenting practices, sleep partner)

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Comfort
- Coping
- Emotional
- Knowledge
- Pharmacologic function
- Sleep/rest

EXPECTED OUTCOMES

- The patient will identify factors that changed usual sleep pattern.
- The patient will achieve uninterrupted sleep for ____ hour(s).
- The patient will express feelings of being well rested.
- The patient will alter diet and habits to promote sleep.
- The patient will incorporate sleep preparation measures into evening routine.
- The patient will perform relaxation exercise.

SUGGESTED NOC OUTCOMES

Rest; Sleep; Well-Being; Symptom Control

INTERVENTIONS AND RATIONALES

Determine: Complete a sleep history and help patient identify factors that may impair sleep. *Review of patterns may elicit insights that can be used to correct the problem.*

Assist patient to identify environmental factors that make sleeping difficult. Suggest the use of "white noise" machines to mask unwanted

noise. *A strange or new environment may affect rapid eye movement and non–rapid eye movement sleep.*

Ask patient what changes would help promote sleep *to encourage patient to play an active role in care.*

Ask patient to evaluate the quality of sleep the night before, *to help detect sleep-related behavioral symptoms.*

Assess the daytime schedule to ensure adequate time for rest. *Excessive fatigue can result in insomnia.*

Perform: Offer interventions to promote sleep, such as a warm bath, back rub, comfortable positioning, additional pillows, and food or drink. *Personal hygiene routine precedes sleep for many individuals. Milk and some high-protein snacks, such as cheese or nuts, contain L-tryptophan and are sleep promoters.*

Inform: Teach patient relaxation techniques such as guided imagery, meditation, and progressive muscle relaxation. *Purposeful relaxation efforts commonly promote sleep.*

Instruct patient to limit alcohol and caffeine intake. Avoid foods and beverages with caffeine 4 to 5 hours before bedtime. *Dietary changes may help promote restful sleep.*

Advise patient to avoid daytime naps *to promote restful nocturnal sleep.*

Attend: Encourage regular evening routines that promote sleep, such as taking a warm bath or eating a small snack. *Personal hygiene routine precedes sleep for many individuals. Milk and some high-protein snacks, such as cheese or nuts, contain L-tryptophan, a sleep promoter.*

Manage: Refer patient experiencing extended sleep changes to a sleep disorder center especially if activities of daily living are affected or sleep apnea occurs. *A specialist may be required to assist in treatment.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Simple Guided Imagery; Energy Management; Environmental Management: Comfort; Progressive Muscle Relaxation; Sleep Enhancement; Anticipatory Guidance; Calming Technique; Simple Relaxation Therapy

REFERENCES

Bakken, L. N., Kim, H. S., Finset, A., & Lerdal, A. (2014). Subjective sleep quality in relation to objective sleep estimates: Comparison, gender differences and changes between the acute phase and the six-month follow-up after stroke. *Journal of Advanced Nursing*, *70*(3), 639–650. doi:10.1111/jan.12228

Hsiao-Yean, C., Wen-Cheng, L., Yung-Hsiao, C., & Pei-Shan, T. (2014). The effects of sleep on the relationship between brain injury severity and recovery of cognitive function: A prospective study. *International Journal of Nursing Studies*, *51*(6), 892–899. doi:10.1016/j.ijnurstu.2013.10.020

Miller, N. (2015). Sleep deprivation and delirium risk in hospitalized patients. *Nursing Made Incredibly Easy*, *13*(1), 22–28. doi:10.1097/01.NME.0000457284.31841.36

490 IMPAIRED SOCIAL INTERACTION

DEFINITION

Insufficient or excessive quantity or ineffective quality of social exchange

DEFINING CHARACTERISTICS

- Discomfort in social situations
- Dissatisfaction with social engagement (e.g., belonging, caring, interest, shared history)
- Dysfunctional interaction with others
- Family reports change in interaction (e.g., style, pattern,)
- Impaired social functioning

RELATED FACTORS

- Absence of significant others
- Communication barrier
- Disturbance in self-concept
- Disturbance in thought processes
- Environmental barrier
- Impaired mobility
- Insufficient knowledge about how to enhance mutuality
- Insufficient skills to enhance mutuality
- Sociocultural dissonance
- Therapeutic isolation

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication
- Coping
- Knowledge
- Self-perception

EXPECTED OUTCOMES

- The patient will provide information concerning cultural background.
- The patient will identify needs and communicate (verbally or through behavior) whether needs are met.
- The patient will express understanding of care-related instructions.
- The patient will participate in planning care.
- The patient will identify effective coping techniques to deal with sociocultural differences.
- The patient will express feelings of comfort and trust in interacting with caregivers.
- The patient will use resources outside normal sociocultural group, as necessary.

SUGGESTED NOC OUTCOMES

Communication; Social Interaction Skills; Social Involvement; Stress Levels; Client Satisfaction: Cultural Needs Fulfillment

INTERVENTIONS AND RATIONALES

Determine: Assess sociocultural background; usual pattern of social interaction; dominant language; position in family; support systems, including clergy, family members, and friends; and education and level of intelligence. *Assessment information* will help identify appropriate outcomes and interventions.

Perform: Assist patient with self-care activities of bathing, grooming, eating, and toileting. Encourage patient to do as much as possible *to reduce feelings of helplessness and to build a sense of control over current situation.*

Explain care-related activities clearly and answer questions as accurately as possible *to enhance the patient's understanding of procedures and facility routines.*

Inform: Teach patient to use effective social interaction behaviors, such as increased eye contact, calling people by name, and asking questions. *Teaching patient effective communication skills helps the patient function more effectively in a social environment.*

Attend: Provide a specific time to talk to the patient and family about their sociocultural background. *In many cultural groups, trust develops slowly and may be hampered by lengthy interviews.*

Involve patient and family members in planning care and in encouraging patient's participation in self-care *to increase their sense of control over the present situation.*

Demonstrate respect for the patient's privacy, personal belongings, cultural norms, and religious beliefs and practices to demonstrate sensitivity to patients from varied cultural backgrounds.

Manage: Use an interpreter, when necessary, to ensure effective communication with non-English-speaking patients. *The primary reasons to use an interpreter to communicate with a patient are legal and financial and to provide quality care.*

Involve family, friends, and clergy *to provide appropriate spiritual support.*

SUGGESTED NIC INTERVENTIONS

Behavior Modification: Social Skills; Active Listening; Anxiety Reduction; Coping Enhancement; Family Support; Normalization Promotion Spiritual Support; Family Integrity Promotion; Cultural Brokerage

REFERENCES

Beattie, L., Kyle, S. D., Espie, C. A., & Biello, S. M. (2015). Social interactions, emotion and sleep: A systematic review and research agenda. (2015). *Sleep Medicine Reviews*, *24,* 83–100. doi:10.1016/j.smrv.2014.12.005

Pelzer, B., Schaffrath, S., & Vernaleken, I. (2014). Coping with unemployment: The impact of unemployment on mental health, personality, and social interaction skills. *Work*, *48*(2), 289–295. doi:10.3233/WOR-131626

Yoon, J. A., Park, S. G., & Roh, H. L. (2015). Comparisons of social interaction and activities of daily living between long-term care facility and community-dwelling stroke patients. *Journal of Physical Therapy Science*, *27*(10), 3127–3131.

DEFINITION

Aloneness experienced by the individual and perceived as imposed by others and as a negative or threatening state

DEFINING CHARACTERISTICS

- Absence of support system
- Aloneness imposed by others
- Cultural incongruence
- Desire to be alone
- Developmental delay
- Developmentally inappropriate interest
- Disabling condition
- Feeling different from others
- Flat affect
- History of rejection
- Hostility
- Illness
- Inability to meet expectations of others
- Insecurity in public
- Meaningless actions
- Member of a subculture
- Poor eye contact
- Preoccupation with own thoughts
- Purposelessness
- Repetitive actions
- Sad affect
- Values incongruent with cultural norms
- Withdrawn

RELATED FACTORS

- Alterations in mental status
- Alterations in physical appearance
- Alteration in wellness
- Developmentally inappropriate interests
- Factors impacting satisfying personal relationships (e.g., developmental delay)
- Inability to engage in satisfying personal relationship
- Insufficient personal resources (e.g., poor achievement, poor insight, affect unavailable and poorly controlled)
- Social behavior incongruent with norms
- Values incongruent with cultural norms

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior

- Coping
- Emotional
- Self-perception

EXPECTED OUTCOMES

- The patient will express feelings associated with social isolation.
- The patient will identify possible causes of social isolation and participate in developing plan for increasing social activity.
- The patient will interact with family members, friends, and caregivers.
- The patient will perform self-care activities independently.
- The patient will participate daily in meaningful diversional activity.
- The patient will indicate that social relationships have improved and negative feelings have diminished.
- The patient will achieve expected state of wellness.

SUGGESTED NOC OUTCOMES

Leisure Participation; Loneliness Severity; Personal Well-Being; Social Interaction Skills; Social Involvement; Social Support

INTERVENTIONS AND RATIONALES

Determine: Assess reason for hospitalization, family support systems available, functional ability, financial resources, occupation, educational level, and coping and problem-solving ability. *Assessment information will assist in identifying appropriate outcomes and interventions.*

Perform: Assist patient with daily self-care activities, such as bathing, grooming, dressing, eating, and ambulating. Encourage patient to take on more of this responsibility for self, as the patient is able. *This will reduce feelings of helplessness.*

Inform: Teach self-healing techniques to both the patient and the family, such as meditation, guided imagery, yoga, and prayer, *to prevent anxiety and aid in keeping patient in a frame of mind to make positive decisions.*

Teach patient coping techniques *to help increase ability to deal with especially challenging situations.*

Provide patient with concise information about decision-making skills, *to produce benefits that can reinforce health-seeking behaviors.*

Attend: Encourage patient to express feelings about self (past and present). *Self-exploration encourages patient to consider future change.*

Encourage patient to identify the causes of social isolation *to help the patient to develop a plan to reduce the isolation the patient is experiencing.*

Provide private time for patient to spend with family, including specific amount of noncore time to engage patient in conversation. *Such discussions help patient assume responsibility for coping responses.*

Provide patient with positive feedback for verbal reports or behaviors that indicate a return to positive self-appraisal. *This gives patient feelings*

of significance, approval, and competence, which can help the patient cope effectively with stressful situations.

Provide emotional support to family by being available to answer questions. *Accurate information will help family cope with current situation.* Manage: Arrange with patient specific periods for appropriate diversional activity *to provide pleasure, increase feelings of self-worth, and decrease negative self-absorption.*

Schedule time to meet with family and patient to listen to ways in which they plan to enhance their coping skills in the present situation.

Refer family to community resources and support groups available *to assist in managing patient's illness and providing emotional and financial assistance to caregivers.*

SUGGESTED NIC INTERVENTIONS

Behavior Modification: Social Skills; Activity Therapy; Family Integrity Promotion; Mood Management; Socialization Enhancement; Support System Enhancement; Therapy Group

REFERENCES

Cantrell, K. A., & Boles, J. (2015). The children's corner: Perspectives on supportive care. Bridging isolation for youth with chronic conditions: Are we thinking virtually? *Pediatric Nursing*, *41*(5), 254–256.

Hagan, R., Manktelow, R., Taylor, B. J., & Mallett, J. (2014). Reducing loneliness amongst older people: A systematic search and narrative review. *Aging & Mental Health*, *18*(6), 683–693. doi:10.1080/13607863.2013.875122

McCarthy, A. (2015). Summer camp for children and adolescents with chronic conditions. *Pediatric Nursing*, *41*(5), 245–250.

DEFINITION

Cyclical, recurring, and potentially progressive pattern of pervasive sadness experienced (by a parent, caregiver, individual with chronic illness or disability) in response to continual loss, throughout the trajectory of an illness or disability

DEFINING CHARACTERISTICS

- Feelings that interfere with well-being (e.g., personal, social)
- Overwhelming negative feelings
- Sadness (e.g., periodic, recurrent)

RELATED FACTORS

- Chronic disability (e.g., physical mental)
- Chronic illness
- Crisis in disability management
- Crisis in illness management
- Crisis related to developmental stage
- Death of significant other
- Length of time as a caregiver
- Missed milestones
- Missed opportunities

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Communication
- Coping
- Emotional
- Nutrition
- Sleep patterns
- Values/beliefs

EXPECTED OUTCOMES

- The patient will identify losses associated with changes in health status.
- The patient will express feelings about changes in health status.
- The patient will seek assistance in dealing with emotions related to loss.
- The patient will develop healthy coping mechanisms such as open expression of grief.
- The patient will seek out support from family, friends, clergy, or others, when necessary.
- The patient will begin to plan for discharge and the future.
- The patient will express realistic expectations with regard to health.

SUGGESTED NOC OUTCOMES

Acceptance: Health Status; Depression; Self-Control; Hope; Mood Equilibrium

INTERVENTIONS AND RATIONALES

Determine: Assess history of recent loss; usual pattern of coping; behavioral manifestation of grief and loss; sleep problems; lifestyle changes related to the situation; appetite; change in weight; religious beliefs and practices; and sources of support. *Assessment information will help identify appropriate outcomes and interventions.*

Perform: For patient who has lost weight, weigh daily at the same time *to evaluate improvements in nutrition.*

Provide bathing, grooming, and other hygiene functions for patient every day, as needed. Encourage patient to do as much as possible for self. *Greater independence will help build self-esteem.*

Inform: Teach skills that enhance coping strategies and relaxation strategies such as meditation, guided imagery, yoga, and exercise. *These mechanisms help reduce the level of anxiety that prevents the patient from coping with grief and loss.*

Attend: Let patient know that expressions of anger are acceptable, but place limits on destructive behavior. *Inability to identify anger as a normal response to loss may cause patient to express aggression inappropriately.*

Encourage patient to reach out to people who can offer emotional support, to increase emotional support. *Sensitive listening provides emotional support that can allow the patient to broaden focus beyond the cause of the sorrow.*

Encourage patient and family to reminisce. *Engaging in life review promotes a peaceful atmosphere and helps understanding the meaning of loss in relation to health and life.*

Encourage patient to take an active part in setting goals for health care, *to facilitate independence and enhance self-esteem.*

Manage: Help patient involve the family, community, clergy, and friends with changes to the care plan, *to increase the potential of the patient's control over self-care outcomes.*

Refer patient and family to other professional caregivers (e.g., dietitian, social worker, clergy, mental health professional). *Support groups can be helpful to the patient and the family.*

SUGGESTED NIC INTERVENTIONS

Coping Enhancement; Decision-Making Support; Emotional Support; Hope Installation; Mood Management; Spiritual Support; Guided Imagery; Reminiscence Therapy

REFERENCES

Bjorgvinsdottir, K., & Halldorsdottir, S. (2014). Silent, invisible and unacknowledged: Experiences of young caregivers of single parents diagnosed with multiple sclerosis. *Scandinavian Journal of Caring Sciences*, *28*(1), 38–48. doi:10.1111/scs.12030

Knight, C. C., Dailey, K. D., & Currie, E. R. (2015). An introduction to unexpected grief for pre-licensure nursing students: A simulation and interprofessional expert panel regarding fetal demise. *Nursing Education Perspectives*, *36*(6), 414–416.

Monaro, S., Stewart, G., & Gullick, J. (2014). A 'lost life': Coming to terms with haemodialysis. *Journal of Clinical Nursing*, *23*(21/22), 3262–3273. doi:10.1111/jocn.12577

DEFINITION

A state of suffering related to the impaired ability to experience meaning in life through connections with self, others, the world, or a superior being

DEFINING CHARACTERISTICS

- Anxiety
- Crying
- Fatigue
- Fear
- Insomnia
- Questioning identity
- Questioning meaning of life
- Questioning meaning of suffering

Connections to self

- Anger
- Decrease in serenity
- Feeling of being unloved
- Guilt
- Inadequate acceptance
- Ineffective coping strategies
- Insufficient courage
- Perceived insufficient meaning in life

Connections with others

- Alienation
- Refuses to interact with spiritual leader
- Refuses to interact with significant other
- Separation from support system

Connections with art, music, literature, and nature

- Decrease in expression of previous pattern of creativity
- Disinterest in nature
- Disinterest in reading spiritual literature

Connections with power greater than self

- Anger toward power greater than self
- Feeling abandoned
- Hopelessness
- Inability for introspection
- Inability to experience the transcendent
- Inability to participate in religious activities
- Inability to pray
- Perceived suffering
- Request for a spiritual leader
- Sudden change in spiritual practice

RELATED FACTORS

- Active dying
- Aging
- Birth of a child
- Death of significant other
- Exposure to death
- Illness
- Imminent death
- Increasing dependence on another
- Life transition
- Loneliness
- Loss of body part
- Loss of function of a body part
- Pain
- Perception of having unfinished business
- Receiving bad news
- Self-alienation
- Social alienation
- Sociocultural deprivation
- Treatment regimen
- Unexpected life event

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Communication
- Coping
- Emotional
- Values/beliefs

EXPECTED OUTCOMES

- The patient will communicate conflicts about beliefs.
- The patient will identify understanding of source of spiritual conflict.
- The patient will specify whatever spiritual assistance is perceived as needed.
- The patient will discuss beliefs about religious practices.
- The patient will identify coping techniques to deal with spiritual discomfort and not harm self while in the hospital.

SUGGESTED NOC OUTCOMES

Suffering Severity; Hope; Quality of Life; Spiritual Health

INTERVENTIONS AND RATIONALES

Determine: Assess behavioral responses; coping strategies; experiences with illness; knowledge; environmental, social factors; spiritual beliefs and practices; and spiritual support system. *Assessment information will help the nurse identify appropriate interventions.*

Perform: Assist the patient to list those aspects of spiritual care the patient would like the hospital to provide. *Having documentation from the patient is useful to communicate the patient's spiritual needs with the staff.*

Spend time with the patient developing goals for skill development that will help the patient deal with current diagnosis. *Without the necessary skills, the patient will continue to feel distressed and anxious.*

Inform: Teach patient's coping strategies to family members and friends *so they can help patient practice adaptive methods of coping with self-destructive feelings.*

Have patient and family members practice role-playing *to increase the confidence in the patient's ability to handle difficult situations.*

Teach self-healing techniques and relaxation strategies to both the patient and family, such as meditation, aromatherapy, guided imagery, yoga, and prayer. *These techniques can reduce the anxiety that comes from attempting to cope with patient's disease.* Teach patient how to incorporate the use of self-healing techniques in carrying out usual daily activities.

Self-healing gives the patient a better sense of control over regaining independence.

Attend: Acknowledge patient's spiritual concerns and encourage expression of thoughts and feelings *to help build a therapeutic relationship.*

For the patient whose spiritual comfort is derived from music, art, or nature, attempt to find such items (e.g., CDs, posters, or picture books) that will provide spiritual nourishment. *Not everyone finds spiritual comfort in organized religion. Each person is entitled to find spiritual hope and consolation in whatever way patient's needs are met.*

Encourage patient to continue religious practices while in the hospital; do whatever you must to facilitate this. *These measures demonstrate support and convey caring and acceptance.*

Manage: Communicate and collaborate with patient's clergy person or with the hospital chaplain, as appropriate. *This ensures consistent care and provides a more complete database.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Hope Instillation; Referral; Spiritual Growth Facilitation; Spiritual Support; Guided Imagery; Aromatherapy; Religious Ritual Enhancement

REFERENCES

Bornet, M. A., Rochat, E., Dürst, A. V., Fustinoni, S., Büla, C., von Gunten, A., & Monod, S. (2016). Instruments to assess depressive symptoms and spiritual distress investigate different dimensions. *Clinical Gerontologist*, *39*(2), 104–116. doi:10.1080/07317115.2015.1120255

Skalla, K. A., & Ferrell, B. (2015). Challenges in assessing spiritual distress in survivors of cancer. *Clinical Journal of Oncology Nursing*, *19*(1), 99–104. doi:10.1188/15.CJON.99-104

Wen-Pei, W., & Hsin-Tien, H. (2014). Applying Swanson's caring theory to manage spiritual distress in a patient with terminal lung cancer. *Journal of Nursing*, *61*(4), 97–102. doi:10.6224/JN.61.4.97

DEFINITION

Vulnerable to an impaired ability to experience and integrate meaning and purpose in life through connectedness with self, literature, nature, and/or a power greater than oneself, which may compromise health

RISK FACTORS

Developmental
- Life change

Environmental
- Environmental change
- Natural disaster

Physical
- Chronic illness
- Physical illness
- Substance abuse

Psychosocial
- Anxiety
- Barrier to experiencing love
- Change in religious ritual
- Change in spiritual practice
- Cultural conflict
- Depression
- Inability to forgive
- Ineffective relationships
- Loss
- Low self-esteem
- Racial conflict
- Separation from support system
- Stressors

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)
- Behavior
- Coping
- Emotional
- Self-perception
- Values/beliefs

EXPECTED OUTCOMES

- The patient will discuss current beliefs and concerns.
- The patient will discuss effects of illness, injury, or disability on beliefs and spiritual practices.
- The patient will express feelings of spiritual well-being.

- The patient will use healthy coping techniques to maintain spiritual well-being.
- The patient will refrain from causing harm to self.
- The patient will be supported in efforts to pursue spirituality in coping with illness or disability.
- The patient will reach out to family members, clergy, or friends for assistance.

SUGGESTED NOC OUTCOMES

Coping; Grief Resolution; Hope; Spiritual Health

INTERVENTIONS AND RATIONALES

Determine: Assess health history; impact of the current illness on lifestyle; spiritual status; religious affiliation; relationship with spiritual leaders; importance of spirituality in the patient's life; desire for help in coping with spiritual concerns; family status; and socioeconomic status.

Assessment information will assist in identifying appropriate interventions.

Inform: Teach coping strategies that appeal to the patient, such as meditation, relaxation, and guided imagery. *This will help the patient focus on what the patient would like to achieve in spiritual life.*

Attend: Express your willingness to discuss spirituality if the patient desires. *This helps reduce isolation and bring spiritual realities into the open.*

Be certain about understanding your own beliefs and accept the patient's beliefs even if they are different from your own. *It is essential to understand what you believe in order to listen and be nonjudgmental when listening to the patient. It is unacceptable for the nurse to argue with the patient about spiritual beliefs.*

Communicate to the patient that you accept his or her expression of spiritual concerns, even if his or her feelings are angry and negative to reassure him or her that his feelings are valid. *The feeling of acceptance will facilitate the patient's ability to express his or her spiritual issues more freely.*

Listen attentively to patient's discussion of spiritual concerns. *Thoughtful listening fosters open discussion.*

Encourage patient to discuss recent life-threatening experience, *to help the patient clarify and cope with patient's feelings.*

Provide for continuation of the patient's religious practices. For example, help patient obtain ritual items and respect dietary restrictions, if possible, *to demonstrate support and convey caring and acceptance to patient.*

Manage: Collaborate with patient's clergy person or hospital chaplain *to develop a plan to integrate spiritual interventions into patient's care to ensure continuity of care.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Anticipatory Guidance; Anxiety Reduction; Caregiver Support; Hope Instillation; Spiritual Growth Facilitation; Spiritual Support; Religious Ritual Enhancement

REFERENCES

Caldeira, S., de Carvalho, E. C., & Vieira, M. (2014). Between spiritual wellbeing and spiritual distress: possible related factors in elderly patients with cancer. *Revista Latino-Americana de Enfermagem*, *22*(1), 28–34. doi:10.1590/0104-1169.3073.2382

Daly, L., & Fahey-McCarthy, E. (2014). Attending to the spiritual in dementia care nursing. *British Journal of Nursing*, *23*(14), 787–791. doi:10.12968/bjon.2014.23.14.787

Elham, H., Hazrati, M., Momennasab, M., & Sareh, K. (2015). The effect of need-based spiritual/religious intervention on spiritual well-being and anxiety of elderly people. *Holistic Nursing Practice*, *29*(3), 136–143. doi:10.1097/HNP.0000000000000083

506 IMPAIRED SPONTANEOUS VENTILATION

DEFINITION

Decreased energy reserves resulting in an inability to maintain independent breathing that is adequate to support life

DEFINING CHARACTERISTICS

- Alteration in metabolism
- Apprehensiveness
- Decrease in arterial oxygen saturation (Sao_2)
- Decrease in cooperation
- Decrease in partial pressure of oxygen (Po_2)
- Decrease in tidal volume
- Dyspnea
- Increase in accessory muscle use
- Increase in heart rate
- Increase in partial pressure of carbon dioxide (Pco_2)
- Restlessness

RELATED FACTORS

- Alteration in metabolism
- Respiratory muscle fatigue

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Coping
- Fluid and electrolytes
- Neurocognition
- Physical regulation
- Respiratory function

EXPECTED OUTCOMES

- The patient will maintain respiratory rate at 5 breaths/minute within baseline.
- The patient will demonstrate arterial blood gas (ABG) levels normal for that patient.
- The patient will indicate feelings of comfort without pain or dyspnea.
- The patient will have breathing pattern return to baseline.
- The patient will demonstrate Pao_2 within normal limits as activity level increases.
- The patient will breathe spontaneously after ventilation support is withdrawn.

SUGGESTED NOC OUTCOMES

Anxiety Level; Endurance; Energy Conservation; Respiratory Status: Gas Exchange; Ventilation; Vital Signs

INTERVENTIONS AND RATIONALES

Determine: Assess vital signs; respiratory status, including rate, rhythm, and depth of respiration. Look for nasal flaring, effectiveness of cough; suctioning demands; sputum characteristics, including color, consistency, amount; ABGs; hemoglobin and hematocrit. *Assessment information will help identify appropriate outcomes and interventions.*

Perform: Check vital signs every 15 minutes to 1 hour *to detect tachypnea and tachycardia, both of which are early indicators of respiratory distress.*

Begin oxygen support using the smallest concentration needed, *to make patient comfortable.* Monitor closely *to avoid oxygen toxicity.*

Place patient in Fowler's position *to increase comfort and facilitate adequate chest expansion and diaphragmatic excursion, thereby decreasing the work of breathing.*

Assist patient to progress gradually from bed rest to increased activity, *to improve sense of well-being.*

Monitor vital signs and ABGs closely. If respiratory status is compromised, return to bed rest *to decrease metabolic rate and lower oxygen demands.*

Inform: Explain procedures to the patient, and describe specific sensations the patient may feel during each procedure. *Keeping patient informed about what to expect and when to expect it reduces anxiety.*

Teach self-healing techniques to both the patient and the family, such as meditation, guided imagery, yoga, and prayer. Teach patient how to incorporate the use of self-healing techniques in carrying out usual daily activities. *These techniques help calm the mind, reduce anxiety, and promote ability to cooperate with treatment regimen.*

Attend: Avoid respiratory depressants such as opiates, sedatives, and paralytics because *these drugs will further depress the patient's ability to breathe adequately on own and have the potential to cause respiratory arrest.*

Anticipate possible complications. Keep in mind that if the patient decompensates while on 100% fraction of inspired oxygen mask, the patient may require intubation. *Anticipating complications facilitates prompt intervention.*

Manage: If patient requires intubation, monitor the patient for spontaneous breathing and gradually wean the patient from ventilator. *Progressive weaning helps patient to adjust physiologically and emotionally to increased work of breathing.*

Refer patient and family to other professional caregivers, for example, dietitian, social worker, clergy, and mental health professional. Assist patient to utilize appropriate resources by contacting family and scheduling follow-up appointments. *These measures help give patient and family a sense of direction and control over future care.*

SUGGESTED NIC INTERVENTIONS

Acid–Base Management; Airway Suctioning; Artificial Airway Management; Coping Enhancement; Mechanical Ventilation; Oxygen Therapy; Positioning; Respiratory Monitoring; Self-Care Assistance; Guided Imagery

REFERENCES

Buonocore, D., Wiegand, D. L., & Campbell, M. L. (2015). Caring for dying patients in the intensive care unit. *AACN Advanced Critical Care*, *26*(2), 110–122. doi:10.1097/NCI.0000000000000077

Fournier, M. (2014). Caring for patients in respiratory failure. *American Nurse Today*, *9*(11), 18–23.

Tanios, M., Epstein, S., Grzeskowiak, M., Nguyen, H. M., Hyunsoon, P., & Leo, J. (2014). Influence of sedation strategies on unplanned extubation in a mixed intensive care unit. *American Journal of Critical Care*, *23*(4), 306–315. doi:10.4037/ajcc20144446

DEFINITION

Limitation of ability to independently and purposefully attain and/or maintain the body in an upright position from feet to head

DEFINING CHARACTERISTICS

- Impaired ability to adjust position of one or both lower limbs on uneven surface
- Impaired ability to attain a balanced position of the torso
- Impaired ability to extend one or both hips
- Impaired ability to extend one or both knees
- Impaired ability to flex one or both hips
- Impaired ability to flex one or both knees
- Impaired ability to maintain the torso in balanced position
- Impaired ability to stress torso with body weight
- Insufficient muscle strength

RELATED FACTORS

- Circulatory perfusion disorder
- Emotional disturbance
- Impaired metabolic functioning
- Injury to lower extremity
- Insufficient endurance
- Insufficient energy
- Malnutrition
- Neurologic disorder
- Obesity
- Pain
- Prescribed posture
- Sarcopenia
- Self-imposed relief posture
- Surgical procedure

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Comfort
- Knowledge
- Sensation/perception

EXPECTED OUTCOMES

- The patient will achieve highest level of independence possible when standing.
- The patient will show no evidence of complications.
- The patient will achieve balance while standing.
- The patient will maintain muscle strength.

SUGGESTED NOC OUTCOMES

Activity Tolerance; Endurance; Joint Movement: Hip; Joint Movement: Spine; Neurological Status: Central Motor Control; Neurological Status: Spinal Sensory/Motor Function; Physical Fitness; Skeletal Function

INTERVENTIONS AND RATIONALES

Determine: Identify level of functioning using a functional mobility scale. Communicate patient's skill level to all staff members *to provide continuity and preserve identified level of independence.*

Monitor and record daily any evidence of immobility complications *as they may be more prone to develop complications.*

Perform: Use a transfer belt, if necessary, *to support patient and prevent staff injury.*

Carry out medical regimen to manage or prevent complications (e.g., administer prophylactic heparin for venous thrombosis). *This promotes patient's health and well-being.*

Provide progressive mobilization to the limits of patient's condition (bed mobility to chair mobility to ambulation) *to maintain muscle tone and prevent complications of immobility.*

Inform: Instruct patient and family members on ROM exercises, transfers, skin inspection, and mobility regimen *to help prepare for discharge and promote continuity of care.* Request return demonstration *to ensure use of proper technique.*

Instruct patient to call before attempting to stand without assistance. *Ensure patient safety from falls.*

Attend: Encourage independence by helping patient to use assistive devices. *This increases muscle tone and patient's self-esteem.*

Manage: Refer patient to a physical therapist for development of sitting regimen *to help rehabilitate musculoskeletal deficits.*

SUGGESTED NIC INTERVENTIONS

Body Mechanics Promotion; Exercise Therapy: Balance; Exercise Therapy: Muscle Control; Positioning; Self-Care Assistance

REFERENCES

Engelhart, D., Pasma, J. H., Schouten, A. C., Meskers, C. G., Maier, A. B., Mergner, T., & van der Kooij, H. (2014). Impaired standing balance in elderly: A new engineering method helps to unravel causes and effects. *Journal of the American Medical Directors Association*, *15*(3), 227. doi:10.1016/j.jamda.2013.09.009

Travers, B., Powell, P., Klinger, L., & Klinger, M. (2013). Motor difficulties in autism spectrum disorder: Linking symptom severity and postural stability. *Journal of Autism & Developmental Disorders*, *43*(7), 1568–1583. doi:10.1007/s10803-012-1702-x

Pan, T., Liao, K., Roenigk, K., Daly, J. J., & Walker, M. F. (2015). Static and dynamic postural stability in veterans with combat-related mild traumatic brain injury. *Gait & Posture*, *42*(4), 550–557. doi:10.1016/j.gaitpost.2015.08.012

DEFINITION

Excessive amounts and types of demands that require action

DEFINING CHARACTERISTICS

- Excessive stress
- Feeling of pressure
- Impaired decision making
- Impaired functioning
- Increase in anger
- Increase in anger behavior
- Increase in impatience
- Negative impact from stress (e.g., physical symptoms, psychological distress, feeling sick)
- Tension

RELATED FACTORS

- Excessive stress
- Insufficient resources (e.g., financial, social, knowledge)
- Repeated stressors
- Stressors

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Emotional
- Pharmacological
- Self-perception
- Sleep/rest

EXPECTED OUTCOMES

- The patient will experience reduced signs of stress overload as evidenced by subjective report and observations of reduced stress, such as less facial tension and less restlessness.
- The patient will connect environmental stressors with manifestations of stress such as insomnia, tearful outbursts, irritability, or headache.
- The patient will set limits on activities assumed by saying "no" without expressions of guilt.
- The patient will develop more effective coping strategies to manage stress such as guided imagery, exercise, healthy diet, and recreation and leisure activities.
- The patient will develop strategies to reframe distorted thinking patterns relating to internal and environmental demands, such as talking about feelings and asking for help.

SUGGESTED NOC OUTCOMES

Abusive Behavior Self-Restraint; Aggression Self-Control; Anxiety Self-Control; Coping; Stress Level; Risk Control

INTERVENTIONS AND RATIONALES

Determine: Establish and promote a trusting relationship before asking patient to make any changes. *A trusting relationship can facilitate patient's attempts to make changes, whereas too many demands early in relationship can foster resistance.*

Perform: Explore support systems with patient, such as appropriate Internet chat rooms, support groups, or hobbies and outings with partner or family and friends. *Often, patient is caretaker who perceives there is little time for self and is at risk for caregiver burden. Promoting verbalization of feelings with support persons can reduce feeling of stress overload.*

Explore the lack of exercise and excessive intake of caffeine, alcohol, nicotine, and carbohydrates during periods of stress overload and adoption of healthier alternatives. *Inappropriate food choices, inactivity, and substance abuse can occur when patient feels stress overload.*

Inform: Teach prioritization of responsibilities and deadlines *to facilitate patient's sense of control over stressors. Stressors may seem overwhelming, and nurse can promote increased self-esteem when a plan is made cooperatively with nurse and patient as partners.*

Teach patient about positive self-talk. *Positive self-talk helps change and, ultimately, reverse negative emotions of guilt, fear, and worry.*

Teach coping strategies such as reframing thoughts or using music, guided imagery, yoga, deep-breathing exercises, progressive neuromuscular relaxation, or pet therapy. *Strategies that reduce tense muscles and feelings can promote deeper relaxation and reduce heart rate, respirations, and blood pressure by promoting the parasympathetic response.*

Teach assertiveness training techniques with role-play exercises. *Assertiveness training can provide a concrete way to manage stressors and enhance feeling of being empowered, such as in communicating with demanding individuals.*

Attend: Provide opportunities for patient to ventilate feelings about stressors. *Promoting a time to talk can help the patient share feelings of mounting stress before irritability and tension worsen.*

Manage: As needed, refer patient to a psychiatric liaison nurse, support group, or other mental health provider. *Stress may be an indicator of other more serious mental health problems.*

SUGGESTED NIC INTERVENTIONS

Anger Control Assistance; Assertiveness Training; Behavior Management; Behavior Modification; Calming Techniques; Cognitive Restructuring; Coping Enhancement; Impulse Control Training; Stress Management Assistance; Guided Imagery

REFERENCES

Amirkhan, J. H., Urizar, G. G., & Clark, S. (2015). Criterion validation of a stress measure: The stress overload scale. *Psychological Assessment*, *27*(3), 985–996. doi:10.1037/pas0000081

Beattie, L., & Griffin, B. (2014). Day-level fluctuations in stress and engagement in response to workplace incivility: A diary study. *Work & Stress*, *28*(2), 124–142. doi:10.1080/02678373.2014.898712

Jess, A. (2015). Stress, coping strategies, and depression—Uninsured primary care patients. *American Journal of Health Behavior*, *39*(6), 742–750. doi:10.5993/AJHB.39.6.1

514 RISK FOR SUDDEN INFANT DEATH SYNDROME

DEFINITION

Vulnerable to unpredicted death of an infant

RISK FACTORS

Modifiable

- Delay in prenatal care
- Exposure to smoke
- Infant overheating
- Infant overwrapping
- Infant placed in prone position to sleep
- Infant placed in side-lying position to sleep
- Insufficient prenatal care
- Soft underlayment (e.g., loose items placed near infant)

Partially modifiable

- Low birth weight
- Prematurity
- Young maternal age

Nonmodifiable

- Age 2 to 4 months
- Ethnicity (e.g., African American or Native American)
- Male gender
- Season of the year (i.e., winter and fall)

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Sleep/rest
- Roles/responsibilities
- Values/beliefs

EXPECTED OUTCOMES

- The parents will be receptive to teaching and guidance.
- The parents will verbalize understanding of risk factors and provide all precautions possible to prevent disorder.
- The parents will verbalize feelings of preparedness and ability to handle emergencies utilizing cardiopulmonary resuscitation (CPR) techniques and services.
- The parents will exhibit appropriate coping skills in dealing with high-risk infant.
- The infant will sleep alone in a crib on a firm sleep surface.
- The infant will be placed in proper position on back with head of crib slightly elevated.
- The infant will maintain normal body temperature.
- The infant will be monitored with an apnea monitor worn during sleep.

SUGGESTED NOC OUTCOMES

Knowledge: Infant Care; Knowledge: Parenting; Parent Performance; Risk Control; Risk Detection

INTERVENTIONS AND RATIONALES

Determine: Assess prenatal history; maternal history; parental experience; monitor heart rate, blood pressure; respiratory rate, quality, depth of respirations, breath sounds; reflexes, response to touch. *The assessment information will assist in identifying appropriate interventions.*

Perform: Position infant on back when placed in the crib. *Incidence of SIDS is higher when infant is placed in a prone position.*

Elevate infant's head slightly when placed in the crib, *to decrease abdominal pressure on diaphragm and allow better expansion of lungs.*

Place infant on a firm sleep surface, *to prevent the infant from sinking into the mattress cover or blanket.*

Maintain room at appropriate temperature and avoid wrapping the infant in heavy blankets. *Excessive heat has been identified as a possible risk factor.*

Inform: Educate parents about risk factors of SIDS *because modification of current practices can reduce risk and prevent occurrence.* Instruct caregivers on ways to maintain a safe environment in the home. Provide written information to caregivers on all important aspects of the infant's care.

Teach parents to avoid having loose blankets, toys, or other articles in the crib, *to decrease risk of accidental suffocation.*

Encourage mother to breast-feed *because there is a lower incidence of SIDS in babies who are breast-fed.*

Teach parents how to correctly apply leads and set alarms of the apnea monitor. The *benefit of the monitor can be achieved only if it is used correctly.*

Instruct parents on CPR *to reduce anxiety and promote confidence in performing correct technique.* Allow time for return demonstrations *to prepare parents to cope with infant when the infant returns home.*

Attend: Encourage parents in their efforts to care for the infant. Provide suggestions for coping mechanisms *to help reduce the anxieties associated with caring for a high-risk infant.* Be aware that parents may be sensitive to your unspoken feelings about the situation.

Encourage parents to interact with other parents managing high-risk infants well. *Peer support may help to reduce fear in the parents.*

Involve parents in planning and decision making for their infant. *Investment in decision making will promote compliance with the plan.*

Manage: Refer to case manager/social worker/home health agency *to ensure that parents receive adequate support in caring for the infant.*

Refer parents to support group if one is available.

SUGGESTED NIC INTERVENTIONS

Family Support; Infant Care; Risk Control; Teaching: Infant Safety; Environmental Management; Safety

REFERENCES

Ball, H. L. (2015). Empowering families to make informed choices about sleep safety. *British Journal of Midwifery, 23*(3), 164–165.

Bartlow, K. L. (2016). Nurses' knowledge and adherence to sudden infant death syndrome prevention guidelines. *Pediatric Nursing, 42*(1), 7–13.

Brännström, I. (2014). Speaking discourses and silent lips: Women and gender-based portraits in sudden infant death publications. *Journal of Clinical Nursing, 23*(7/8), 1120–1132. doi:10.1111/jocn.12288

DEFINITION

Vulnerable to inadequate air availability for inhalation, which may compromise health

RISK FACTORS

External

- Access to empty refrigerator/freezer
- Eating large mouthfuls of food
- Gas leak
- Low-strung clothesline
- Pacifier around infant's neck
- Playing with plastic bag
- Propped bottle in infant's crib
- Small object in airway
- Smoking in bed
- Soft underlayment (e.g., loose items placed near infant)
- Unattended in water
- Unvented fuel-burning heater
- Vehicle running in closed garage

Internal

- Alteration in cognitive functioning
- Alteration in olfactory function
- Emotional disturbance
- Face/neck disease
- Face/neck injury
- Impaired motor functioning
- Insufficient knowledge of safety precautions

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Self-care
- Knowledge
- Values/beliefs

EXPECTED OUTCOMES

- The patient will demonstrate a patent airway at all times.
- The patient will maintain vital signs within normal parameters.
- The patient will demonstrate along with family knowledge of safety measures to prevent suffocation.

SUGGESTED NOC OUTCOMES

Aspiration Prevention; Personal Safety Behavior; Respiratory Status: Ventilation; Risk Control; Risk Detection; Knowledge: Personal Safety; Safe Home Environment

INTERVENTIONS AND RATIONALES

Determine: Assess vital signs; history of current situation; neurologic status; and hemoglobin, hematocrit, clotting factors, platelet count, and WBC; mental illness; history of abuse. *Assessment information will assist in formulating goals and interventions.*

Perform: Position patient on side or position head and neck *to prevent relaxed neck muscles from obstructing airway to allow maximal chest expansion and prevent aspiration and airway obstruction.*

Check all ventilator connections and alarms every 30 minutes if patient is on mechanical ventilation, *to ensure that patient receives the proper amount of oxygen at appropriate volume and rate.*

Suction airway, as needed, *to prevent accumulation of secretions.* Suction only as needed *to prevent tracheal irritation.*

Position patient on side or position head and neck to prevent relaxed neck muscles from obstructing the airway. *This allows maximal chest expansion and prevents aspiration and airway obstruction.*

Obtain suction equipment, assemble, and keep at bedside *to ensure equipment readiness in case it is needed.*

Inform: Educate patient's family about safety measures in the home, for example, proper positioning, suction procedure, fall prevention, *to enable them to take an active role in the patient's care and ensure performance of safety measures.*

Attend: Be attentive to the fears of both patient and family. Listen with sensitivity and reinforce safety measures to prevent injury. *To achieve a level of comfort, the family may need to ask the same questions multiple times and have the information repeated frequently.*

Manage: Offer referral to counselors or support persons, as needed. *Many families will need additional support after hospitalization.*

SUGGESTED NIC INTERVENTIONS

Airway Management; Aspiration Precautions; Energy Management; Vital Signs Monitoring; Respiratory Monitoring; Security Enhancement; Surveillance

REFERENCES

Furuya, J., Hara, A., Nomura, T., & Kondo, H. (2014). Volitional chewing with a conscious effort alters and facilitates swallowing during feeding sequence. *Journal of Oral Rehabilitation*, *41*(3), 191–198. doi:10.1111/joor.12140

Lindroos, E., Saarela, R., Soini, H., Muurinen, S., Suominen, M., & Pitkala, K. (2014). Caregiver-reported swallowing difficulties, malnutrition, and mortality among older people in assisted living facilities. *Journal of Nutrition, Health & Aging*, *18*(7), 718–722. doi:10.1007/s12603-014-0506-4

DEFINITION

Vulnerable to self-inflicted, life-threatening injury

RISK FACTORS

- *Behavioral:* Changing a will, giving away possessions, history of suicide attempt, impulsiveness, making a will, marked change in attitude, marked change in behavior, marked change in school performance, purchase of a gun, stockpiling medication, sudden euphoric recovery from a major depression
- *Demographic:* Age (e.g., elderly people, young adult males, adolescents), divorced status, ethnicity (e.g., white, Native American), male gender, widowed
- *Physical:* Chronic pain, physical illness, terminal illness
- *Psychological:* Family history of suicide, guilt, history of childhood abuse (e.g., physical, psychological, sexual), homosexual youth, psychiatric disorder, substance abuse
- *Situational:* Access to weapon, adolescents living in nontraditional settings (e.g., juvenile detention center, prison, halfway house, group home), economically disadvantaged, institutionalization, living alone, loss of autonomy, loss of independence, relocation, retired
- *Social:* Cluster suicides, disciplinary problems, disruptive family life, grieving, helplessness, hopelessness, insufficient social support, legal difficulty, loneliness, loss of important relationship, social isolation
- *Verbal:* Reports desire to die, threat of killing self

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Emotional
- Pharmacologic function
- Self-perception

EXPECTED OUTCOMES

- The patient will discuss feelings that precipitate suicide attempts.
- The patient will refrain from harming self.
- The patient will recover from suicidal episode.
- The patient will consult with mental health professional.
- The patient will describe available resources for crisis prevention and management.
- The patient will voice improvement in feelings of self-worth.

SUGGESTED NOC OUTCOMES

Impulse Self-Control; Self-Mutilation Restraint; Suicide Self-Restraint

INTERVENTIONS AND RATIONALES

Determine: Assess medical history, life situation, recent stressors, coping skills, history of suicidal attempts, history of substance abuse, safety hazards, and medications. *Assessment results will provide information that will assist in identifying goals and selecting appropriate interventions.*
Perform: Initiate suicidal precaution protocol, including checks every 15 minutes, *to ensure that the patient is protected and is in a safe environment.*

Make a short-term contract with the patient that the patient won't harm self during a specific period. Continue negotiating until no evidence of suicidal ideation exists. *A contract gets the subject of suicide out in the open, places some responsibility for safety on the patient, and conveys acceptance of the patient as a worthwhile person.*

Remove anything from the patient's environment that could be used to inflict injury to self such as razor blades, belts, glass objects, knives, pills, cans, and mirrors. *This helps ensure the patient's safety.*
Inform: Provide the patient with telephone numbers and other information about crisis centers, hot lines, and counselors. *Alternatives may ease anxiety about the perceived threat of long-term psychotherapy.*
Attend: Use nonjudgmental manner *to show unconditional positive regard.*

Listen carefully to patient and avoid challenging the patient *in order to communicate caring and support.*

Demonstrate caring but do not reinforce denial of current situation, *because roots of suicidal feelings can be masked by denial.*

Encourage patient to participate in group activities, especially those the patient enjoys *to help build self-esteem.* Assist patient to recognize inappropriate coping mechanisms and help identify those that enhance personal well-being, *to use strengths and skills in preventing self-destructive behavior.*
Manage: Make a referral to mental health professional, *to help patient through suicidal ideations and develop healthier alternatives.*

SUGGESTED NIC INTERVENTIONS

Impulse Control Training; Behavior Management: Self-Harm; Environmental Management: Violence Prevention; Suicide Prevention

REFERENCES

Greenlee, K., & Hyde, P. S. (2014). Suicide and depression in older adults: Greater awareness can prevent tragedy. *Generations*, *38*(3), 23–26.

Procter, N., & Ferguson, M. (2015). Are there warning signs for suicide? *Australian Nursing & Midwifery Journal*, *23*(5), 31.

Xu, G., & Li, N. (2014). A comparison study on mental health status between suicide survivors and survivors of accidental deaths in rural China. *Journal of Psychiatric & Mental Health Nursing*, *21*(10), 859–865. doi:10.1111/jpm.12147

DEFINITION

Extension of the number of postoperative days required to initiate and perform activities that maintain life, health, and well-being

DEFINING CHARACTERISTICS

- Discomfort
- Evidence of interrupted healing of surgical area
- Excessive time required for recuperation
- Impaired mobility
- Inability to resume employment
- Loss of appetite
- Postpones resumption of work
- Requires assistance for self-care

RELATED FACTORS

- American Society of Anesthesiologists (ASA) Physical Status classification score ≥3
- Diabetes mellitus
- Edema at surgical site
- Extensive surgical procedure
- Extremes of age
- History of delayed wound healing
- Impaired mobility
- Malnutrition
- Obesity
- Pain
- Perioperative surgical site infection
- Persistent nausea
- Persistent vomiting
- Pharmaceutical agent
- Postoperative emotional response
- Prolonged surgical procedure
- Psychological disorder in postoperative period
- Surgical site contamination
- Trauma at surgical site

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Cardiac function
- Neurocognition
- Physical regulation
- Respiratory function
- Risk management

EXPECTED OUTCOMES

- The patient will have vital signs and laboratory values within normal limits.
- The patient will have evidence of wound healing; incision site will appear free from signs and symptoms of infection.
- The patient will have resolution of any postoperative complications.
- The patient will resume normal mobility status.
- The patient will seek and obtain emotional support from family and friends.
- The patient will resume normal eating, bowel, and bladder habits.
- The patient will use community resources that are available to assist after discharge.

SUGGESTED NOC OUTCOMES

Ambulation; Endurance; Health Beliefs; Immobility Consequences: Physiological; Nutritional Status; Pain Level; Wound Healing: Primary Intention

INTERVENTIONS AND RATIONALES

Determine: Assess all body systems *to detect signs and symptoms of postoperative complications that delay surgical recovery.*

Assess surgical site for signs of infection, such as erythema, edema, pain, drainage, odor, incision approximation, and intact sutures. Monitor wound healing. Document and report assessment findings *to facilitate the development of an individualized care plan.*

Monitor nutritional status; *optimal nutritional status promotes wound healing and provides energy for recovery.*

Monitor bowel and bladder activity. Report urine retention and absent or decreased bowel sounds. *Abnormal bowel and bladder patterns slow surgical recovery.*

Monitor postoperative bleeding; monitor hemoglobin level and hematocrit. *Bleeding can lead to a low hemoglobin level and hematocrit, reducing the ability of red blood cells to carry oxygen, which can hinder wound healing and diminish patient's energy level.*

Perform: Follow proper pulmonary regimen *to facilitate resolution of respiratory complications, if present, which lead to decreased oxygen levels, slow wound healing, and delayed mobility.*

If patient suffers from psychosis, continue to reorient during postoperative recovery period *to prevent delay in recovery and report psychological reaction (e.g., depression-like symptoms).*

Administer pain medication, as prescribed. *A patient in pain won't move, cough, and deep-breathe as needed for timely recovery.*

As appropriate, make sure that someone is available to walk with patient or assistive devices (walkers or canes) are available. Don't allow patient to ambulate alone until steady. *Assistance enhances safety and*

encourages patient to improve mobility without fear of falling. Mobility facilitates improved strength, helps prevent such complications as deep vein thrombosis, and, ultimately, enhances recovery.

Enforce use of support stockings or a sequential compression device *to facilitate venous return and prevent deep vein thrombosis.*

Inform: Educate patient and family regarding appropriate care after discharge *to promote compliance with medication and treatment regimens.*

Attend: Make sure patient and family members have access to community resources *to assist with recovery when patient returns home to ensure ongoing recovery.*

Manage: Initiate an interdisciplinary care conference for patient *to help develop a plan that will put the patient on a faster track to recovery.*

SUGGESTED NIC INTERVENTIONS

Bed Rest Care; Case Management; Discharge Planning; Energy Management; Exercise Therapy: Ambulation; Incision Site Care; Multidisciplinary Care Conference; Nutrition Management; Pain Management; Sleep Enhancement

REFERENCES

Appoloni, A. H., Herdman, T. H., Napoleão, A. A., Campos de Carvalho, E., & Hortense, P. (2013). Concept analysis and validation of the nursing diagnosis, delayed surgical recovery. *International Journal of Nursing Knowledge*, *24*(3), 115–121. doi:10.1111/j.2047-3095.2013.01241.x

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Santana, R. F., do Amaral, D. M., Pereira, S. K., Delphino, T. M., & Cassiano, K. M. (2014). The occurrence of the delayed surgical recovery nursing diagnosis among adults and the elderly. *Acta Paulista de Enfermagem*, *27*(1), 35–39. doi:10.1590/1982-0194201400008

524 RISK FOR DELAYED SURGICAL RECOVERY

DEFINITION

Vulnerable to an extension of the number of postoperative days required to initiate and perform activities that maintain life, health, and well-being, which may compromise health

RISK FACTORS

- American Society of Anesthesiologists (ASA) Physical Status classification score ≥3
- Diabetes mellitus
- Edema at surgical site
- Extensive surgical procedure
- Extremes of age
- History of delayed wound healing
- Impaired mobility
- Malnutrition
- Obesity
- Pain
- Perioperative surgical site infection
- Persistent nausea
- Persistent vomiting
- Pharmaceutical agent
- Postoperative emotional response
- Prolonged surgical procedure
- Psychological disorder in postoperative period
- Surgical site contamination
- Trauma at surgical site

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Cardiac function
- Neurocognition
- Physical regulation
- Respiratory function
- Risk management

EXPECTED OUTCOMES

- The patient will maintain vital signs and laboratory values within normal limits.
- The patient will remain free of signs and symptoms of infection at the incision site.
- The patient will exhibit optimal nutritional status.
- The patient will remain free of postoperative complications.
- The patient will resume normal mobility status.

- The patient will seek and obtain emotional support from family and friends.
- The patient will resume normal eating, bowel, and bladder habits.
- The patient will utilize available community resources after discharge.

SUGGESTED NOC OUTCOMES

Ambulation; Mobility; Self-Care: Activities of Daily Living (ADLs); Knowledge: Treatment Regimen

INTERVENTIONS AND RATIONALES

Determine: Assess for factors that may be related to a delay in recovery, such as respiratory complications and infection. Document and report assessment findings *to facilitate the development of an individualized care plan.*

Monitor nutritional status; *optimal nutritional status promotes wound healing and provides energy for recovery.*

Monitor bowel and bladder activity. Report urine retention and absent or decreased bowel sounds. *Abnormal bowel and bladder patterns slow surgical recovery.*

Monitor postoperative bleeding; monitor hemoglobin level and hematocrit. *Bleeding can lead to a low hemoglobin level and hematocrit, reducing the ability of red blood cells to carry oxygen, which can hinder wound healing and diminish patient's energy level.*

Perform: Preprocedure, teach patient use of incentive spirometer and encourage use. *Respiratory complications can lead to decreased oxygen levels, which can slow wound healing and delay mobility.*

If patient suffers from psychosis, continue to reorient during postoperative recovery period *to prevent delay in recovery and report psychological reaction (e.g., depression-like symptoms).*

Administer pain medication, as prescribed. *A patient in pain won't move, cough, and deep-breathe as needed for timely recovery.*

As appropriate, make sure that someone is available to walk with patient or assistive devices (walkers or canes) are available. Don't allow patient to ambulate alone until steady. *Assistance enhances safety and encourages patient to improve mobility without fear of falling. Mobility facilitates improved strength, helps prevent such complications as deep vein thrombosis, and, ultimately, enhances recovery.*

Enforce use of support stockings or a sequential compression device, *to facilitate venous return and prevent deep vein thrombosis.*

Inform: Educate patient and family regarding appropriate care after discharge *to promote compliance with medication and treatment regimens.*

Attend: Make sure patient and family members have access to community resources *to assist with recovery when patient returns home to ensure ongoing recovery.*

Manage: Initiate an interdisciplinary care conference for patient to *help develop a plan that will put the patient on a faster track to recovery*

Make sure patient and family members have access to community resources *to assist with recovery when patient returns home to ensure ongoing recovery.*

SUGGESTED NIC INTERVENTIONS

Embolus Precautions; Exercise Therapy: Ambulation; Medication Management; Pain Management; Self-Care Assistance; Vital Signs Monitoring

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Spruce, L. (2014). Back to basics: Implementing the surgical checklist. *AORN Journal*, *100*(5), 466–476. doi:10.1016/j.aorn.2014.06.020

DEFINITION

Abnormal functioning of the swallowing mechanism associated with deficits in oral, pharyngeal, or esophageal structure or function

DEFINING CHARACTERISTICS

- *First Stage: Oral*—abnormal oral phase of swallow study, chocking prior to swallowing, coughing prior to swallowing, drooling, food falls from mouth, food pushed out of mouth, gagging prior to swallowing, inability to clear oral cavity, incomplete lip closure, inefficient nippling, inefficient suck, insufficient chewing, nasal reflux, piecemeal deglutition, pooling of bolus in lateral sulci, premature entry of bolus, prolonged bolus formation, prolonged meal time with insufficient consumption, tongue action ineffective in forming bolus
- *Second Stage: Pharyngeal*—abnormal pharyngeal phase of swallow study, alteration in head position, chocking, coughing, delayed swallowing, fevers of unknown etiology, food refusal, gagging sensation, gurgly voice quality, inadequate laryngeal elevation, nasal reflux, recurrent pulmonary infection, repetitive swallowing
- *Third Stage: Esophageal*—abnormal esophageal phase of swallow study, acidic-smelling breath, bruxism, difficulty swallowing, epigastric pain, food refusal, heartburn, hematemesis, hyperextension of head, nighttime awakening, nighttime coughing, odynophagia, regurgitation, repetitive swallowing, reports "something stuck," unexplained irritability surrounding mealtimes, volume limiting, vomiting, vomitus on pillow

RELATED FACTORS

- *Congenital Defects:* Behavioral feeding problem, condition with significant hypotonia, congenital heart disease, failure to thrive, history of enteral feeding, mechanical obstruction, neuromuscular impairment, protein-energy malnutrition, respiratory condition, self-injurious behavior, upper airway abnormality
- *Neurological Problems:* Achalasia, acquired anatomic defects, brain injury (e.g., cerebrovascular impairment, neurologic illness, trauma, tumor), cerebral palsy, cranial nerve involvement, developmental delay, esophageal reflux disease, laryngeal abnormality, laryngeal defect, nasal defect, nasopharyngeal cavity defect, neurologic problems, oropharynx abnormality, prematurity, tracheal defect, trauma, upper airway anomaly

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Neurocognition
- Nutrition
- Respiratory function

EXPECTED OUTCOMES

- The patient will show no evidence of aspiration pneumonia.
- The patient will achieve adequate nutritional intake.
- The patient will maintain weight.
- The patient will maintain oral hygiene.
- The patient will demonstrate correct feeding techniques to maximize swallowing.
- The patient will list strategies to prevent aspiration.

SUGGESTED NOC OUTCOMES

Appetite; Aspiration Prevention; Cognition; Nutritional Status: Food & Fluid Intake; Swallowing Status; Swallowing Status: Esophageal Phase; Swallowing Status: Oral Phase; Swallowing Status: Pharyngeal Phase

INTERVENTIONS AND RATIONALES

Determine: Monitor intake and output and weight daily until stabilized. Establish an intake goal (specify), "Patient consumes ____ mL of fluid and ____ % of solid food." Record and report any deviation from this. *Evaluating calorie and protein intake daily allows any necessary modifications to begin quickly.*

Perform: Elevate head of the bed 90 degrees during mealtimes and for 30 minutes after the completion of a meal. Position patient on side when recumbent. *These measures decrease the risk of aspiration.*

Keep suction apparatus at the bedside to be prepared for episodes of aspiration that require immediate suctioning. Observe and report instances of cyanosis, dyspnea, or choking. *Symptoms indicate the presence of material in the lungs.*

Provide mouth care three times daily. Keep oral mucous membrane moist by frequent rinses; use a bulb syringe or suction, if necessary. *These measures promote comfort and enhance appetite.* Lubricate patient's lips *to prevent cracking and blisters.*

Inform: Teach patient and family about positioning, dietary requirements, and specific feeding techniques, *to allow patient to take an active role in maintaining health.* These include facial exercises (such as whistling) to promote muscle activity, using a short straw *to provide sensory stimulation to the lips*, tipping the head forward *to decrease aspiration*, applying pressure above the lip *to stimulate mouth closure and the swallowing reflex*, and checking the oral cavity frequently *to determine presence of food particles* (remove if present).

Attend: Encourage patient to wear properly fitted dentures *to enhance chewing ability.*

Serve food in attractive surroundings. Encourage patient to smell and look at food. Remove soiled equipment, control smells, and provide a

quiet atmosphere for eating. *A pleasant atmosphere stimulates appetite. Food aroma stimulates salivation.*

Manage: Consult with a dietitian to modify patient's diet, and conduct a calorie count, as needed, *to establish nutritional requirements.*

Consult with a dysphagia rehabilitation team, if available, *to obtain expert advice.*

SUGGESTED NIC INTERVENTIONS

Airway Suctioning; Aspiration Precautions; Feeding; Positioning; Referral; Risk Identification; Swallowing Therapy

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530 RISK FOR THERMAL INJURY

DEFINITION

Vulnerable to extreme temperature damage to skin and mucous membranes, which may compromise health

RISK FACTORS

- Alteration in cognitive functioning
- Extremes of age
- Extremes of environmental temperature
- Fatigue
- Inadequate protective clothing (e.g., flame-retardant sleepwear, gloves, ear covering)
- Inadequate supervision
- Inattentiveness
- Insufficient knowledge of safety precautions (patient, caregiver)
- Intoxication (alcohol, drugs)
- Neuromuscular impairment
- Neuropathy
- Smoking
- Treatment regimen
- Unsafe environment

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Risk management
- Knowledge
- Self-care
- Sensation/perception

EXPECTED OUTCOMES

- The patient will not experience thermal injury.
- The patient will acknowledge presence of environmental hazards in home.
- The patient will take safety precautions to prevent injury.

SUGGESTED NOC OUTCOMES

Risk Control; Risk Detection; Safe Home Environment; Knowledge: Personal Safety

INTERVENTIONS AND RATIONALES

Determine: Assess environment for potential risks for thermal injury *to prevent accidents.*

Assess patient for any cognitive impairment *that would increase risk for thermal injury.*

Assess knowledge of fire safety and emergency response *to ensure rapid notification of emergency personnel.*

Perform: Remove dangerous or potentially dangerous items from the environment *to avoid injury.*

Suggest a decrease in the maximum water temperature, *to decrease potential scalding.*

Ensure proper functioning of all fire/smoke alarms, *to provide quick intervention in case of fire.*

Inform: Encourage adults/family member to discuss fire safety measures with children and elderly family members *to promote household safety.*

Encourage use of flame-retardant sleepwear *to minimize injury in the event of a fire.*

Attend: Encourage patient/family to report any potential safety hazards, *to decrease chance of thermal accident.*

Manage: Refer patient/family to community resources for fire safety, *to ensure all possible precautions have been identified and implemented.*

Refer at-risk patients who are living alone to home health services *for follow-up home safety evaluation.*

SUGGESTED NIC INTERVENTIONS

Environmental Management: Safety; Fire Setting Precautions; Risk Identification; Surveillance: Safety

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DEFINITION

Temperature fluctuation between hypothermia and hyperthermia

DEFINING CHARACTERISTICS

- Cyanotic nail beds
- Fluctuations in body temperature above or below normal range
- Flushed skin
- Hypertension
- Increase in body temperature above normal range
- Increase in respiratory rate
- Mild shivering
- Moderate pallor
- Piloerection
- Reduction in body temperature below normal range
- Seizures
- Skin cool to touch
- Skin warm to touch
- Slow capillary refill
- Tachycardia

RELATED FACTORS

- Extremes of age
- Fluctuating environmental temperature
- Illness
- Trauma

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Fluid and electrolytes
- Neurocognition
- Physical regulation
- Respiratory function
- Tissue integrity

EXPECTED OUTCOMES

- The patient will maintain body temperature at normothermic levels.
- The patient will have no episodes of shivering.
- The patient will express feelings of comfort.
- The patient will exhibit skin that is warm and dry.
- The patient will maintain heart rate and blood pressure within normal range.
- The patient will show no signs of compromised neurologic status.
- The patient will voice an understanding of health problem.

SUGGESTED NOC OUTCOMES

Hydration; Thermoregulation; Vital Signs

INTERVENTIONS AND RATIONALES

Determine: Monitor patient's body temperature every 4 hours or more often, as indicated, *to determine effectiveness of therapy or if intervention is needed*. Record temperature and route *(baseline data depends on route)*.

Monitor and record patient's neurologic status every 8 hours. Report any changes to the physician. *Hyperthermia increases cerebral edema and thus intracranial pressure; hypothermia depresses metabolic rate.*

Monitor and record patient's heart rate and rhythm, blood pressure, and respiratory rate every 4 hours. *Hyperthermia may create hypoxia by increasing oxygen demand, which results from increased tissue metabolism (metabolism increases 7% with each increase of 1° F [0.6° C]). This, in turn, results in faster breathing and a rising pulse rate.*

Perform: Administer analgesics, antipyretics, and medications that prevent shivering, as indicated. Monitor and record their effectiveness. *Antipyretics help reduce fever. Shivering tends to retard the lowering of body temperature.*

If patient develops excessive fever, take the following steps:

- Reduce excessive fever.
- Remove blankets; place a loincloth over patient.
- Apply ice bags to the axilla and groin.
- Initiate a tepid water sponge bath.
- Use a hypothermia blanket if temperature rises above ____. Cool patient to ____.
- Maintain hydration.
- Monitor intake and output.
- Administer parenteral fluids, as ordered.
- Maintain the environmental temperature at a comfortable setting.
- Ensure that all metal and plastic surfaces that come into contact with patient's body are covered.
- Make sure that linens and clothing are clean and dry.

These measures aid in reducing core temperature.

Inform: Instruct patient and family members about the following:

- Signs and symptoms of altered body temperature
- Precautionary measures to avoid hypothermia or hyperthermia
- Adherence to other aspects of health care management to help normalize patient's temperature (such as dietary habits and measures to prevent increased intracranial pressure)
- Rationale for treatment

These measures allow patient to take an active role in health maintenance.

Attend: Acknowledge patient's fluid preference. Keep oral fluids at the bedside and encourage patient to drink. *These measures help maintain fluid balance and encourage patient to actively participate in the prescribed treatment.*

Manage: Make referral to community health agency, if needed, *to obtain adequate heating or cooling in home.*

SUGGESTED NIC INTERVENTIONS

Bathing; Environmental Management; Fever Treatment; Fluid Management; Fluid Monitoring; Temperature Regulation; Vital Signs Monitoring

REFERENCES

Gaither, J. B., Galson, S., Curry, M., Mhayamaguru, M., Williams, C., Keim, S. M., . . . Spaite, D. W. (2015). Environmental hyperthermia in prehospital patients with major traumatic brain injury. *Journal of Emergency Medicine*, *49*(3), 375–381. doi:10.1016/j.jemermed.2015.01.038

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DEFINITION

Damage to the mucous membrane, cornea, integumentary system, muscular fascia, muscle, tendon, bone, cartilage, joint capsule, and/or ligament

DEFINING CHARACTERISTICS

- Damaged tissue
- Destroyed tissue

RELATED FACTORS

- Alteration in metabolism
- Alteration in sensation
- Chemical injury agent (e.g., burn, capsaicin, methylene chloride, mustard agent)
- Excessive fluid volume
- Extremes of age
- Extremes of environmental temperature
- High voltage power supply
- Humidity
- Imbalanced nutritional state (e.g., obesity, malnutrition)
- Impaired circulation
- Impaired mobility
- Insufficient fluid volume
- Insufficient knowledge about maintaining tissue integrity
- Mechanical factor
- Peripheral neuropathy
- Pharmaceutical agent
- Radiation
- Surgical procedure

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Neurocognition
- Nutrition
- Tissue integrity

EXPECTED OUTCOMES

- The patient will experience relief from immediate signs and symptoms (pain, ulcers, color changes, and edema).
- The patient will maintain collateral circulation.
- The patient will voice intent to stop smoking.
- The patient will voice intent to follow specific management routines after discharge.

SUGGESTED NOC OUTCOMES

Knowledge: Treatment Regimen; Self-Care Hygiene; Tissue Integrity: Skin & Mucous Membranes; Tissue Perfusion: Peripheral; Wound Healing: Secondary Intention; Smoking Cessation Behavior

INTERVENTIONS AND RATIONALES

Determine: Monitor intake and output and record daily weight *to detect imbalances*. Maintain adequate hydration. *Adequate hydration reduces blood viscosity and decreases the risk of clot formation.*

Perform: Provide scrupulous foot care *to prevent fungal infections and ingrown toenails, stimulate circulation, and promote detection of signs and symptoms to decrease tissue perfusion.*

Administer and monitor treatments according to institutional protocols. Immediately report abnormal findings to the physician.

For patient with venous insufficiency, apply antiembolism stockings or intermittent pneumatic compression stockings, removing them for 1 hour every 8 hours or according to institutional protocol. Elevate patient's feet while sitting, and elevate foot of bed 69 to 89 degrees (15 to 20.5 cm) while lying down. *These measures promote venous return and decrease venous congestion in lower extremities.*

For patient with arterial insufficiency, elevate the head of the bed 69 to 89 degrees while patient is lying down, *to increase arterial blood supply to extremities.*

Inform: Instruct patient to avoid pressure on popliteal space. For example, say, "Don't cross your legs or wear constrictive clothing" *to avoid reducing arterial blood supply and increasing venous congestion.*

Educate patient about risk factors and prevention of injury. *Teaching about factors influencing peripheral vascular disease and prevention of tissue damage helps prevent complications.*

Attend: Encourage adherence to an exercise regimen, as tolerated. *Exercise improves arterial circulation and venous return by promoting muscle contraction and relaxation.*

Manage: Refer patient to a smoking cessation program. *Smoking constricts vessels and contributes to reduced circulation.*

SUGGESTED NIC INTERVENTIONS

Circulatory Care: Arterial Insufficiency; Circulatory Precautions; Nutrition Management; Oral Health Maintenance; Positioning; Pressure Management; Pressure Ulcer Prevention; Skin Surveillance; Teaching: Foot Care; Smoking Cessation Assistance

REFERENCE

da Silva, N. M., de Cássia Lopes Chaves, É., de Carvalho, E. C., & Iunes, D. H. (2013). Instrument for assessing tissue integrity of the feet of patients with diabetes mellitus. *Acta Paulista de Enfermagem*, *26*(6), 535–541.

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RISK FOR IMPAIRED TISSUE INTEGRITY

DEFINITION

Vulnerable to damage to the mucous membrane, cornea, integumentary system, muscular fascia, muscle, tendon, bone, cartilage, joint capsule, and/or ligament, which may compromise health

RISK FACTORS

- Alteration in metabolism
- Alteration in sensation
- Chemical injury agent (e.g., burn, capsaicin, methylene chloride, mustard agent)
- Excessive fluid volume
- Extremes of age
- Extremes of environmental temperature
- High voltage power supply
- Humidity
- Imbalanced nutritional state (e.g., obesity, malnutrition)
- Impaired circulation
- Impaired mobility
- Insufficient fluid volume
- Insufficient knowledge about maintaining tissue integrity
- Insufficient knowledge about protecting tissue integrity
- Mechanical factor
- Peripheral neuropathy
- Pharmaceutical agent
- Radiation therapy
- Surgical procedure

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Neurocognition
- Nutrition
- Tissue integrity

EXPECTED OUTCOMES

- The patient will maintain tissue integrity.
- The patient will maintain collateral circulation.
- The patient will describe measures to protect tissue.
- The patient will maintain adequate hydration.

SUGGESTED NOC OUTCOMES

Body Positioning: Self-Initiated; Circulation Status; Hydration; Mobility; Nutritional Status; Tissue Perfusion: Peripheral

INTERVENTIONS AND RATIONALES

Determine: Monitor intake and output and record daily weight *to detect* imbalances. Maintain adequate hydration. *Adequate hydration reduces blood viscosity and decreases the risk of clot formation.*

Inspect patient's skin every shift; document skin condition and report status changes. *Early detection of changes prevents or minimizes skin breakdown.*

Monitor placement of tubing and devices. *Correct placement and frequent inspection of devices prevents skin breakdown.*

Perform: Provide scrupulous foot care *to prevent fungal infections and ingrown toenails, stimulate circulation, and promote detection of signs and symptoms to decrease tissue perfusion.*

Administer and monitor treatments according to institutional protocols. Immediately report abnormal findings to the physician.

For patient with venous insufficiency, apply antiembolism stockings or intermittent pneumatic compression stockings, removing them for 1 hour every 8 hours or according to institutional protocol. Elevate patient's feet while sitting, and elevate foot of bed 69 to 89 degrees (15 to 20.5 cm) while lying down. *These measures promote venous return and decrease venous congestion in lower extremities.*

For patient with arterial insufficiency, elevate the head of the bed 69 to 89 degrees while patient is lying down, *to increase arterial blood supply to extremities.*

Inform: Instruct patient to avoid pressure on popliteal space. For example, say, "Don't cross your legs or wear constrictive clothing" *to avoid reducing arterial blood supply and increasing venous congestion.*

Educate patient about risk factors and prevention of injury. *Teaching about factors influencing peripheral vascular disease and prevention of tissue damage helps prevent complications.*

Attend: Encourage adherence to an exercise regimen, as tolerated. *Exercise improves arterial circulation and venous return by promoting muscle contraction and relaxation.*

Manage: Refer patient to a smoking cessation program. *Smoking constricts vessels and contributes to reduced circulation.*

SUGGESTED NIC INTERVENTIONS

Circulatory Care: Arterial Insufficiency; Circulatory Precautions; Electrolyte Monitoring; Fluid Monitoring; Nutrition Management; Positioning; Pressure Management; Positioning; Pressure Ulcer Prevention; Skin Surveillance

REFERENCES

da Silva, N. M., de Cássia Lopes Chaves, É., de Carvalho, E. C., & Iunes, D. H. (2013). Instrument for assessing tissue integrity of the feet of patients with diabetes mellitus. *Acta Paulista De Enfermagem*, *26*(6), 535–541.

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RISK FOR DECREASED CARDIAC TISSUE PERFUSION

DEFINITION

Vulnerable to a decrease in cardiac (coronary) circulation, which may compromise health

RISK FACTORS

- Cardiac tamponade
- Cardiovascular surgery
- Coronary artery spasm
- Diabetes mellitus
- Family history of cardiovascular disease
- Hyperlipidemia
- Hypertension
- Hypovolemia
- Hypoxemia
- Hypoxia
- Increase in C-reactive protein
- Insufficient knowledge about modifiable risk factors (e.g., smoking, sedentary lifestyle, obesity)
- Pharmaceutical agent
- Substance abuse

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Physical regulation

EXPECTED OUTCOMES

- The patient will remain hemodynamically stable.
- The patient will not experience any signs or symptoms of decreased cardiac tissue perfusion.
- The patient will verbalize modifiable risk factors for decreased cardiac perfusion.
- The patient will identify reportable symptoms of possible decreased cardiac perfusion.

SUGGESTED NOC OUTCOMES

Knowledge: Cardiac Disease Management, Cardiac Pump Effectiveness, Circulation Status; Tissue Perfusion: Cardiac; Vital Signs

INTERVENTIONS AND RATIONALES

Determine: Assess hemodynamic status, including blood pressure, heart rate, oxygen saturation, and respiratory rate for any abnormalities *that may be early indicators of altered perfusion.*

Monitor cardiac rhythm for any irregularities *that may indicate cardiac irritability.*

Perform: Assist with the preparation and completion of diagnostic tests and the postprocedural patient care. *Safe completion of diagnostic test will result in improved patient outcomes.*

Treat episodes of tachycardia promptly. *Cardiac tissue is perfused during diastole, and perfusion time is decreased if tachycardia is not treated.*

Inform: Provide patient with information regarding modifiable risk factors and interventions to minimize risks. *Knowledge of risk factors will contribute to informed decisions about lifestyle changes.*

Attend: Encourage patient and family to share concerns regarding outcomes of tests, *to reduce anxiety.*

Manage: Collaborate with other members of health care team to ensure that all underlying medical conditions are being managed effectively. *This will minimize the possibility of cardiac perfusion complications.*

SUGGESTED NIC INTERVENTIONS

Risk Identification; Teaching: Disease Process; Cardiac Care; Hemodynamic Regulation; Vital Signs Monitoring

REFERENCES

Duruturk, N., Tonga, E., Karatas, M., & Doganozu, E. (2015). Activity performance problems of patients with cardiac diseases and their impact on quality of life. *Journal of Physical Therapy Science*, *27*(7), 2023–2028.

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RISK FOR INEFFECTIVE CEREBRAL TISSUE PERFUSION

DEFINITION

Vulnerable to a decrease in cerebral circulation, which may compromise health

RISK FACTORS

- Abnormal partial thromboplastin time (PTT)
- Abnormal prothrombin time (PT)
- Akinetic left ventricular wall segment
- Aortic atherosclerosis
- Arterial dissection
- Atrial fibrillation
- Atrial myxoma
- Brain injury (e.g., cerebrovascular impairment, neurologic illness, trauma, tumor)
- Brain neoplasm
- Carotid stenosis
- Cerebral aneurysm
- Coagulopathy (e.g., sickle cell anemia)
- Dilated cardiomyopathy
- Disseminated intravascular coagulopathy
- Embolism
- Hypercholesterolemia
- Hypertension
- Infective endocarditis
- Mechanical prosthetic valve
- Mitral stenosis
- Pharmaceutical agent
- Recent myocardial infarction
- Sick sinus syndrome
- Substance abuse
- Treatment regimen

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Neurocognition
- Sensation/perception

EXPECTED OUTCOMES

- The patient will understand the need for frequent neurologic assessments to assess for any changes.
- The patient will experience adequate cerebral perfusion evidenced by normal neurologic checks.
- The patient will remain hemodynamically stable.
- The patient will participate in diagnostic testing when necessary.

- The patient will verbalize strategies to minimize or decrease modifiable risk factors.

SUGGESTED NOC OUTCOMES

Tissue Perfusion: Cerebral; Neurological Status; Circulation Status; Knowledge: Illness Care; Knowledge: Treatment Procedure

INTERVENTIONS AND RATIONALES

Determine: Assess patient for positive risk factors for decrease in cerebral perfusion, including carotid stenosis, hypertension, coagulopathies, atrial fibrillation, and smoking. *Risk factor reduction will result in positive patient outcomes.*

Perform: Facilitate completion of diagnostic tests and provide postprocedure care to prevent complications, *to ensure accurate safe and timely diagnosis and treatment.*

Maintain adequate oxygenation *to ensure cerebral perfusion.*

Inform: Educate at-risk patients of the signs of decreased cerebral perfusion about the importance of timely medical intervention for positive symptoms. *Change in mental status is a sensitive indicator for decreased cerebral perfusion.*

Educate patients about need for prompt intervention if signs of stroke have occurred. *Early intervention can prevent or minimize stroke severity.*

Attend: Encourage at-risk patient and family to ask questions and share concerns, *to increase their confidence and ability to recognize and respond to warning signs of decreased cerebral perfusion.*

Manage: Collaborate with community organizations to educate public on risk factors for and symptoms of decreased cerebral perfusion and the appropriate response. *Increased community awareness may result in a more timely intervention for decreased cerebral perfusion conditions.*

SUGGESTED NIC INTERVENTIONS

Cerebral Perfusion Promotion; Neurologic Monitoring

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DEFINITION

Decrease in blood circulation to the periphery that may compromise health

DEFINING CHARACTERISTICS

- Absence of peripheral pulses
- Alteration in motor functioning
- Alteration in skin characteristic (e.g., color, elasticity, hair, moisture, nails, sensation, temperature)
- Ankle-brachial index <0.90
- Capillary refill time >3 seconds
- Color does not return to lowered limb after 1-minute leg elevation
- Decrease in blood pressure in extremities
- Decrease in pain-free distances achieved in the 6-minute walk test
- Decrease in peripheral pulses
- Delay in peripheral wound healing
- Distance in the 6-minute walk test below normal range (400 to 700 m in adults)
- Edema
- Extremity pain
- Femoral bruit
- Intermittent claudication
- Paresthesia
- Skin color pales with limb elevation

RELATED FACTORS

- Diabetes mellitus
- Hypertension
- Insufficient knowledge of aggravating factors (e.g., smoking, sedentary lifestyle, trauma, obesity, salt intake, immobility)
- Insufficient knowledge of disease process
- Sedentary lifestyle
- Smoking

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Comfort
- Self-care
- Cardiac function
- Physical regulation
- Sensation/perception
- Tissue integrity

EXPECTED OUTCOMES

- The patient will understand the need to maintain moderate activity level to promote circulation.
- The patient will articulate the need and rationale for smoking cessation.
- The patient will not experience ischemic damage to involved extremity.
- The patient will experience adequate perfusion to promote prompt wound healing.
- The patient will acknowledge the importance of protecting involved extremity from injury.
- The patient will recognize reportable changes in skin characteristics to the involved extremity that indicate decreased perfusion.

SUGGESTED NOC OUTCOMES

Activity Tolerance; Tissue Integrity: Skin and Mucous Membranes; Tissue Perfusion: Peripheral; Smoking Cessation Behavior

INTERVENTIONS AND RATIONALES

Determine: Evaluate involved extremity for clinical signs (pain, decreased temperature, pallor, delayed capillary refill, weak or absent pulse, decreased sensation, and decreased pulse oximetry) *that are indicators of ineffective peripheral perfusion.*

Perform: Protect the extremity from injury using sheepskin or bed cradle and position extremity at or lower than level of heart *to promote collateral blood flow.*

Inform: Instruct patient to increase walking activity *to promote collateral circulation and improve blood supply to extremity.*

Teach patient to avoid crossing legs or keeping legs in a dependent position, *to avoid constriction of veins.*

Attend: Encourage patient to protect extremity from injury or extreme hot or cold temperatures. *Infection or ulcer formation may develop more easily because of decreased blood supply.*

Manage: Refer patients who smoke to smoking cessation program, *because continued smoking will significantly increase risks for further damage.*

SUGGESTED NIC INTERVENTIONS

Circulatory Care: Arterial Insufficiency, Exercise Promotion, Positioning, Skin Surveillance; Smoking Cessation Assistance

REFERENCES

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548 RISK FOR INEFFECTIVE PERIPHERAL TISSUE PERFUSION

DEFINITION

Vulnerable to a decrease in blood circulation to periphery, which may compromise health

RISK FACTORS

- Diabetes mellitus
- Endovascular procedure
- Excessive sodium intake
- Hypertension
- Insufficient knowledge of aggravating factors (e.g., smoking, sedentary lifestyle, trauma, obesity, salt intake, immobility)
- Insufficient knowledge of disease process
- Insufficient knowledge of risk factors
- Sedentary lifestyle
- Smoking
- Trauma

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Risk management
- Knowledge
- Self-care
- Sensation/perception

EXPECTED OUTCOMES

- The patient will remain free of tissue injury due to decreased peripheral perfusion.
- The patient will understand the need for smoking cessation.
- The patient will state reportable changes that indicate decreased peripheral perfusion.
- The patient will understand the need for moderate activity to promote circulation.

SUGGESTED NOC OUTCOMES

Activity Tolerance; Tissue Integrity: Skin and Mucous Membranes; Tissue Perfusion: Peripheral; Smoking Cessation Behavior

INTERVENTIONS AND RATIONALES

Determine: Assess lower extremities for early signs of ineffective peripheral perfusion. *Early identification and intervention will improve patient outcomes.*

Assess patient's history for presence of heart disease, hyperlipidemia, diabetes, and smoking, *which are significant risk factors for impaired peripheral tissue perfusion.*

Evaluate patient's understanding of lifestyle modifications *to enable patient participation in risk factor reduction.*

Perform: Administer and evaluate effectiveness of medications to treat underlying medical conditions that place patient at risk for decreased peripheral perfusion. C*ontrol of risk factors will prevent or delay onset of tissue hypoperfusion.*

Position extremity at or lower than level of the heart *to promote peripheral perfusion.*

Inform: Instruct patient to initiate a regular walking program *to promote collateral circulation and improve perfusion.*

Teach patient to avoid crossing of the legs *to avoid constriction.*

Attend: Encourage patient to carefully follow treatment regimens for existing medical conditions *that are risk factors for decreased peripheral tissue perfusion.*

Manage: Refer patients who smoke to smoking cessation program, *because continued smoking will significantly increase risks for development of peripheral tissue damage.*

SUGGESTED NIC INTERVENTIONS

Circulatory Care: Arterial Insufficiency, Exercise Promotion, Positioning, Skin Surveillance; Smoking Cessation Assistance

REFERENCES

Ait-Oufella, H., Bige, N., Boelle, P. Y., Pichereau, C., Alves, M., Bertinchamp, R., . . . Guidet, B. (2014). Capillary refill time exploration during septic shock. *Intensive Care Medicine*, *40*(7), 958–964. doi:10.1007/s00134-014-3326-4

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550 IMPAIRED TRANSFER ABILITY

DEFINITION

Limitation of independent movement between two nearby surfaces

DEFINING CHARACTERISTICS

- Impaired ability to transfer between bed and chair
- Impaired ability to transfer between bed and standing position
- Impaired ability to transfer between car and chair
- Impaired ability to transfer between chair and floor
- Impaired ability to transfer between chair and standing position
- Impaired ability to transfer between floor and standing position
- Impaired ability to transfer between uneven levels
- Impaired ability to transfer in or out of bath tub
- Impaired ability to transfer in or out of shower
- Impaired ability to transfer on or off a commode
- Impaired ability to transfer on or off a toilet

RELATED FACTORS

- Alteration in cognitive functioning
- Environmental barrier (e.g., bed height, inadequate space, wheelchair type, treatment equipment, restraints)
- Impaired balance
- Impaired vision
- Insufficient knowledge of transfer techniques
- Insufficient muscle strength
- Musculoskeletal impairment
- Neuromuscular impairment
- Obesity
- Pain
- Physical deconditioning

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Knowledge
- Physical regulation
- Pharmacologic function

EXPECTED OUTCOMES

- The patient will have no evidence of complications associated with impaired transfer mobility, such as depression, altered health maintenance, and falls.
- The patient will maintain or improve muscle strength and joint range of motion (ROM).
- The patient will achieve the highest level of mobility possible (independence with regard to need for assistive device, verbalization of needs regarding transfer).

- The patient will maintain safety during transfer.
- The patient will adapt to alteration in ability to perform transfer.
- The patient will demonstrate understanding of transfer techniques.
- The patient will participate in social and occupational activities to the greatest extent possible.

SUGGESTED NOC OUTCOMES

Balance; Body Positioning: Self-Initiated; Joint Movement: Hip, Knee, Spine; Knowledge: Body Mechanics; Mobility; Transfer Performance; Coordinated Movement

INTERVENTIONS AND RATIONALES

Determine: Identify patient's level of independence using the functional mobility scale. Report findings to the staff *to provide continuity and preserve the documented level of independence.*

Monitor and record daily evidence of complications related to altered mobility or decreased ability to perform transfer with assistive device (contractures, venous stasis, skin breakdown, thrombus formation, depression, altered health maintenance, or self-care deficit). *Patients with neuromuscular dysfunction are at risk for complications.*

Assess patient's skin upon return to bed. If patient is using a wheelchair, request a seat cushion, if necessary, *to maintain skin integrity.*

Perform: Perform ROM exercises to the joints of affected limbs, unless contraindicated, at least once per shift. Progress from passive to active ROM, as tolerated, *to prevent joint contractures and muscle atrophy.*

Inform: Teach patient transfer techniques, such as performing a standing or sitting transfer, *to maintain muscle tone, prevent complications of immobility, and promote independence.*

Adapt teaching to the limits imposed by patient's condition *to prevent injury.* As part of teaching plan, demonstrate transfer techniques to family members *to ensure that necessary adaptations are made by family.* Have patient's family perform a return demonstration, *to ensure the use of proper technique and to promote continuity of care.*

Attend: Encourage patient to attend physical therapy. Request a written copy of instructions for assistive device to use as a reference *to maintain continuity of care and foster safety.*

Manage: Refer patient to a physical therapist for the development of a mobility program related to assistive device, *to assist with rehabilitation of musculoskeletal deficits.*

Identify resources (stroke program, sports association for disabled, National Multiple Sclerosis Society) *to promote patient's reintegration into the community.*

SUGGESTED NIC INTERVENTIONS

Body Mechanics Promotion; Energy Management; Exercise Promotion: Strength Training; Exercise Therapy: Balance; Fall Prevention; Self-Care Assistance: Transfer; Health System Guidance

REFERENCES

Kent-Braun, J. A., Callahan, D. M., Fay, J. L., Foulis, S. A., & Buonaccorsi, J. P. (2014). Muscle weakness, fatigue, and torque variability: Effects of age and mobility status. *Muscle & Nerve*, *49*(2), 209–217. doi:10.1002/mus.23903

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DEFINITION

Vulnerable to accidental tissue injury (e.g., wound, burn, fracture), which may compromise health

RISK FACTORS

External

- Absence of call-for-aid device
- Absence of stairway gate
- Absence of window guard
- Access to weapon
- Bathing in very hot water
- Bed in high position
- Children riding in front seat of car
- Defective appliance
- Delay in ignition of gas appliance
- Dysfunctional call-for-aid device
- Electrical hazard (e.g., faulty plug, frayed wire, overloaded outlet/fuse box)
- Exposure to corrosive product
- Exposure to dangerous machinery
- Exposure to radiation
- Exposure to toxic chemical
- Extremes of environmental temperature
- Flammable object (e.g., clothing, toys)
- Gas leak
- Grease on stove
- High-crime neighborhood
- Icicles hanging from roof
- Inadequate stair rails
- Inadequately stored combustible (e.g., matches, oily rags)
- Inadequately stored corrosive (e.g., lye)
- Insufficient protection from heat source
- Misuse of headgear (e.g., hard hat, motorcycle helmet)
- Misuse of seat restraint
- Insufficient antislip material in bathroom
- Nonuse of seat restraints
- Obstructed passage way
- Playing with dangerous object
- Playing with explosive
- Pot handle facing front of stove
- Proximity to vehicle pathway (e.g., driveway, railroad track)
- Slippery floor
- Smoking in bed
- Smoking near oxygen

- Struggling with restraints
- Unanchored electric wires
- Unsafe operation of heavy equipment (e.g., excessive speed, while intoxicated, without required eyewear)
- Unsafe road
- Unsafe walkway
- Use of cracked dishware
- Use of throw rugs
- Use of unstable chair
- Use of unstable ladder
- Wearing loose clothing around open flames

Internal

- Alteration in cognitive functioning
- Alteration in sensation (resulting from spinal cord injury, diabetes mellitus, etc.)
- Decrease in eye–hand coordination
- Decrease in muscle coordination
- Economically disadvantaged
- Emotional disturbances
- History of trauma (e.g., physical, psychological, sexual)
- Impaired balance
- Insufficient knowledge of safety precautions
- Insufficient vision
- Weakness

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Behavior
- Coping
- Emotional
- Knowledge
- Risk management

EXPECTED OUTCOMES

- The patient will avoid injury.
- The patient will voice need for understanding safety precautions.
- The patient will demonstrate correct use of safety devices (i.e., walker or cane).

SUGGESTED NOC OUTCOMES

Falls Occurrence; Personal Safety Behavior; Physical Injury Severity; Risk Control; Safe Home Environment; Tissue Integrity: Skin & Mucous Membranes

INTERVENTIONS AND RATIONALES

Determine: Observe, record, and report falls, seizures, and unsafe practices. *Accurate assessment promotes appropriate interventions; documentation ensures continuity of care.*

Monitor and record patient's respiratory status. *Trauma increases respiratory rate; other respiratory effects depend on the nature of the trauma.*

Monitor and record patient's neurologic status *to detect changes and to report deteriorated status.*

Perform: If patient has a seizure, remain with the patient, loosen restrictive clothing, and protect the patient from environmental hazards. Don't restrain patient or pry the patient's mouth open. Keep an oral airway at the bedside and maintain a patent airway. Turn patient to side after the seizure stops, and suction if secretions occlude the airway. Record seizure characteristics, including onset, duration, and body movements. Reorient patient to surroundings and allow a rest period. *Remaining with patient provides safety and information for accurate documentation of the event. Loosening clothing and proper positioning may prevent further harm.*

Keep bedrails raised, *to ensure safety.* Maintain position of the bed as low as possible *to prevent the patient from falling and sustaining further injury.* Help debilitated, weak, or unsteady patient to get out of bed. Ensure that the floor is dry and that furniture and litter don't block patient's way, *to help prevent falls.*

Inform: Instruct patient and family members on safety practices such as correct use of a walker, crutches, or cane. *These enable patient and family members to take an active role in health care and maintain a safe environment.*

Provide patient and family with information about necessary safety precautions, *to enable them to take an active role in health care and maintain a safe environment.*

Instruct patient on the use of assistive devices *to ensure their proper use and provide the patient with a feeling of security.*

Attend: Encourage patient and family to express feelings and concerns related to trauma. *Discussing feelings can be therapeutic. Active listening conveys respect for the patient.*

Facilitate opportunities for spiritual nourishment and growth *to address patient's holistic needs for maximal therapeutic environment.*

Schedule time to meet with family and patient to listen to ways in which they plan to enhance their coping skills in the present situation.

Manage: Refer family to community resources and support groups available *to assist in managing patient's illness and providing emotional and financial assistance to caregivers.*

SUGGESTED NIC INTERVENTIONS

Environmental Management: Safety; Fall Prevention; Health Education; Pressure Ulcer Prevention; Seizure Precautions; Surveillance: Safety; Teaching: Disease Process

REFERENCES

Cordovilla-Guardia, S., Guerrero-López, F., Maldonado, A., Vilar-López, R., Salmerón, J., Romero, I., . . . Fernández-Modéjar, E. (2014). Trauma risk perception related to alcohol, cannabis, and cocaine intake. *European Journal of Trauma & Emergency Surgery*, *40*(6), 693–699. doi:10.1007/s00068-014-0384-9

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DEFINITION

Vulnerable to damage to vein and its surrounding tissues related to the presence of a catheter and/or infused solutions, which may compromise health

RISK FACTORS

- Difficulty visualizing artery or vein
- Inadequate anchoring of catheter
- Inappropriate catheter type
- Inappropriate catheter width
- Insertion site
- Irritating solution (e.g., concentration, temperature, pH)
- Length of time catheter is in place
- Rapid infusion rate

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Fluid and electrolytes
- Tissue integrity

EXPECTED OUTCOMES

- The patient will not experience vascular trauma as a result of catheter or infused solution.
- The patient will communicate reportable signs and symptoms indicating possible catheter- or infusion-related problems.
- The patient will maintain recommended position of extremity during treatment.

SUGGESTED NOC OUTCOMES

Tissue Integrity: Skin & Mucous Membranes; Comfort Status: Physical; Knowledge: Treatment Procedure

INTERVENTIONS AND RATIONALES

Determine: Assess patient for pain at insertion site. *Pain is often the first symptom of vascular trauma.*

Perform: Use transparent dressing over the insertion site. *This will secure the catheter and facilitate frequent assessment of the insertion site.*

Perform prescribed insertion site checks and progress of the infusion *to ensure early identification of problems and timely interventions to avoid vascular trauma.*

Inform: Educate patient about the purpose of the infusion and reportable symptoms indicative of trauma, for example, burning, swelling, warmth. *Prompt termination of the infusion and the catheter will minimize damage to the tissue.*

Attend: Support the patient throughout intravenous therapy *to decrease anxiety and promote positive patient outcomes.*

Manage: Collaborate with experienced team members in the management of complex intravenous therapy *to ensure that all possible steps are taken to minimize complications.*

SUGGESTED NIC INTERVENTIONS

Intravenous (IV) Therapy; Medication Administration: Intravenous (IV); Skin Surveillance; Teaching: Procedure/Treatment

REFERENCES

Higgins, N., Keogh, S., & Rickard, C. (2015). Evaluation of a pilot educational program on safe and effective insertion and management of peripheral intravenous catheters. *Journal of the Association for Vascular Access*, *20*(1), 37–42. doi:10.1016/j.java.2014.12.001

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Weir, G. R., Smart, H., van Marie, J., & Cronje, F. J. (2014). Arterial disease ulcers, part 1: Clinical diagnosis and investigation. *Advances in Skin & Wound Care*, *27*(9), 422–430. doi:10.1097/01.ASW.0000453095.19109.5c

DEFINITION

Impairment in sensory and motor response, mental representation, and spatial attention of the body, and the corresponding environment, characterized by inattention to one side and overattention to the opposite side. Left-side neglect is more severe and persistent than right side neglect

DEFINING CHARACTERISTICS

- Alteration in safety behavior on neglected side
- Disturbance of sound lateralization
- Failure to dress neglected side
- Failure to eat food from portion of plate on neglected side
- Failure to groom neglected side
- Failure to move eyes in the neglected hemisphere
- Failure to move head in the neglected hemisphere
- Failure to move limbs in the neglected hemisphere
- Failure to move trunk in the neglected hemisphere
- Failure to notice people approaching from the neglected side
- Hemianopsia
- Impaired performance on line cancellation, line bisection, and target cancellation tests
- Left hemiplegia from cerebrovascular accident
- Marked deviation of the eyes to stimuli on the non-neglected side
- Marked deviation of the trunk to stimuli on the non-neglected side
- Omission of drawing on the neglected side
- Perseveration
- Representational neglect (e.g., distortion of drawing on the neglected side)
- Substitution of letters to form alternative words when reading
- Transfer of pain sensation to the non-neglected limb
- Unaware of positioning of neglected limb
- Unilateral visuospatial neglect
- Use of vertical half of page only when writing

RELATED FACTORS

- Brain injury (e.g., cerebrovascular impairment, neurological illness, trauma, tumor)

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Coping
- Neurocognition
- Self-care
- Sensation/perception
- Tissue integrity

EXPECTED OUTCOMES

- The patient/family will avoid injury, skin breakdown, and contractures on affected body part.
- The patient/family will recognize the neglected body part.
- The patient/family will demonstrate exercises for the affected body part.
- The patient/family will demonstrate measures for maximum functioning and arrange environment to protect the affected body part.
- The patient/family will express feelings about altered state of health and neurologic deficits.
- The patient/family will identify community resources and support groups to help cope with the effects of illness.

SUGGESTED NOC OUTCOMES

Adaptation to Physical Disability; Body Image; Body Mechanics Performance; Body Positioning: Self-Initiated; Self-Care: Activities of Daily Living (ADLs); Heedfulness of Affected Side

INTERVENTIONS AND RATIONALES

Determine: Observe the position of the affected body part frequently *to prevent injury.*

Perform: Place a sling on the affected arm *to prevent dangling or injury.*

Support affected leg and foot and perform other measures, as appropriate, *to keep patient's limbs in functional position and avoid contractures.* Use a drawsheet to move patient up in bed *to avoid skin abrasions.*

Touch and rub the affected limb, and describe the limb in conversation with patient. *This reminds the patient of the neglected body part.*

Use safety belts or protective devices *to remind patient of limitations and prevent falls.* Use devices according to facility policy.

Remove splints and other devices at least every 2 hours. Inspect the skin for pressure areas. Reapply the splint. *Proper use of splints and other devices prevents deformities and maintains skin integrity.*

Perform range of motion (ROM) exercises on the affected side at least once every shift, unless medically contraindicated, *to maintain joint flexibility and prevent contractures.* Establish and follow a regular turning schedule *to maintain skin integrity.*

Arrange environment for maximum functioning; for example, place water, television controls, and the call bell within reach. *These measures enhance orientation and encourage independence.*

Assist patient with ADLs or provide supervision, as appropriate, *to protect patient's affected side.*

Inform: Encourage patient to perform activities that require use of the affected limb *to more easily integrate paretic or paralyzed limb into body image.*

Instruct family and nursing personnel to observe the position of the affected body part frequently; to remove food or drainage from the face if

unnoticed by patient; and to place the arm or leg in the proper position as often as necessary. *These measures help avoid injury and maintain dignity.*
Attend: Encourage patient to check the position of the affected body part with each repositioning or transfer *to reestablish awareness of the body part.*

Encourage patient and family members to express their feelings regarding patient's condition and level of functioning *to release tension and enhance coping.*
Manage: Request consultations with occupational and physical therapists about adaptive equipment and exercise programs *to promote use of the affected limb.*

Refer patient and family members to appropriate support groups and other community resources *to assist in adjusting to patient's altered state of health.*

SUGGESTED NIC INTERVENTIONS

Anticipatory Guidance; Body Image Enhancement; Coping Enhancement; Exercise Therapy: Joint Mobility; Mutual Goal-Setting; Self-Care Assistance; Unilateral Neglect Management

REFERENCES

Chin-Ying, D., & Li-Chan, L. (2015). Nursing care of unilateral neglect patients. *Journal of Nursing*, *62*(1), 92–97. doi:10.6224/JN.62.1.92

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DEFINITION

Dysfunction in urine elimination

DEFINING CHARACTERISTICS

- Dysuria
- Frequent voiding
- Hesitancy
- Nocturia
- Urinary incontinence
- Urinary retention
- Urinary urgency

RELATED FACTORS

- Anatomical obstruction
- Multiple causality
- Sensory motor impairment
- Urinary tract infection

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Elimination
- Fluid and electrolytes
- Nutrition
- Reproduction

EXPECTED OUTCOMES

- The patient will maintain fluid balance; intake will equal output.
- The patient will voice increased comfort.
- The patient will voice understanding of treatment.
- The patient will have few, if any, complications.
- The patient will discuss impact of urologic disorder on self and family members.
- The patient will demonstrate skill in managing urinary elimination problem.
- The patient will maintain urinary continence.

SUGGESTED NOC OUTCOMES

Urinary Continence; Urinary Elimination

INTERVENTIONS AND RATIONALES

Determine: Observe patient's voiding pattern. Document intake and output, urine color and characteristics, and patient's daily weight. Report any changes. *Accurate intake and output measurements are essential for correct fluid replacement therapy. Urine characteristics help verify diagnosis.*

Observe bowel habits; check for constipation; check for fecal impaction; if present, disimpact and institute a bowel regimen. *These measures*

promote comfort and prevent loss of rectal muscle tone from prolonged distension.

Perform: Administer appropriate care for the urologic condition and monitor progress (e.g., strain urine). Report favorable and adverse responses to the treatment regimen. *Appropriate care helps patient recover from the underlying disorder. Reporting responses to treatment allows modification of the treatment, as needed.*

If patient requires surgery, give appropriate preoperative and postoperative instructions and care. *Accurate information allows patient to understand the procedure and builds trust in caregivers.*

Provide supportive measures, as indicated.

- Administer pain medication and monitor patient, *to reduce pain and assess the effects of medication.*
- Encourage fluids, as ordered, *to moisten mucous membranes and dilute chemical materials within the body.*
- Assist with general hygiene and comfort measures, as needed. *Cleanliness prevents bacterial growth and promotes comfort.*
- Maintain patency of catheters, drainage bags, and other urinary elimination equipment *to avoid reflux and risk of infection and ensure the effectiveness of therapy.*
- Provide mental care according to facility policy *to promote cleanliness and comfort and reduce the risk of infection.*

Inform: Explain reasons for therapy and intended effects to patient and family members *to increase patient's understanding and build trust in caregivers.*

If patient needs urinary diversion, prepare the patient for a change in body appearance (instruct patient and family members how to care for the ostomy site postoperatively). *Preparation and appropriate information help patient and family members cope with changes.*

Explain the urologic condition to patient and family members, including instructions on preventive measures, if appropriate. Prepare for discharge according to individual needs. *Accurate health knowledge increases patient's ability to maintain health. Involving family members assures patient that he or she will be cared for.*

Assist with bladder elimination procedure, as indicated.

- For bladder training, place patient on the commode or toilet every 2 hours while awake and once during the night. Maintain regular fluid intake while patient is awake. Provide privacy. Teach patient how to perform Kegel exercises to strengthen sphincter control. *These measures aid adaptation to routine physiologic function. Women with good muscle tone can improve levator muscle action significantly if they perform Kegel exercises regularly.*
- For intermittent catheterization, catheterize patient using clean or sterile technique every 2 hours. Record amount voided spontaneously and

amount obtained with catheterization (e.g., 7 a.m., spontaneous void of 200 mL; catheter void of 150 mL). Record bladder balance daily. *These measures promote normal voiding, prevent infection, and help maintain integrity of ureterovesical function. Catheterization schedule is based on flow sheet data and can provide a baseline chart.*

- Bladder balance for amount of residual urine/amount of voided urine.
- For external catheterization (in a male patient), monitor patency. Apply a condom catheter according to the established policy. *Applying a foam strip in a spiral fashion increases the adhesive surface and reduces the risk of impairing circulation.* Avoid constriction. Observe the skin condition of the penis, and clean with soap and water at least twice daily. *These measures prevent infection and ensure therapeutic effectiveness.*
- For an indwelling urinary catheter, monitor patency. Keep the tubing free from kinks and keep the drainage bag below the level of the bladder *to avoid urine reflux*. Clean the urinary meatus according to the established policy, and maintain a closed drainage system *to prevent skin irritation and bacteriuria*. Secure the catheter to patient's leg (female) or abdomen (male); avoid tension on the sphincter. *Anchoring the catheter avoids straining the trigone muscle of the bladder and prevents friction leading to inflammation.*
- For a suprapubic catheter, monitor patency. Change the dressing and clean the catheter site according to policy. Keep the tubing free from kinks; keep the drainage bag below bladder level. Maintain a closed drainage system. *Suprapubic drainage allows increased patient mobility and reduces the risk of bladder infection.*

Attend: Encourage patient to ventilate feelings and concerns related to patient's urologic problem. *Active listening conveys respect for patient; ventilation helps pinpoint patient's fears.*

Manage: Refer patient to a dietitian for instructions on diet. *Dietary changes may decrease urinary infections.*

Refer patient and family members to a psychiatric liaison nurse, sex counselor, or support group, when appropriate. *These resources help patient gain knowledge of self and the situation, reduce anxiety, and promote personal growth. Community resources usually provide support and care not available in other health care agencies.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Fluid Management; Urinary Elimination Management; Urinary Retention Care; Weight Management; Urinary Bladder Training; Urinary Catheterization

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Patel, J. A., Kaufman, A. S., Howard, R. S., Rodriguez, C. J., & Jessie, E. M. (2015). Risk factors for urinary retention after laparoscopic inguinal hernia repairs. *Surgical Endoscopy*, *29*(11), 3140–3145. doi:10.1007/s00464-014-4039-z

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DEFINITION

Incomplete emptying of the bladder

DEFINING CHARACTERISTICS

- Absent urinary output
- Bladder distension
- Dribbling of urine
- Dysuria
- Frequent voiding
- Overflow incontinence
- Residual urine
- Sensation of bladder fullness
- Small voiding

RELATED FACTORS

- Blockage in urinary tract
- High urethral pressure
- Reflex arc inhibition
- Strong sphincter

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Coping
- Elimination
- Fluid and electrolytes
- Nutrition
- Reproduction

EXPECTED OUTCOMES

- The patient will maintain fluid balance, with intake equal to output.
- The patient will voice increased comfort with few or no complications.
- The patient will voice understanding of treatment and demonstrate skill in managing urine retention.
- The patient will have urinalysis within normal limits.
- The patient will avoid bladder distension.
- The patient will discuss impact of urologic disorder on self and family members.
- The patient will identify resources to assist with care following discharge.

SUGGESTED NOC OUTCOMES

Urinary Continence; Urinary Elimination; Knowledge: Treatment Regimen; Symptom Control; Fluid Balance

INTERVENTIONS AND RATIONALES

Determine: Monitor intake and output and report if intake exceeds output *to promote adequate fluid replacement therapy.*

Monitor voiding pattern. Record data on time, place, amount, and patient's awareness of micturition *to establish a pattern of incontinence.*

Monitor therapeutic and adverse effects of prescribed medications *for early recognition and treatment of drug reactions.*

Perform: Assist with ordered bladder elimination procedure as follows:

- Voiding techniques. Perform Credé's or Valsalva's maneuver every 2 to 3 hours to increase bladder pressure to pass urine. Repeat until empty.
- Intermittent catheterization. Catheterize using clean or sterile technique every 2 hours. Record the amount voided spontaneously and the amount obtained with catheterization.

These measures promote normal voiding, prevent infection, and help maintain the integrity of ureterovesical function.

Perform catheter care according to established policy, and maintain a closed drainage system to prevent skin irritation and bacteriuria. Secure the catheter to patient's leg (female) or abdomen (male), avoiding tension on the sphincter. *Anchoring the catheter prevents straining of the bladder's trigone muscle and prevents friction leading to inflammation.*

Use an indwelling urinary catheter or suprapubic catheter. Monitor patency and avoid kinks in tubing. Keep the drainage bag below bladder level to avoid urine reflux. Change dressings according to facility policy. Maintain closed drainage system.

Administer pain medication, as ordered, and monitor patient, *to reduce pain and assess the medication's effects.*

For fecal impaction, disimpact and institute a bowel regimen *to promote comfort and prevent the loss of rectal muscle tone from prolonged distension.*

If patient requires surgery, give appropriate preoperative and postoperative instructions and care *to increase patient's understanding.* If patient undergoes urinary diversions, prepare the patient for a change in body image. *Preparation and appropriate information help patient and family members cope with changes.*

Inform: Instruct patient and family members on voiding techniques to be used at home. Provide for return demonstrations until they can perform the procedure well. *Knowledge of procedures and rationales reduces anxiety and promotes comfort. Demonstrations may progress through several sessions until patient can perform independently.*

Attend: Encourage high fluid intake 2,000 mL (2 L)/day, unless contraindicated, *to moisten mucous membranes and dilute chemical materials in the body.* Limit fluid intake after 7 p.m. *to prevent nocturia.*

Encourage patient and family members to share feelings and concerns related to urologic problems. *Ventilation helps pinpoint patient's fears and establishes an environment of trust in which patient and family members can begin to deal with the situation.*

Manage: Refer patient and family members to a psychiatric liaison nurse, enterostomal therapist, sex counselor, support group, or home health care agency, when appropriate. *These resources help patient gain knowledge of self and situation, reduce anxiety, and help promote personal growth. Community resources usually provide services not available at other health care agencies.*

SUGGESTED NIC INTERVENTIONS

Perineal Care; Urinary Bladder Training; Urinary Catheterization: Intermittent; Urinary Elimination Management

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DYSFUNCTIONAL VENTILATORY WEANING RESPONSE

DEFINITION

Inability to adjust to lowered levels of mechanical ventilator support that interrupts and prolongs the weaning process

DEFINING CHARACTERISTICS

Mild

- Breathing discomfort
- Fatigue
- Fear of machine malfunction
- Increase in focus on breathing
- Mild increase of respiratory rate over baseline
- Perceived need for increase in oxygen
- Restlessness
- Warmth

Moderate

- Abnormal skin color (e.g., pale, dusky, cyanosis)
- Apprehensiveness
- Decrease in air entry on auscultation
- Diaphoresis
- Facial expression of fear
- Hyperfocused on activities
- Impaired ability to cooperate
- Impaired ability to respond to coaching
- Increase in blood pressure from baseline (≤20 mm Hg)
- Increaser in heart rate from baseline (≤20 beats/minute)
- Minimal use of respiratory accessory muscles
- Moderate increase in respiratory rate over baseline

Severe

- Abnormal skin color (e.g., pale, dusky, cyanosis)
- Adventitious breath sounds
- Agitation
- Asynchronized breathing with the ventilator
- Decrease in level of consciousness
- Deterioration in arterial blood gases from baseline
- Gasping breaths
- Increase in blood pressure from baseline (≥20 mm Hg)
- Increase in heart rate from baseline (≥20 beats/minute)
- Paradoxical abdominal breathing
- Profuse diaphoresis
- Shallow breathing
- Significant increase in respiratory rate above baseline
- Use of significant respiratory accessory muscles

DYSFUNCTIONAL VENTILATORY WEANING RESPONSE

RELATED FACTORS

- *Physiological*: Alteration in sleep pattern, ineffective airway clearance, inadequate nutrition, pain
- *Psychological*: Anxiety, decrease in motivation, fear, hopelessness, insufficient knowledge of weaning process, insufficient trust in health care professional, low self-esteem, powerlessness, uncertainty about ability to wean
- *Situational*: Environmental barrier (e.g., distractions, low nurse to patient ratio, unfamiliar health care staff), history of unsuccessful weaning attempt, history of ventilator dependence >4 days, inappropriate pace of weaning process, insufficient social support, uncontrolled episodic energy demands

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Coping
- Communication
- Fluid and electrolytes
- Knowledge
- Neurocognition
- Physical regulation
- Respiratory function

EXPECTED OUTCOMES

- The patient will maintain respiratory rate at 5 breaths/minute within baseline.
- The patient will have ABG levels normal for that patient.
- The patient will maintain stable mental and emotional status during weaning process.
- The patient will indicate feelings of comfort without pain or dyspnea.
- The patient will have breathing pattern return to baseline.
- The patient will maintain Pa_{O_2} within normal limits as activity level increases.
- The patient will breathe spontaneously after ventilation support is withdrawn.

SUGGESTED NOC OUTCOMES

Anxiety Self-Control; Client Satisfaction; Technical Aspects of Care; Depression Self-Control; Respiratory Status; Respiratory Status: Ventilation; Risk Control; Vital Signs; Electrolyte & Acid/Base Balance

INTERVENTIONS AND RATIONALES

Determine: Assess vital signs; respiratory status, including rate, rhythm, and depth of respiration. Look for nasal flaring, effectiveness of cough;

suctioning demands; sputum characteristics, including color, consistency, amount; ABGs; hemoglobin and hematocrit; and respiratory effects of medications. *Assessment information will help identify appropriate outcomes and interventions.*

Perform: Check vital signs every 15 minutes to 1 hour *to detect tachypnea and tachycardia, both of which are early indicators of respiratory distress.*

Begin oxygen support by using the smallest concentration needed, *to make the patient comfortable.* Monitor closely *to avoid oxygen toxicity.*

Place patient in Fowler's position *to increase comfort and facilitate adequate chest expansion and diaphragmatic excursion, thereby decreasing the work of breathing.*

Assist patient to progress gradually from bed rest to increased activity *to improve sense of well-being.*

Monitor vital signs and ABGs closely. If respiratory status is compromised, return to bed rest *to decrease metabolic rate and lower oxygen demands.*

Inform: Explain procedures to the patient, and describe specific sensations the patient may feel during each procedure. *Keeping patient informed about what to expect and when to expect it reduces anxiety.*

Teach self-healing techniques to both the patient and the family, such as meditation, guided imagery, yoga, and prayer. Teach patient how to incorporate the use of self-healing techniques in carrying out usual daily activities. *These measures help reduce the anxiety related to respiratory problems and will be less likely to hyperventilate and panic when the patient experiences difficulty breathing normally.*

Attend: Avoid respiratory depressants such as opiates, sedatives, and paralytics *because these drugs further depress respirations and have the potential to cause respiratory arrest* that if the patient decompensates while on 100% fraction of inspired oxygen mask, the patient may require intubation. *Anticipating complications facilitates prompt intervention.*

Explain in a firm, calm voice that you will help the patient maintain control. *This encourages the patient to take control of patient's behavior.*

Manage: Organize family conferences to explore ways in which the family can help support the ventilatory weaning process. *Meetings can help the family members ventilate fears in a safe environment.*

SUGGESTED NIC INTERVENTIONS

Acid–Base Management; Airway Management; Anxiety Reduction; Mechanical Ventilatory Weaning; Respiratory Monitoring; Support System Enhancement; Teaching: Procedure/Treatment; Vital Signs Monitoring; Guided Imagery

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DEFINITION

Decreased, delayed, or absent ability to receive, process, transmit, and/or use a system of symbols

DEFINING CHARACTERISTICS

- Absence of eye contact
- Difficulty comprehending communication
- Difficulty expressing thoughts verbally (e.g., aphasia, dysphasia, apraxia, dyslexia)
- Difficulty forming sentences
- Difficulty forming words (e.g., aphonia, dyslalia, dysarthria)
- Difficulty in selective attending
- Difficulty in use of body expressions
- Difficulty in use of facial expressions
- Difficulty maintaining communication
- Difficulty speaking
- Difficulty verbalizing
- Disoriented to person
- Disoriented to place
- Disoriented to time
- Does not speak
- Dyspnea
- Inability to speak
- Inability to speak language of caregiver
- Inability to use body expressions
- Inappropriate verbalization
- Partial visual deficit
- Refusal to speak
- Slurred speech
- Stuttering
- Total visual deficit

RELATED FACTORS

- Absence of significant others
- Alteration in development
- Alteration in perception
- Alteration in self-concept
- Central nervous system impairment
- Cultural incongruence
- Emotional disturbance
- Environmental barrier
- Insufficient information
- Insufficient stimuli

- Low self-esteem
- Oropharyngeal defect
- Physical barrier (e.g., tracheostomy, intubation)
- Physiologic condition (e.g., brain tumor, decreased circulation to brain, weakened musculoskeletal system)
- Psychotic disorder
- Treatment regimen
- Vulnerability

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Cardiac function
- Communication
- Neurocognition
- Respiratory function

EXPECTED OUTCOMES

- The patient/family will have needs met by staff members.
- The patient/family will express satisfaction with level of communication ability.
- The patient/family will maintain orientation.
- The patient/family will maintain effective level of communication.
- The patient/family will answer direct questions correctly.

SUGGESTED NOC OUTCOMES

Cognition; Communication; Communication: Expressive; Communication: Receptive; Information Processing; Client Satisfaction: Communication

INTERVENTIONS AND RATIONALES

Determine: Observe patient closely for cues to patient's needs and desires, such as gestures, pointing to objects, looking at items, and pantomime, *to enhance understanding*. Avoid continually responding to gestures if the potential exists to improve speech, *to encourage desire to improve*.

Monitor and record changes in patient's speech pattern or level of orientation. *Changes may indicate improvement or deterioration of condition.*
Perform: Speak slowly and distinctly in a normal tone when addressing patient and stand where patient can see and hear you. *These actions promote comprehension.*

Reorient the patient to reality: Call patient by name; tell the patient your name; give the patient background information (place, date, and time); use television or radio to augment orientation; use large calendars and communication boards (including alphabet and some common words and pictures). *These measures develop orientation skills through repetition and recognition of familiar objects.*

Use short, simple phrases and yes-or-no questions when patient is very frustrated, *to reduce frustration.*

Inform: Instruct family members to use techniques listed above *to ease their frustration in communication with the patient.*

Attend: Encourage attempts at communication and provide positive reinforcement *to aid comprehension.*

Allow ample time for a response. Don't answer questions yourself if patient has ability to respond. *This improves patient's self-concept and reduces frustration.*

Repeat or rephrase questions, if necessary, *to improve communication.* Don't pretend to understand if you don't, *to avoid misunderstanding.*

Remove distractions from the environment during attempts at communication. *Reduced distractions improve comprehension.*

Manage: Review diagnostic test results *to determine improvement or deterioration of the disease process.* Adjust the care plan accordingly.

SUGGESTED NIC INTERVENTIONS

Active Listening; Communication Enhancement: Hearing Deficit; Communication Enhancement: Speech Deficit; Learning Facilitation; Touch

REFERENCES

Cheba, M., Żuralska, R., & Skrzypek-Czerko, M. (2014). Difficulties related to the communication with the patient with aphasia according to the nursing staff. *Journal of Neurological & Neurosurgical Nursing, 3*(2), 75–80. doi:10.15225/PNN.2014.3.2.4

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576 IMPAIRED WALKING

DEFINITION

Limitation of independent movement within the environment on foot

DEFINING CHARACTERISTICS

- Impaired ability to climb stairs
- Impaired ability to navigate curbs
- Impaired ability to walk on decline
- Impaired ability to walk on incline
- Impaired ability to walk on uneven surface
- Impaired ability to walk required distance

RELATED FACTORS

- Alteration in cognitive functioning
- Alteration in mood
- Decrease in endurance
- Environmental barrier (e.g., stairs, inclines, uneven surfaces, obstacles, distance, lack of assistive device)
- Fear of falling
- Impaired balance
- Impaired vision
- Insufficient knowledge of mobility strategies
- Insufficient muscle strength
- Musculoskeletal impairment
- Neuromuscular impairment
- Obesity
- Pain
- Physical deconditioning

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Neurocognition
- Pharmacologic function
- Physical regulation

EXPECTED OUTCOMES

- The patient will have no evidence of complications associated with impaired walking, such as alteration in skin integrity, contractures, venous stasis, or thrombus formation.
- The patient will maintain or improve muscle strength and joint range of motion (ROM).
- The patient will achieve the highest level of ambulation possible (independence using wheelchair, ambulation with device, ambulation without device).
- The patient will maintain safety during ambulation.
- The patient will demonstrate ability to use equipment or devices safely.

- The patient will adapt to alteration in walking.
- The patient will participate in social and occupational activities.
- The patient will demonstrate understanding of specific interventions related to coping with alteration in walking.
- The patient will utilize community resources to promote and maintain the highest level of mobility.

SUGGESTED NOC OUTCOMES

Ambulation; Balance; Coordinated Movement; Endurance; Fall Prevention Behavior; Mobility; Safe Home Environment; Self-Care: Activities of Daily Living (ADLs); Joint Movement

INTERVENTIONS AND RATIONALES

Determine: Identify patient's level of independence using the functional mobility scale.

Communicate the findings to the staff *to provide continuity and preserve documented level of independence.*

Monitor and record daily evidence of complications related to altered walking, such as contractures, venous stasis, skin breakdown, or thrombus formation. *Patient with a history of neuromuscular dysfunction is at risk for complications.*

Perform: Perform ROM exercises for joints of affected limbs, unless contraindicated, at least once per shift. Progress from passive to active ROM, as tolerated, *to prevent joint contractures and muscle atrophy.*

Make sure that patient maintains anatomically correct and functional body positioning. *Proper positioning relieves pressure, thereby preventing skin breakdown and fluid accumulation in dependent extremities.* Encourage repositioning every 2 hours when patient is in bed, *to decrease pressure.* Establish a turning schedule for dependent patients *to provide a method for checking on position changes.*

Implement a preambulation program (e.g., turning in bed, sitting on the side of the bed, sitting up in a chair) *to increase independence and patient's self-esteem.*

Perform the indicated medical regimen to manage or prevent complications (e.g., administration of prophylactic heparin for venous thrombosis), *to promote patient's health and well-being.*

Provide progressive ambulation up to the limits imposed by patient's condition, *to maintain muscle tone and prevent complications associated with immobility.*

Inform: Instruct patient and family members on ambulation techniques and measures *to prevent complications to help prepare patient and family for discharge.*

Demonstrate ambulation regimen and note the date. Have patient and family members perform a return demonstration *to ensure continuity of care and use of proper technique.*

Attend: Encourage attendance at physical therapy sessions and reinforce prescribed activities by using the same equipment, devices, and techniques used in therapy sessions. Request a written copy of patient's ambulation program to use as a reference. *These measures maintain continuity and help ensure patient's safety.*

Manage: Refer patient to a physical therapist for development of a program to promote walking, *to assist with rehabilitation of musculoskeletal deficits.*

Assist in identifying resources, such as a community stroke program, sports associations for the disabled, or the National Multiple Sclerosis Society, *to promote patient's reintegration into the community.*

SUGGESTED NIC INTERVENTIONS

Energy Management; Exercise Promotion: Strength Training; Exercise Therapy: Ambulation; Self-Care Assistance

REFERENCES

Brach, J. S., Lowry, K., Perera, S., Hornyak, V., Wert, D., Studenski, S. A., & VanSwearingen, J. M. (2015). Improving motor control in walking: A randomized clinical trial in older adults with subclinical walking difficulty. *Archives of Physical Medicine & Rehabilitation*, *96*(3), 388–394. doi:10.1016/j.apmr.2014.10.018

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DEFINITION

Meandering, aimless, or repetitive locomotion that exposes the individual to harm; frequently incongruent with boundaries, limits, or obstacles

DEFINING CHARACTERISTICS

- Continuous movement from place to place
- Eloping behavior
- Frequent movement from place to place
- Fretful locomotion
- Haphazard locomotion
- Hyperactivity
- Impaired ability to locate landmarks in a familiar setting
- Locomotion into unauthorized spaces
- Locomotion resulting in getting lost
- Locomotion that cannot be easily dissuaded
- Long periods of locomotion without an apparent destination
- Pacing
- Periods of locomotion interspersed with periods of nonlocomotion (e.g., sitting, standing, sleeping)
- Persistent locomotion in search of something
- Scanning behavior
- Searching behavior
- Shadowing a caregiver's locomotion
- Trespassing

RELATED FACTORS

- Alteration in cognitive functioning
- Cortical atrophy
- Overstimulating environment
- Physiologic state (e.g., hunger, thirst, pain, need to urinate)
- Premorbid behavior (e.g., outgoing, sociable personality)
- Psychological disorder
- Sedation
- Separation from familiar environment
- Time of day

ASSESSMENT FOCUS

(*Refer to comprehensive assessment parameters.*)

- Activity/exercise
- Emotional
- Cardiac function
- Comfort
- Communication
- Coping

- Sensation/perception
- Neurocognition

EXPECTED OUTCOMES

- The patient will participate in physical or other _____ (specify) activities to minimize wandering behavior.
- The patient will ambulate safely.
- The patient will not have unplanned exits or elopements.
- The patient and the family will anticipate patient's wandering behavior or ambulation patterns and provide gratification before onset of wandering behavior.
- The patient and the family will identify factors that contribute to wandering behaviors.

SUGGESTED NOC OUTCOMES

Elopement Occurrence; Elopement Propensity Risk; Safe Wandering; Personal Safety Behavior; Safe Home Environment; Ambulation

INTERVENTIONS AND RATIONALES

Determine: Assess characteristics of wandering behavior, *to determine severity of problem and plan interventions.*

Assess reasons for specific behavior problems *to determine possible triggers for wandering behaviors.*

Determine how family members or partner handles wandering behavior, *to provide a comprehensive database for planning care.*

Assess patient's hobbies and previous social, leisure, and exercise activities and patterns *to assist in planning interventions.*

Perform: Provide safe and structured daily routine (including regular exercise, walking, and range of motion exercises) and *environment to decrease wandering behavior and minimize caregiver stress.*

Avoid using physical or chemical restraints to control patient's wandering behavior. *Restraints may increase agitation, anxiety, sensory deprivation, falls, and wandering behavior.*

Check patient for hunger, thirst, discomfort, or need for toileting. *These needs may precipitate wandering.*

Inform: Instruct patient and/or family about the following:

- Use dead bolt locks on doors and keep a key accessible for quick exit, *to prevent unplanned exits and facilitate entrance and exit in emergency situations.*
- Use fences and hedges around patios or yards and lock gates *to prevent unsafe exits.*
- Install electronic devices with buzzers or bells *to alert others when door or window is open.*

Attend: Encourage participation in activities (e.g., dancing) and simple household chores (e.g., raking leaves, folding laundry) *to reduce anxiety and restlessness.*

Manage: Notify neighbors, local police department, and staff in retirement communities about patient's condition. Keep a list of neighbors' names and phone numbers handy. *Awareness by others can prevent patient from becoming lost or injured.*

Utilize community resources, such as the Alzheimer's Association's Safe Return Program, *to assist in identification, location, and return of individuals with disorders characterized by wandering behaviors.*

SUGGESTED NIC INTERVENTIONS

Activity Therapy; Surveillance: Safety; Environmental Management: Safety; Home Maintenance Management; Elopement Precautions

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Bantry White, E., & Montgomery, P. (2015). Dementia, walking outdoors and getting lost: Incidence, risk factors and consequences from dementia-related police missing-person reports. *Aging & Mental Health*, *19*(3), 224–230. doi:10.1080/13607863.2014.924091

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PART II

Selected Nursing Diagnoses by Medical Diagnosis

Abnormal rupture of membranes
- Deficient fluid volume
- Fear
- Hyperthermia
- Impaired resilience
- Readiness for enhanced childbearing process
- Risk for bleeding
- Risk for disturbance of maternal–fetal dyad
- Risk for imbalanced fluid volume
- Risk for infection
- Risk for shock

Abortion
- Anxiety
- Complicated grieving
- Ineffective coping
- Hopelessness
- Impaired resilience
- Moral distress
- Readiness for enhanced coping
- Readiness for enhanced decision-making
- Risk for bleeding
- Risk for complicated grieving
- Risk for infection
- Risk for interruption of maternal–fetal dyad
- Readiness for enhanced resilience
- Risk for impaired resilience
- Risk for shock
- Situational low self-esteem

Abruptio placentae
- Acute pain
- Anxiety
- Risk for bleeding
- Complicated grieving
- Readiness for enhanced hope
- Risk for shock

Acoustic neuroma
- Chronic pain
- Disturbed sensory perception (auditory)
- Nausea
- Imbalanced nutrition: Less than body requirements
- Impaired skin integrity
- Ineffective breathing pattern
- Ineffective tissue cerebral perfusion
- Insomnia

- Readiness for enhanced knowledge
- Risk for deficient fluid volume
- Risk for electrolyte imbalance
- Risk for interruption of maternal–fetal dyad

Acquired immunodeficiency syndrome
- Caregiver role strain
- Chronic confusion
- Death anxiety
- Decisional conflict
- Defensive coping
- Deficient community health
- Grieving
- Hopelessness
- Impaired resilience
- Impaired memory
- Ineffective community coping
- Ineffective denial
- Ineffective protection
- Ineffective health management
- Ineffective sexuality patterns
- Ineffective therapeutic regimen management
- Moral distress
- Powerlessness
- Readiness for enhanced communication
- Readiness for enhanced emancipated decision-making
- Readiness for enhanced resilience
- Readiness for enhanced self-care
- Risk for caregiver role strain
- Risk for complicated grieving
- Risk for compromised human dignity
- Risk for contamination
- Risk for delayed surgical recovery
- Risk for impaired oral mucous membrane
- Risk for infection
- Risk for loneliness
- Risk-prone health behavior
- Social isolation

Acute pancreatitis
- Acute pain
- Deficient knowledge (specify)
- Impaired comfort
- Insomnia
- Nausea
- Readiness for enhanced coping
- Risk for dysfunctional gastrointestinal motility
- Risk for electrolyte imbalance
- Risk for imbalanced fluid volume
- Risk for impaired liver function
- Risk for unstable glucose level
- Risk-prone health behavior

Acute renal failure
- Death anxiety
- Decreased cardiac output
- Deficient fluid volume
- Disturbed thought processes
- Dressing or grooming self-care deficit
- Excess fluid volume
- Fear
- Impaired physical mobility
- Impaired skin integrity
- Ineffective tissue perfusion (renal)
- Interrupted family processes
- Readiness for enhanced spiritual well-being
- Risk for acute confusion
- Risk for complicated grieving
- Risk for electrolyte imbalance
- Risk for imbalanced fluid volume
- Risk for ineffective renal perfusion
- Risk for infection
- Risk-prone health behavior
- Sexual dysfunction
- Disturbed sleep pattern

- Sleep deprivation
- Spiritual distress

Acute respiratory distress syndrome
- Anxiety
- Bathing or hygiene self-care deficit
- Deficient fluid volume
- Denial
- Dysfunctional ventilatory weaning response
- Fear
- Impaired comfort
- Imbalanced nutrition: Less than body requirements
- Impaired gas exchange
- Impaired skin integrity
- Impaired spontaneous ventilation
- Impaired verbal communication
- Ineffective airway clearance
- Ineffective breathing pattern
- Ineffective coping
- Ineffective tissue perfusion (cardiopulmonary)
- Insomnia
- Risk for acute confusion
- Risk for electrolyte imbalance
- Risk for ineffective cardiac tissue perfusion
- Risk for ineffective cerebral tissue perfusion
- Risk for infection
- Risk for shock
- Risk for vascular trauma
- Sleep deprivation

Acute respiratory failure
- Activity intolerance
- Death anxiety
- Decreased cardiac output
- Denial
- Disturbed sensory perception
- Disturbed thought processes
- Fear
- Impaired gas exchange
- Impaired resilience
- Impaired verbal communication
- Ineffective breathing pattern
- Ineffective tissue perfusion (cardiopulmonary)
- Insomnia
- Powerlessness
- Readiness for enhanced spiritual well-being
- Risk for ineffective activity planning
- Risk for acute confusion
- Risk for aspiration
- Risk for electrolyte imbalance
- Risk for ineffective cardiac tissue perfusion
- Risk for ineffective renal tissue perfusion
- Risk for infection
- Risk for shock
- Risk for suffocation
- Spiritual distress

Adrenal insufficiency
- Acute pain
- Chronic low self-esteem
- Compromised family coping
- Disturbed body image
- Disturbed personality identity
- Readiness for enhanced resilience
- Readiness for enhanced self-care
- Risk for electrolyte imbalance
- Risk for imbalanced body temperature
- Risk for impaired skin integrity
- Risk for infection
- Risk-prone health behavior
- Sexual dysfunction
- Sleep deprivation

Adrenocortical insufficiency
- Risk for disproportionate growth
- Risk for infection

Affective disorders
- Anxiety
- Disturbed personality identity
- Disturbed sensory perception (specify)
- Disturbed thought processes
- Hopelessness
- Impaired mood regulation
- Impaired religiosity
- Ineffective coping
- Ineffective impulse control
- Ineffective relationship
- Ineffective role performance
- Insomnia
- Labile emotional control
- Readiness for enhanced coping
- Readiness for enhanced emancipated decision-making
- Risk for loneliness
- Risk for other-directed violence
- Risk-prone health behavior
- Risk for self-directed violence
- Sexual dysfunction
- Disturbed sleep pattern
- Stress overload

Alcohol addiction and abuse
- Acute confusion
- Bathing or hygiene self-care deficit
- Defensive coping
- Deficient knowledge (specify)
- Disturbed personality identity
- Dysfunctional family processes: Alcoholism
- Functional urinary incontinence
- Imbalanced nutrition: Less than body requirements
- Impaired emancipated decision-making
- Impaired resilience
- Impaired physical mobility
- Ineffective activity planning
- Ineffective community therapeutic regimen management
- Ineffective coping
- Ineffective denial
- Ineffective family health management
- Ineffective impulse response
- Insomnia
- Labile emotional control
- Powerlessness
- Readiness for enhanced emancipated decision-making
- Readiness for enhanced family processes
- Readiness for enhanced family coping
- Readiness for enhanced self-concept
- Risk for acute confusion
- Risk for compromised human dignity
- Risk for electrolyte imbalance
- Risk for imbalanced fluid volume
- Risk for impaired emancipated decision-making
- Risk for impaired liver function
- Risk for poisoning
- Risk for self-directed violence
- Risk-prone health behavior
- Self-neglect
- Sexual dysfunction
- Sleep deprivation
- Spiritual distress
- Social isolation
- Stress overload

Alzheimer's disease
- Anxiety
- Bathing or hygiene self-care deficit
- Bowel incontinence
- Caregiver role strain
- Chronic confusion
- Chronic functional constipation
- Chronic low self-esteem
- Complicated grieving
- Compromised family coping

- Deficient knowledge (specify)
- Disturbed sensory perception
- Disturbed thought processes
- Frail elderly syndrome
- Functional urinary incontinence
- Grieving
- Hopelessness
- Imbalanced nutrition: Less than body requirements
- Impaired comfort
- Impaired emancipated decision-making
- Impaired home maintenance
- Impaired memory
- Impaired verbal communication
- Ineffective coping
- Ineffective health maintenance
- Ineffective role performance
- Ineffective sexuality patterns
- Interrupted family processes
- Moral distress
- Readiness for enhanced knowledge
- Readiness for enhanced self-care
- Relocation stress syndrome
- Risk for caregiver role strain
- Risk for chronic functional constipation
- Risk for compromised human dignity
- Risk for frail elderly syndrome
- Risk for impaired emancipated decision-making
- Risk for injury
- Risk for poisoning
- Risk for trauma
- Social isolation
- Stress urinary incontinence
- Wandering

Amniotic fluid embolism
- Ineffective tissue perfusion (cardiopulmonary)
- Risk for electrolyte imbalance
- Risk for ineffective cardiac tissue perfusion
- Risk for ineffective peripheral tissue perfusion
- Risk for injury
- Risk for shock

Amputation
- Acute pain
- Anxiety
- Chronic low self-esteem
- Chronic pain
- Decisional conflict
- Deficient knowledge (specify)
- Delayed surgical recovery
- Denial
- Disturbed body image
- Disturbed personality identity
- Grieving
- Impaired resilience
- Impaired wheelchair mobility
- Impaired walking
- Ineffective activity planning
- Impaired transfer ability
- Readiness for enhanced self-care
- Readiness for enhanced hope
- Readiness for enhanced knowledge
- Risk for impaired resilience
- Risk for compromised human dignity
- Risk for impaired tissue integrity
- Risk for injury
- Risk-prone health behavior

Amyotrophic lateral sclerosis
- Bowel incontinence
- Caregiver role strain
- Chronic low self-esteem
- Complicated grieving
- Compromised family coping
- Constipation
- Death anxiety
- Disturbed personality identity
- Dressing or grooming self-care deficit

- Dysfunctional ventilatory weaning response
- Grieving
- Hopelessness
- Impaired physical mobility
- Impaired sitting
- Impaired skin integrity
- Impaired spontaneous ventilation
- Impaired standing
- Impaired verbal communication
- Impaired walking
- Impaired wheelchair ability
- Ineffective airway clearance
- Ineffective breathing pattern
- Ineffective coping
- Ineffective health maintenance
- Ineffective sexuality patterns
- Readiness for enhanced knowledge
- Risk for aspiration
- Risk for caregiver role strain
- Risk for constipation
- Risk for dysfunctional gastrointestinal motility
- Risk for electrolyte imbalance
- Risk for falls
- Risk for imbalanced fluid volume
- Risk for impaired skin integrity
- Risk for ineffective peripheral tissue perfusion
- Risk for infection
- Risk for pressure
- Social isolation

Anaphylactic shock
- Decreased cardiac output
- Impaired gas exchange
- Ineffective tissue perfusion (cardiopulmonary)
- Ineffective tissue perfusion (renal)
- Ineffective tissue perfusion (cerebral)

Anemias
- Activity intolerance
- Decreased cardiac output
- Fatigue
- Impaired gas exchange
- Impaired skin integrity
- Ineffective breathing patterns
- Ineffective protection
- Ineffective tissue perfusion (cardiopulmonary)
- Readiness for enhanced resilience
- Risk for infection

Angina pectoris
- Activity intolerance
- Acute pain
- Anxiety
- Deficient knowledge (specify)
- Impaired comfort
- Ineffective denial
- Ineffective role performance
- Ineffective sexuality patterns
- Readiness for enhanced knowledge
- Risk for ineffective activity planning
- Risk for ineffective cardiac tissue perfusion
- Risk for ineffective cerebral tissue perfusion
- Risk for ineffective renal tissue perfusion
- Sedentary lifestyle
- Stress overload

Anorexia nervosa
- Anxiety
- Constipation
- Deficient fluid volume
- Disturbed body image
- Disturbed personality image
- Hyperthermia
- Imbalanced nutrition: Less than body requirements
- Impaired resilience
- Ineffective denial
- Ineffective impulse control

- Ineffective relationships
- Interrupted family processes
- Readiness for enhanced emancipated decision-making
- Readiness for enhanced nutrition
- Readiness for enhanced relationship
- Readiness for enhanced sleep
- Risk for chronic low self-esteem
- Risk for constipation
- Risk for dysfunctional gastrointestinal motility
- Risk-prone health behavior
- Sleep deprivation
- Social isolation
- Spiritual distress
- Stress overload

Antisocial personality disorder
- Chronic low self-esteem
- Defensive coping
- Disturbed personal identity
- Disturbed sensory perception
- Dysfunctional family processes: Alcoholism
- Impaired home maintenance
- Impaired resilience
- Ineffective coping
- Ineffective role performance
- Interrupted family processes
- Readiness for enhanced relationships
- Readiness for enhanced family coping
- Risk for other-directed violence
- Risk for self-mutilation
- Risk for suicide
- Sexual dysfunction
- Social isolation

Anxiety disorder
- Anxiety
- Caregiver role strain
- Chronic low self-esteem
- Constipation
- Defensive coping
- Diarrhea
- Disturbed sensory perception
- Disturbed thought processes
- Hopelessness
- Impaired emancipated decision-making
- Impaired home maintenance
- Impaired mood regulation
- Ineffective denial
- Interrupted family processes
- Posttrauma syndrome
- Powerlessness
- Readiness for enhanced communication
- Readiness for enhanced coping
- Readiness for enhanced emancipated decision-making
- Readiness for enhanced nutrition
- Readiness for enhanced self-concept
- Readiness for enhanced sleep
- Readiness for enhanced spiritual well-being
- Risk for imbalanced nutrition: Less than required
- Risk for impaired religiosity
- Risk for loneliness
- Risk for posttrauma syndrome
- Social isolation
- Sleep deprivation
- Stress overload

Aortic aneurysm
- Acute pain
- Excess fluid volume
- Impaired gas exchange
- Ineffective tissue perfusion (cardiopulmonary)
- Ineffective tissue perfusion (peripheral)
- Ineffective tissue perfusion (renal)
- Risk for bleeding
- Risk for electrolyte imbalance

- Risk for imbalanced fluid volume
- Risk for ineffective cerebral tissue perfusion
- Risk for shock

Aortic insufficiency
- Activity intolerance
- Decreased cardiac output
- Deficient knowledge (specify)
- Impaired gas exchange
- Ineffective tissue perfusion (cardiopulmonary)
- Risk for decreased cardiac output
- Risk for impaired cardiovascular function
- Risk for ineffective renal tissue perfusion

Aortic stenosis
- Activity intolerance
- Decreased cardiac output
- Deficient knowledge (specify)
- Impaired gas exchange
- Ineffective tissue perfusion (cardiopulmonary)
- Risk for decreased cardiac output

Appendicitis
- Acute pain
- Delayed surgical recovery
- Imbalanced nutrition: Less than body requirements
- Impaired comfort
- Risk for imbalanced fluid volume
- Risk for infection

Arterial insufficiency
- Chronic pain
- Impaired tissue integrity
- Readiness for enhanced knowledge
- Risk for ineffective peripheral tissue perfusion

Arterial occlusion
- Acute pain
- Deficient knowledge (specify)
- Disturbed sensory perception (tactile)
- Impaired comfort
- Impaired skin integrity
- Ineffective tissue perfusion (cerebral)
- Ineffective tissue perfusion (peripheral)
- Risk for ineffective peripheral tissue perfusion
- Risk-prone health behavior

Asphyxia
- Hypothermia
- Ineffective breathing pattern
- Ineffective gas exchange
- Risk for aspiration
- Risk for injury
- Risk for hypothermia
- Risk for suffocation

Asthma
- Activity intolerance
- Anxiety
- Deficient knowledge (specify)
- Dressing or grooming self-care deficit
- Dry eye
- Impaired gas exchange
- Impaired oral mucous membrane
- Ineffective airway clearance
- Ineffective breathing pattern
- Ineffective coping
- Latex allergy response
- Readiness for enhanced comfort
- Readiness for enhanced family coping
- Readiness for enhanced knowledge
- Risk for impaired resilience
- Risk for infection
- Risk for latex allergy response
- Risk-prone health behavior
- Sleep deprivation
- Stress overload

Atelectasis
- Anxiety
- Bathing or hygiene self-care deficit
- Impaired gas exchange
- Impaired physical mobility
- Ineffective airway clearance
- Ineffective breathing pattern
- Impaired gas exchange
- Readiness for enhanced self-care

Attention deficit hyperactivity disorder
- Denial
- Disturbed sleep pattern
- Family therapeutic regimen management
- Ineffective activity planning
- Interrupted family processes
- Readiness for enhanced family processes
- Readiness for enhanced relationships
- Risk for delayed development
- Stress overload

Autism
- Compromised family coping
- Disabled family coping
- Impaired emancipated decision-making
- Ineffective denial
- Interrupted family processes
- Labile emotional control
- Risk for delayed development
- Risk for impaired emancipated decision-making
- Risk for self-mutilation

Bell's palsy
- Acute pain
- Anxiety
- Chronic low self-esteem
- Disturbed body image
- Disturbed sleep pattern
- Disturbed sensory perception (gustatory)
- Impaired comfort
- Impaired swallowing
- Impaired verbal communication
- Ineffective sexuality patterns
- Powerlessness
- Risk for compromised human dignity
- Social isolation
- Stress overload
- Unilateral neglect

Benign prostatic hypertrophy
- Deficient knowledge (specify)
- Impaired comfort
- Impaired urinary elimination
- Ineffective sexuality patterns
- Sexual dysfunction
- Urinary retention

Bipolar disorder: Depressive phase
- Chronic low self-esteem
- Constipation
- Disturbed personality identity
- Disturbed sensory perception
- Disturbed thought processes
- Feeding self-care deficit
- Hopelessness
- Imbalanced nutrition: Less than body requirements
- Impaired emancipated decision-making
- Impaired mood regulation
- Ineffective coping
- Ineffective denial
- Ineffective relationships
- Ineffective health maintenance
- Insomnia
- Readiness for enhanced communication
- Readiness for enhanced coping
- Readiness for enhanced self-concept
- Risk for compromised human dignity
- Risk for ineffective activity planning

- Risk for injury
- Risk for self-directed violence
- Self-neglect
- Sexual dysfunction
- Sleep deprivation
- Social isolation
- Spiritual distress
- Stress overload

Bipolar disorder: Manic phase
- Chronic low self-esteem
- Disabled family coping
- Disturbed personality identity
- Disturbed sensory perception
- Disturbed thought processes
- Feeding self-care deficit
- Impaired home maintenance
- Impaired physical mobility
- Impaired verbal communication
- Ineffective coping
- Ineffective denial
- Ineffective impulse control
- Ineffective sexuality pattern
- Insomnia
- Risk for impaired resilience
- Readiness for enhanced family coping
- Interrupted family processes
- Risk for falls
- Risk for impaired religiosity
- Risk for injury
- Risk for other-directed violence
- Risk-prone health behavior
- Sexual dysfunction
- Spiritual distress

Bladder cancer
- Acute pain
- Fear
- Impaired tissue integrity
- Impaired urinary elimination
- Readiness for enhanced self-care
- Risk for compromised human dignity
- Risk for latex allergy response
- Overflow urinary incontinence
- Urge urinary incontinence

Blindness
- Deficient diversional activity
- Deficient knowledge (specify)
- Disturbed body image
- Disturbed sensory perception (visual)
- Fear
- Hopelessness
- Impaired physical mobility
- Ineffective health management
- Powerlessness
- Risk for falls
- Risk for injury
- Risk for loneliness
- Social isolation

Bone marrow transplantation
- Activity intolerance
- Complicated grieving
- Contamination
- Decreased cardiac output
- Deficient diversional activity
- Diarrhea
- Disturbed body image
- Excess fluid volume
- Grieving
- Imbalanced nutrition: Less than body requirements
- Impaired oral mucous membrane
- Impaired skin integrity
- Ineffective activity planning
- Ineffective protection
- Ineffective therapeutic management
- Risk for contamination
- Risk for electrolyte imbalance
- Risk for imbalanced fluid balance
- Risk for infection

Bone sarcomas
- Activity intolerance
- Acute pain
- Deficient knowledge

- Impaired comfort
- Impaired physical mobility
- Impaired tissue integrity
- Readiness for enhanced knowledge
- Risk for falls
- Risk for injury
- Risk for infection

Borderline personality disorder
- Chronic low self-esteem
- Disturbed personality identity
- Fear
- Impaired religiosity
- Ineffective coping
- Ineffective impulse control
- Ineffective relationships
- Risk for impaired resilience
- Risk for self-directed violence
- Risk for self-mutilation
- Social isolation

Bowel fistula
- Chronic functional constipation
- Risk for chronic functional constipation
- Risk for deficient fluid volume
- Risk for infection

Bowel resection
- Anxiety
- Delayed surgical recovery
- Dysfunctional gastrointestinal motility
- Deficient knowledge
- Diarrhea
- Imbalanced Nutrition: Less than required
- Impaired skin integrity
- Risk for delayed surgical recovery
- Risk for disturbed personal identity
- Risk for infection

Brain abscess
- Acute pain
- Decreased intracranial adaptive capacity
- Disturbed body image
- Impaired physical mobility
- Impaired skin integrity
- Ineffective sexuality patterns
- Ineffective tissue perfusion (cerebral)
- Risk for aspiration
- Risk for infection
- Risk for injury
- Risk for urge urinary incontinence

Brain tumors
- Acute confusion
- Bowel incontinence
- Constipation
- Decreased intracranial adaptive capacity
- Disturbed personality identity
- Disabled family processes
- Disturbed sensory perception
- Disturbed thought processes
- Fear
- Grieving
- Impaired memory
- Impaired physical mobility
- Impaired tissue integrity
- Impaired urinary elimination
- Impaired verbal communication
- Ineffective coping
- Ineffective thermoregulation
- Risk for falls
- Risk for injury
- Total urinary incontinence

Breast cancer
- Acute pain
- Anxiety
- Complicated grieving
- Death anxiety
- Decisional conflict (specify)
- Deficient knowledge (specify)
- Disturbed body image
- Fear
- Grieving

- Impaired skin integrity
- Ineffective coping
- Moral distress
- Powerlessness
- Readiness for enhanced hope
- Readiness for enhanced spiritual well-being
- Readiness for enhanced resilience
- Risk for compromised human dignity
- Spiritual distress

Breast engorgement
- Acute pain
- Impaired comfort
- Impaired skin integrity
- Ineffective breastfeeding
- Readiness for enhanced breastfeeding
- Risk for infection

Bronchiectasis
- Compromised family coping
- Deficient knowledge
- Imbalanced nutrition: Less than body requirements
- Impaired gas exchange
- Ineffective airway clearance
- Ineffective breathing pattern
- Risk for electrolyte imbalance
- Risk for imbalance in fluid volume
- Risk for infection

Bulimia nervosa
- Anxiety
- Constipation
- Deficient fluid volume
- Disabled family coping
- Disturbed body image
- Hyperthermia
- Imbalanced nutrition: Less than body requirements
- Impaired dentition
- Ineffective denial
- Interrupted family processes
- Powerlessness
- Risk for constipation
- Risk for electrolyte imbalance
- Risk for self-mutation
- Risk for self-directed violence
- Sleep deprivation
- Social isolation

Burns
- Acute pain
- Chronic functional constipation
- Constipation
- Deficient diversional activity
- Deficient fluid volume
- Disabled family coping
- Disturbed body image
- Disturbed personal identity
- Dysfunctional ventilatory weaning response
- Electrolyte imbalance
- Grieving
- Hyperthermia
- Hypothermia
- Imbalanced nutrition: Less than body requirements
- Impaired comfort
- Impaired physical mobility
- Impaired skin integrity
- Impaired spontaneous ventilation
- Ineffective breathing pattern
- Ineffective tissue perfusion (renal)
- Powerlessness
- Readiness for enhanced hope
- Readiness for enhanced self-care
- Risk for chronic functional constipation
- Risk for deficient fluid volume
- Risk for electrolyte imbalance
- Risk for falls
- Risk for imbalanced body temperature
- Risk for impaired tissue integrity
- Risk for infection
- Risk for injury

- Risk for hypothermia
- Risk for shock

Cancer
- Chronic functional constipation
- Chronic pain syndrome
- Chronic sorrow
- Death anxiety
- Deficient knowledge
- Disabled family coping
- Grieving
- Ineffective health maintenance
- Nausea
- Readiness for enhanced emancipated decision-making
- Readiness for enhanced knowledge
- Readiness for enhanced religiosity
- Readiness for enhanced self-concept
- Readiness for enhanced spiritual well-being
- Risk for chronic functional constipation
- Risk for impaired tissue integrity
- Risk for infection
- Risk for spiritual distress

Cardiac arrhythmias
- Anxiety
- Decreased cardiac output
- Excess fluid volume
- Fear
- Ineffective sexuality patterns
- Ineffective tissue perfusion (cardiopulmonary)
- Risk for decreased cardiac output
- Risk for electrolyte imbalance
- Risk for imbalanced fluid volume
- Risk for impaired cardiovascular function
- Stress overload

Cardiac disease: End-stage
- Activity intolerance
- Caregiver role strain
- Death anxiety
- Decisional conflict
- Decreased cardiac output
- Defensive coping
- Excess fluid volume
- Grieving
- Hopelessness
- Ineffective breathing pattern
- Ineffective coping
- Impaired physical mobility
- Risk for aspiration
- Risk for caregiver role strain
- Risk for decreased cardiac output
- Risk for electrolyte imbalance
- Risk for falls
- Risk for impaired cardiovascular function
- Risk for infection
- Risk for injury
- Risk for perioperative hypothermia
- Sedentary lifestyle
- Self-care bathing, feeding, dressing, toileting deficit
- Situational low self-esteem

Cardiogenic shock
- Death anxiety
- Decreased cardiac output
- Excess fluid volume
- Fear
- Impaired gas exchange
- Ineffective breathing pattern
- Ineffective tissue perfusion (cardiac)
- Risk for decreased cardiac output
- Risk for impaired cardiovascular function

Carpal tunnel syndrome
- Acute pain
- Impaired physical mobility

- Ineffective tissue perfusion (peripheral)
- Risk for peripheral neurovascular dysfunction
- Sleep deprivation
- Readiness for enhanced comfort

Cataracts
- Disturbed body image
- Disturbed sensory perception (visual)
- Impaired physical mobility
- Ineffective coping
- Ineffective health maintenance
- Risk for falls
- Risk for injury

Cellulitis
- Acute pain
- Anxiety
- Deficient knowledge (specify)
- Impaired physical mobility
- Impaired skin integrity
- Risk for ineffective activity planning

Cerebral aneurysm
- Decreased intracranial adaptive capacity
- Fear
- Impaired physical mobility
- Impaired skin integrity
- Ineffective airway clearance
- Ineffective breathing pattern
- Ineffective tissue perfusion
- Risk for bleeding
- Risk for falls
- Risk for ineffective cerebral tissue perfusion
- Risk for injury
- Risk for shock

Cerebral edema
- Decreased intracranial adaptive capacity
- Impaired gas exchange
- Ineffective thermoregulation
- Risk for electrolyte imbalance
- Risk for ineffective cerebral tissue perfusion

Cerebral palsy
- Impaired physical mobility
- Impaired sitting
- Impaired standing
- Impaired walking
- Impaired verbal communication
- Powerlessness
- Readiness for enhanced self-care
- Risk for caregiver role strain
- Risk for compromised human dignity
- Social isolation
- Toileting self-care deficit
- Total urinary incontinence

Cervical cancer
- Acute pain
- Disturbed body image
- Disturbed personal identity
- Fatigue
- Fear
- Impaired skin integrity
- Ineffective protection
- Deficient knowledge
- Risk-prone health behavior

Chemotherapy
- Constipation
- Deficient diversional activity
- Deficient fluid volume
- Diarrhea
- Disturbed sensory perception (auditory)
- Imbalanced nutrition: Less than body requirements
- Impaired gas exchange
- Impaired oral mucous membrane
- Impaired physical mobility
- Ineffective protection
- Ineffective tissue perfusion
- Nausea
- Readiness for enhanced hope

- Risk for compromised human dignity
- Risk for impaired oral mucous membrane
- Risk for impaired skin integrity
- Risk for impaired tissue integrity
- Risk for infection
- Sexual dysfunction

Chest trauma
- Dysfunctional ventilatory weaning response
- Impaired comfort
- Impaired gas exchange
- Impaired spontaneous ventilation
- Ineffective airway clearance
- Ineffective breathing pattern
- Risk for aspiration
- Risk for ineffective cardiac tissue perfusion
- Risk for shock

Child abuse
- Fear
- Impaired parenting
- Deficient knowledge
- Imbalanced nutrition: Less than body requirements
- Parental role conflict
- Readiness for enhanced parenting
- Risk for impaired parenting
- Risk for other-directed violence
- Disturbed sleep pattern

Childbirth
- Deficient knowledge (specify)
- Ineffective childbearing process
- Interrupted family processes
- Readiness for enhanced childbearing process
- Readiness for enhanced knowledge
- Readiness for enhanced parenting
- Risk for ineffective childbearing process
- Risk for disturbed maternal–fetal dyad

Chlamydia
- Ineffective health management
- Ineffective sexuality patterns
- Risk for infection
- Risk-prone health behavior

Chloride imbalance
- Imbalanced nutrition: Less than body requirements
- Impaired breathing pattern
- Nausea
- Risk for electrolyte imbalance

Cholecystitis
- Acute pain
- Deficient fluid volume
- Imbalanced nutrition: Less than body requirements
- Risk for impaired liver function
- Risk for infection

Chronic bronchitis
- Activity intolerance
- Deficient knowledge (specify)
- Fatigue
- Fear
- Hopelessness
- Impaired comfort
- Impaired gas exchange
- Impaired spontaneous ventilation
- Ineffective airway clearance
- Ineffective breathing pattern
- Risk for ineffective cardiac tissue perfusion
- Risk for infection

Chronic fatigue syndrome
- Acute pain
- Disturbed sleep pattern
- Fatigue
- Hopelessness

- Powerlessness
- Readiness for enhanced therapeutic regimen management
- Social isolation
- Risk for spiritual distress

Chronic obstructive pulmonary disease
- Activity intolerance
- Anxiety
- Caregiver role strain
- Compromised family coping
- Defensive coping
- Deficient fluid volume
- Deficient knowledge (specify)
- Dysfunctional ventilatory weaning response
- Fatigue
- Fear
- Hopelessness
- Imbalanced nutrition: Less than body requirements
- Impaired gas exchange
- Impaired home maintenance
- Impaired oral mucous membrane
- Impaired spontaneous ventilation
- Impaired verbal communication
- Ineffective airway clearance
- Ineffective breathing pattern
- Ineffective denial
- Ineffective health maintenance
- Ineffective health management
- Ineffective tissue perfusion (cardiopulmonary)
- Insomnia
- Noncompliance
- Powerlessness
- Readiness for enhanced coping
- Readiness for enhanced health management
- Readiness for enhanced religiosity
- Risk for falls
- Risk for infection
- Risk for injury
- Risk for suffocation
- Sleep deprivation

Chronic pain
- Anxiety
- Chronic functional constipation
- Chronic low self-esteem
- Chronic pain
- Chronic pain syndrome
- Defensive coping
- Disturbed sleep pattern
- Hopelessness
- Risk for chronic functional constipation
- Risk-prone health behavior
- Situational low self-esteem
- Sleep deprivation

Chronic renal failure
- Caregiver role strain
- Compromised family coping
- Death anxiety
- Deficient knowledge (specify)
- Disturbed body image
- Excess fluid volume
- Ineffective denial
- Ineffective therapeutic management
- Ineffective tissue perfusion (renal)
- Interrupted family processes
- Powerlessness
- Risk for ineffective renal perfusion
- Risk for impaired liver function
- Risk for impaired skin integrity
- Risk for infection
- Risk for vascular trauma
- Sexual dysfunction

Cirrhosis
- Compromised family coping
- Bowel incontinence
- Deficient fluid volume

- Diarrhea
- Disturbed thought processes
- Imbalanced nutrition: Less than body requirements
- Ineffective breathing pattern
- Interrupted family processes: Alcoholism
- Ineffective health management
- Moral distress
- Nausea
- Risk for bleeding
- Readiness for enhanced religiosity
- Risk for electrolyte imbalances
- Risk for falls
- Risk for impaired liver function
- Risk for impaired skin integrity
- Risk for ineffective gastrointestinal tissue perfusion
- Risk for injury
- Risk-prone health behavior
- Self-neglect
- Stress urinary incontinence
- Total urinary incontinence

Cleft lip or palate
- Compromised family coping
- Imbalanced nutrition: Less than body requirements
- Impaired verbal communication
- Ineffective breastfeeding
- Ineffective infant feeding pattern
- Risk for aspiration
- Risk for compromised human dignity

Colic
- Disorganized infant behavior
- Impaired comfort
- Interrupted breastfeeding

Colitis
- Acute pain
- Deficient knowledge
- Deficient fluid volume
- Diarrhea
- Dysfunctional gastrointestinal motility
- Disturbed body image
- Imbalanced nutrition: Less than body requirements
- Ineffective tissue perfusion (GI)
- Risk for imbalanced body temperature
- Risk-prone health behavior

Colon and rectal cancer
- Acute pain
- Anxiety
- Chronic functional constipation
- Constipation
- Deficient fluid volume
- Deficient knowledge (specify)
- Diarrhea
- Fear
- Impaired comfort
- Deficient knowledge
- Risk for chronic functional constipation
- Risk for dysfunctional gastrointestinal motility
- Risk for urinary tract injury

Colostomy
- Complicated grieving
- Deficient fluid volume
- Delayed surgical recovery
- Disturbed body image
- Dysfunctional gastrointestinal motility
- Imbalanced nutrition: Less than body requirements
- Impaired skin integrity
- Ineffective sexuality patterns
- Ineffective tissue perfusion (GI)
- Readiness for enhanced hope
- Readiness for enhanced knowledge

- Readiness for enhanced self-care
- Risk for compromised human dignity
- Situational low self-esteem
- Spiritual distress

Conduct disorder
- Chronic low self-esteem
- Disturbed personal identity
- Hopelessness
- Impaired resilience
- Ineffective impulse control
- Interrupted family processes
- Risk for other-directed violence
- Risk for self-directed violence
- Risk for suicide

Congenital anomalies
- Disabled family coping
- Interrupted family coping
- Risk for falls
- Risk for injury
- Total urinary incontinence

Congenital heart disease
- Activity intolerance
- Decreased cardiac output
- Disturbed body image
- Ineffective breathing pattern
- Interrupted family processes
- Risk for decreased cardiac output
- Risk for impaired cardiovascular function
- Risk for ineffective activity planning
- Risk for disproportionate growth
- Risk for infection
- Risk for injury

Coronary artery disease
- Activity intolerance
- Acute pain
- Anxiety
- Decreased cardiac output
- Deficient knowledge (specify)
- Health-seeking behaviors
- Impaired gas exchange
- Impaired home maintenance
- Ineffective sexuality patterns
- Ineffective therapeutic regimen management
- Ineffective tissue perfusion (cardiopulmonary)
- Readiness for enhanced knowledge
- Readiness for enhanced health management
- Risk for decreased cardiac output
- Risk for impaired cardiovascular function
- Risk for injury
- Risk for overweight
- Risk for perioperative hypothermia
- Risk-prone health behavior
- Sedentary lifestyle
- Stress overload

Cor pulmonale
- Activity intolerance
- Decreased cardiac output
- Excess fluid volume
- Fatigue
- Grieving
- Hopelessness
- Impaired gas exchange
- Ineffective airway clearance
- Ineffective breathing pattern
- Ineffective coping
- Risk for decreased cardiac output
- Risk for impaired cardiovascular function
- Risk for infection

Craniotomy
- Acute pain
- Bathing, feeding, toileting self-care deficit
- Decreased intracranial adaptive capacity
- Delayed surgical recovery

- Disturbed body image
- Disturbed sensory perception
- Disturbed sleep pattern
- Hyperthermia
- Imbalanced nutrition: Less then body requirements
- Impaired physical mobility
- Impaired skin integrity
- Ineffective airway clearance
- Ineffective breathing pattern
- Ineffective tissue perfusion (cerebral)
- Risk for falls
- Risk for infection
- Risk for injury
- Spiritual distress
- Sleep deprivation

Crohn's disease
- Acute pain
- Anxiety
- Compromised family coping
- Deficient fluid volume
- Deficient knowledge (specify)
- Diarrhea
- Disturbed body image
- Dysfunctional gastrointestinal motility
- Fear
- Imbalanced nutrition: Less than body requirements
- Impaired skin integrity
- Insomnia
- Nausea
- Noncompliance
- Readiness for enhanced hope
- Readiness for enhanced self-care
- Risk for imbalanced fluid volume
- Risk for infection
- Stress overload

Cushing's syndrome
- Activity intolerance
- Complicated grieving
- Disturbed body image
- Disturbed thought processes
- Excess fluid volume
- Hopelessness
- Impaired skin integrity
- Ineffective coping
- Risk for acute confusion
- Risk for imbalanced body temperature
- Risk for imbalanced fluid volume
- Risk for overweight

Cystic fibrosis
- Activity intolerance
- Caregiver role strain
- Compromised family coping
- Deficient diversional activity
- Deficient fluid volume
- Imbalanced nutrition: Less than body requirements
- Impaired gas exchange
- Ineffective activity planning
- Ineffective airway clearance
- Ineffective breathing pattern
- Parental role conflict
- Risk for delayed development
- Risk for deficient fluid volume
- Risk for imbalanced body temperature
- Risk for imbalanced fluid volume
- Risk for ineffective activity planning
- Risk for infection

Cystitis
- Acute pain
- Impaired urinary elimination
- Noncompliance
- Overflow urinary incontinence
- Risk for urge urinary incontinence
- Sleep deprivation
- Urge urinary incontinence

Deafness
- Chronic low self-esteem
- Defensive coping

- Disturbed sensory perception (auditory)
- Fear
- Impaired verbal communication
- Ineffective coping
- Readiness for enhanced coping
- Risk for falls
- Risk for injury
- Risk for trauma

Delusional disorder
- Disturbed personality identity
- Impaired home maintenance
- Risk for self-directed violence
- Risk for other-directed violence
- Risk for self-mutilation

Dementia
- Activity intolerance
- Acute confusion
- Caregiver role strain
- Chronic confusion
- Disturbed sensory perception
- Disturbed thought processes
- Frail elderly syndrome
- Functional urinary incontinence
- Impaired emancipated decision-making
- Impaired memory
- Impaired verbal communication
- Interrupted family processes
- Risk for frail elderly syndrome
- Risk for loneliness
- Powerlessness
- Risk for impaired emancipated decision-making
- Risk for injury
- Risk for self-directed violence
- Risk for suicide
- Self-neglect
- Social isolation
- Wandering

Depression
- Caregiver role strain
- Chronic functional constipation
- Chronic low self-esteem
- Constipation
- Deficient diversional activity
- Disturbed body image
- Disturbed personality identity
- Fatigue
- Functional urinary incontinence
- Hopelessness
- Imbalanced nutrition: Less than body requirements
- Impaired home maintenance
- Impaired mood regulation
- Ineffective coping
- Ineffective denial
- Posttrauma syndrome
- Powerlessness
- Rape-trauma syndrome
- Readiness for enhanced nutrition
- Readiness for enhanced resilience
- Readiness for enhanced hope
- Risk for chronic functional constipation
- Risk for impaired resilience
- Risk for constipation
- Risk for injury
- Risk for loneliness
- Risk for poisoning
- Risk for posttrauma syndrome
- Risk for self-directed violence
- Sexual dysfunction
- Sleep deprivation
- Social isolation
- Spiritual distress

Detached retina
- Acute pain
- Anxiety
- Disturbed sensory perception (visual)

- Risk for falls
- Risk for injury

Developmental disorder
- Disabled family coping
- Impaired sitting
- Impaired standing
- Risk for impaired parent–infant–child attachment
- Risk for injury
- Risk for self-mutilation

Diabetes insipidus
- Deficient fluid volume
- Impaired oral mucous membrane
- Risk for deficient fluid volume
- Risk for imbalanced body temperature
- Risk for unstable glucose level

Diabetes mellitus
- Chronic low self-esteem
- Compromised family coping
- Constipation
- Decreased cardiac output
- Deficient knowledge (specify)
- Disturbed body image
- Disturbed sensory perception
- Grieving
- Hopelessness
- Hyperthermia
- Impaired oral mucous membrane
- Impaired skin integrity
- Impaired urinary elimination
- Ineffective coping
- Ineffective health maintenance
- Ineffective sexuality patterns
- Ineffective therapeutic regimen management
- Ineffective tissue perfusion (peripheral)
- Ineffective tissue perfusion (renal)
- Interrupted family coping
- Noncompliance
- Obesity
- Overweight
- Powerlessness
- Readiness for enhanced fluid balance
- Readiness for enhanced nutrition
- Readiness for enhanced resilience
- Readiness for enhanced therapeutic regimen management
- Readiness for enhanced urinary elimination
- Risk for delayed surgical recovery
- Risk for imbalanced fluid volume
- Risk for imbalanced body temperature
- Risk for impaired skin integrity
- Risk for infection
- Risk for injury
- Risk for overweight
- Risk for unstable glucose level
- Risk for vascular trauma
- Risk-prone health behavior
- Self-neglect
- Social isolation

Diabetic ketoacidosis
- Deficient fluid volume
- Deficient knowledge
- Noncompliance
- Risk for acute confusion
- Risk for imbalanced body temperature
- Risk for unstable glucose level
- Risk-prone health behavior

Diarrhea
- Deficient fluid volume
- Diarrhea
- Disturbed body image
- Dysfunctional gastrointestinal motility
- Readiness for enhanced fluid balance

- Risk for electrolyte imbalance
- Risk for imbalanced fluid volume

Digoxin toxicity
- Decreased cardiac output
- Deficient knowledge (specify)
- Risk for decreased cardiac output
- Risk for impaired cardiovascular function
- Risk for ineffective cardiac tissue perfusion
- Risk for poisoning

Disseminated intravascular coagulation
- Decreased cardiac output
- Death anxiety
- Deficient fluid volume
- Fear
- Impaired gas exchange
- Risk for bleeding
- Risk for decreased cardiac output
- Risk for impaired cardiovascular function
- Risk for ineffective cardiac tissue perfusion
- Risk for shock

Dissociative disorder
- Disturbed personality identity
- Disturbed thought processes
- Impaired home maintenance
- Interrupted family processes
- Risk for self-directed violence
- Risk for other-directed violence

Diverticulitis
- Acute pain
- Chronic functional constipation
- Constipation
- Deficient fluid volume
- Diarrhea
- Dysfunctional gastrointestinal motility
- Hyperthermia
- Imbalanced nutrition: Less than body requirements
- Risk for chronic functional constipation
- Risk for electrolyte imbalance

Down syndrome
- Compromised family coping
- Deficient knowledge (specify)
- Defensive coping
- Interrupted family processes
- Readiness for enhanced knowledge
- Readiness for enhanced self-care
- Risk for aspiration
- Risk for delayed development
- Risk for infection
- Risk for injury
- Situational low self-esteem
- Toileting self-care deficit

Drug addiction
- Acute confusion
- Decisional conflict
- Defensive coping
- Deficient community health
- Disturbed personality identity
- Dysfunctional family processes: Alcoholism
- Impaired resilience
- Ineffective community therapeutic regimen management
- Ineffective coping
- Ineffective denial
- Ineffective family health management
- Ineffective health maintenance
- Moral distress
- Risk for compromised human dignity
- Risk for falls
- Risk for injury
- Risk for impaired liver function
- Risk for poisoning

- Risk for self-directed violence
- Risk for sudden infant death syndrome
- Sexual dysfunction
- Sleep deprivation

Drug overdose
- Disturbed thought processes
- Functional urinary incontinence
- Hyperthermia
- Hypothermia
- Impaired comfort
- Impaired gas exchange
- Impaired resilience
- Ineffective coping
- Ineffective thermoregulation
- Risk for compromised human dignity
- Risk for hypothermia
- Risk for poisoning
- Risk for suffocation
- Risk for self-directed violence
- Risk for suicide
- Risk for trauma

Drug toxicity
- Functional urinary incontinence
- Hyperthermia
- Hypothermia
- Impaired resilience
- Impaired gas exchange
- Ineffective protection
- Risk for hypothermia
- Risk for impaired cardiovascular function
- Risk for poisoning

Duodenal ulcer
- Acute pain
- Anxiety
- Imbalanced nutrition: Less than body requirements
- Ineffective tissue perfusion (GI)
- Dysfunctional gastrointestinal motility
- Risk for shock
- Risk for ineffective gastrointestinal tissue perfusion

Ectopic pregnancy
- Acute pain
- Anxiety
- Deficient fluid volume
- Disturbed personal identity
- Fear
- Ineffective tissue perfusion (cardiopulmonary)
- Risk for electrolyte imbalance
- Risk for infection
- Risk for shock
- Situational low self-esteem

Emphysema
- Activity intolerance
- Deficient knowledge (specify)
- Fatigue
- Fear
- Hopelessness
- Imbalanced nutrition: Less than body requirements
- Impaired gas exchange
- Impaired spontaneous ventilation
- Ineffective airway clearance
- Ineffective breathing pattern
- Noncompliance
- Readiness for enhanced coping
- Readiness for enhanced decision-making
- Readiness for enhanced knowledge
- Readiness for enhanced resilience
- Readiness for enhanced sleep
- Risk for infection

Empyema
- Deficient fluid volume
- Impaired gas exchange
- Ineffective breathing pattern
- Risk for infection

Encephalitis
- Activity intolerance
- Acute pain
- Anxiety
- Constipation
- Deficient fluid volume
- Hyperthermia
- Impaired physical mobility
- Ineffective coping
- Ineffective thermoregulation
- Risk for infection

Endocarditis
- Activity intolerance
- Acute pain
- Anxiety
- Decreased cardiac output
- Deficient knowledge (specify)
- Excess fluid volume
- Hyperthermia
- Imbalanced nutrition: Less than body requirements
- Readiness for enhanced knowledge
- Risk for decreased cardiac output
- Risk for impaired cardiovascular function
- Risk for infection
- Risk for ineffective cardiac tissue perfusion

Endometrial cancer
- Acute pain
- Chronic sorrow
- Fear
- Grieving
- Impaired tissue integrity
- Ineffective protection

Endometriosis
- Anxiety
- Decisional conflict
- Deficient fluid volume
- Deficient knowledge (specify)
- Grieving
- Moral distress
- Risk for infection
- Sexual dysfunction
- Spiritual distress

Esophageal cancer
- Acute pain
- Dysfunctional intestinal motility
- Fatigue
- Fear
- Imbalanced nutrition: Less than body requirements
- Impaired resilience
- Impaired swallowing
- Ineffective coping
- Ineffective health management
- Risk for aspiration
- Risk for deficient fluid volume
- Risk for infection

Esophageal fistula
- Imbalanced nutrition: Less than body requirements
- Risk for aspiration
- Risk for deficient fluid volume

Esophageal varices
- Deficient fluid volume
- Disturbed personal identity
- Dysfunctional family processes: Alcoholism
- Imbalanced nutrition: Less than body requirements
- Moral distress
- Readiness for enhanced hope
- Risk for bleeding
- Risk for imbalanced fluid volume
- Risk for impaired skin integrity
- Risk for shock

Failure to thrive
- Deficient fluid volume
- Disorganized infant behavior
- Frail elderly syndrome
- Imbalanced nutrition: Less than body requirements
- Impaired parenting

- Ineffective community coping
- Risk for deficient fluid volume
- Risk for disorganized infant behavior
- Risk for frail elderly syndrome
- Risk for impaired parenting

Fetal alcohol syndrome
- Compromised family coping
- Dysfunctional family processes: Alcoholism
- Ineffective community coping
- Moral distress
- Risk for delayed development
- Risk for disproportionate growth
- Disturbed sleep pattern

Food poisoning
- Acute pain
- Contamination
- Diarrhea
- Disturbed sensory perception (visual)
- Dysfunctional gastrointestinal motility
- Hyperthermia
- Impaired physical mobility
- Impaired verbal communication
- Ineffective breathing pattern
- Nausea
- Risk for contamination
- Risk for electrolyte imbalance
- Risk for imbalance of fluid volume

Fractures
- Activity intolerance
- Acute pain
- Bathing or hygiene self-care deficit
- Compromised family coping
- Deficient diversional activity
- Deficient fluid volume
- Disturbed sensory perception
- Hopelessness
- Impaired parenting
- Impaired physical mobility
- Impaired wheelchair mobility
- Impaired skin integrity
- Impaired transfer ability
- Ineffective breathing pattern
- Ineffective denial
- Risk for constipation
- Risk for disuse syndrome
- Risk for falls
- Risk for infection
- Risk for injury
- Risk for perioperative positioning injury
- Risk for peripheral neurovascular dysfunction
- Risk for trauma
- Risk-prone health behavior

Gallbladder disease
- Acute pain
- Anxiety
- Decisional conflict
- Deficient knowledge
- Delayed surgical recovery
- Fear
- Risk for infection

Gastric cancer
- Imbalanced nutrition: Less than body requirements
- Ineffective tissue perfusion (GI)
- Risk for adverse reaction to iodinated contrast media

Gastric ulcer
- Acute pain
- Anxiety
- Deficient knowledge
- Imbalanced nutrition: Less than body requirements
- Ineffective tissue perfusion (GI)
- Risk for bleeding
- Risk-prone health behavior
- Stress overload

Gastroenteritis
- Deficient fluid volume
- Diarrhea
- Dysfunctional gastrointestinal motility
- Risk for bleeding
- Risk for imbalanced fluid volume
- Risk for imbalanced body temperature

Genital herpes
- Chronic low self-esteem
- Deficient knowledge (specify)
- Hopelessness
- Ineffective community coping
- Ineffective sexuality patterns
- Impaired social interaction
- Powerlessness
- Risk for chronic low self-esteem
- Risk for infection
- Risk for loneliness
- Risk-prone health behavior
- Risk for impaired skin integrity
- Social isolation

Gestational diabetes
- Risk for infection
- Risk for imbalanced fluid level
- Risk for unstable glucose level
- Urge urinary incontinence

Gestational hypertension
- Activity intolerance
- Acute pain
- Deficient fluid volume
- Deficient knowledge (specify)
- Disturbed sensory perception (visual)
- Excess fluid volume
- Fear
- Ineffective tissue perfusion (cerebral)
- Urinary retention

Glaucoma
- Anxiety
- Deficient knowledge (specify)
- Disturbed sensory perception (visual)
- Grieving
- Hopelessness
- Risk for dry eye
- Risk for falls
- Risk for injury
- Social isolation

Glomerulonephritis
- Compromised family coping
- Excess fluid volume
- Imbalanced nutrition: Less than body requirements
- Ineffective tissue perfusion (renal)
- Risk for electrolyte imbalance
- Risk for ineffective renal perfusion
- Risk for infection

Gonorrhea
- Deficient community health
- Deficient knowledge (specify)
- Ineffective community coping
- Ineffective sexuality patterns
- Moral distress
- Noncompliance
- Risk for infection
- Risk-prone health behavior

Gout
- Activity intolerance
- Acute pain
- Deficient knowledge (specify)
- Disturbed body image
- Impaired physical mobility
- Ineffective health management
- Noncompliance
- Risk-prone behavior

Guillain–Barré syndrome
- Activity intolerance
- Acute pain
- Anxiety

- Bathing or hygiene self-care deficit
- Bowel incontinence
- Fatigue
- Impaired gas exchange
- Impaired physical mobility
- Impaired spontaneous ventilation
- Ineffective airway clearance
- Ineffective breathing pattern
- Ineffective coping
- Powerlessness
- Risk for urge urinary incontinence

Headaches
- Acute pain
- Ineffective coping
- Insomnia
- Spiritual distress

Head injury
- Activity intolerance
- Acute confusion
- Bowel incontinence
- Chronic confusion
- Chronic sorrow
- Decreased intracranial adaptive capacity
- Deficient knowledge (specify)
- Disturbed sensory perception
- Disturbed thought processes
- Dressing or grooming self-care deficit
- Fear
- Impaired emancipated decision-making
- Impaired gas exchange
- Impaired memory
- Impaired physical mobility
- Impaired social interaction
- Impaired swallowing
- Impaired verbal communication
- Ineffective thermoregulation
- Ineffective tissue perfusion
- Posttrauma syndrome
- Powerlessness
- Risk for activity intolerance
- Risk for aspiration
- Risk for constipation
- Risk for delayed development
- Risk for disuse syndrome
- Risk for falls
- Risk for imbalanced body temperature
- Risk for imbalanced fluid volume
- Risk for impaired parenting
- Risk for injury
- Risk for trauma
- Risk for urge urinary incontinence
- Sleep deprivation
- Total urinary incontinence
- Unilateral neglect

Head or neck cancer
- Acute pain
- Anxiety
- Disturbed body image
- Disturbed sensory perception
- Impaired oral mucous membrane
- Impaired swallowing
- Impaired tissue integrity
- Impaired verbal communication
- Ineffective airway clearance
- Situational low self-esteem
- Risk for aspiration
- Risk for imbalanced fluid volume

Heart failure
- Activity intolerance
- Acute pain
- Caregiver role strain
- Death anxiety
- Decreased cardiac output
- Deficient knowledge (specify)
- Excess fluid volume
- Fatigue
- Hopelessness
- Impaired gas exchange
- Impaired home maintenance

- Ineffective airway clearance
- Ineffective breathing pattern
- Ineffective tissue perfusion
- Powerlessness
- Risk for activity intolerance
- Risk for caregiver role strain
- Risk for decreased cardiac output
- Risk for deficient fluid volume
- Risk for imbalanced fluid volume
- Risk for impaired cardiovascular function
- Risk for ineffective cardiac tissue perfusion
- Risk for ineffective renal tissue perfusion
- Risk for injury
- Risk for falls

Hemodialysis
- Complicated grieving
- Deficient fluid volume
- Deficient knowledge (specify)
- Disturbed body image
- Excess fluid volume
- Interrupted family processes
- Readiness for enhanced hope
- Risk for falls
- Risk for deficient fluid volume
- Risk for electrolyte imbalance
- Risk for imbalanced fluid volume
- Risk for ineffective renal tissue perfusion
- Risk for ineffective cardiac tissue perfusion
- Risk for infection
- Spiritual distress

Hemophilia
- Acute pain
- Chronic low self-esteem
- Impaired gas exchange
- Ineffective protection
- Parental role conflict
- Readiness for enhanced family coping
- Risk for bleeding
- Risk for falls
- Risk for imbalanced body temperature
- Risk for injury
- Risk for trauma
- Risk-prone health behavior

Hemorrhage
- Deficient fluid volume
- Impaired oral mucous membrane
- Ineffective thermoregulation
- Ineffective tissue perfusion (renal)
- Risk for aspiration
- Risk for bleeding
- Risk for ineffective cardiac tissue perfusion
- Risk for electrolyte imbalance
- Risk for shock

Hemorrhoids
- Acute pain
- Constipation
- Deficient knowledge (specify)
- Impaired comfort
- Impaired skin integrity

Hemothorax
- Acute pain
- Anxiety
- Deficient fluid volume
- Fear
- Impaired gas exchange
- Impaired spontaneous ventilation
- Ineffective breathing pattern
- Ineffective tissue perfusion
- Risk for bleeding
- Risk for shock

Hepatic coma
- Acute confusion
- Deficient fluid volume
- Disturbed sensory perception
- Excess fluid volume

- Imbalanced nutrition: Less than body requirements
- Impaired skin integrity
- Ineffective health management
- Moral distress
- Risk for acute confusion
- Risk for falls
- Risk for infection
- Risk for injury
- Risk for dysfunctional gastrointestinal motility
- Risk for electrolyte imbalance
- Risk for ineffective cerebral tissue perfusion

Hepatitis
- Deficient knowledge (specify)
- Ineffective community coping
- Ineffective community therapeutic regimen management
- Nausea
- Readiness for enhanced community coping
- Risk for electrolyte imbalance
- Risk for imbalanced fluid volume

Hip fracture
- Compromised family coping
- Deficient knowledge (specify)
- Ineffective denial
- Ineffective sexuality patterns
- Powerlessness
- Risk for activity intolerance
- Risk for falls
- Risk for impaired skin integrity
- Risk for infection
- Risk for injury
- Risk for pressure ulcer
- Spiritual distress

Hodgkin's disease
- Deficient knowledge
- Grieving
- Imbalanced nutrition: Less than body requirements
- Impaired physical mobility
- Impaired skin integrity
- Impaired tissue integrity
- Ineffective breathing pattern
- Ineffective oral mucous membrane
- Ineffective protection
- Risk for complicated grieving
- Risk for infection

Huntington's disease
- Bathing or hygiene self-care deficit
- Bowel incontinence
- Caregiver role strain
- Compromised family coping
- Deficient knowledge (specify)
- Hopelessness
- Impaired physical mobility
- Impaired verbal communication
- Ineffective health maintenance
- Risk for loneliness
- Moral distress
- Risk for injury
- Social isolation

Hydatidiform mole
- Acute pain
- Deficient fluid volume
- Grieving
- Risk for situational low self-esteem

Hydrocephalus
- Acute pain
- Anxiety
- Chronic low self-esteem
- Compromised family coping
- Disturbed body image
- Ineffective coping
- Imbalanced nutrition: Less than body requirements
- Interrupted family processes
- Readiness for enhanced family processes
- Risk for impaired skin integrity
- Risk for infection
- Risk for falls

Hyperbilirubinemia
- Interrupted breastfeeding
- Neonatal jaundice
- Risk for injury
- Risk for neonatal jaundice

Hyperemesis gravidarum
- Deficient fluid volume
- Excess fluid volume
- Imbalanced nutrition: Less than body requirements
- Risk for electrolyte imbalance
- Risk for imbalanced fluid volume
- Situational low self-esteem

Hyperosmolar hyperglycemic nonketotic syndrome
- Deficient fluid volume
- Impaired skin integrity
- Ineffective tissue perfusion
- Risk for infection
- Risk for unstable glucose level

Hyperparathyroidism
- Acute pain
- Anxiety
- Deficient knowledge
- Delayed surgical recovery
- Hopelessness
- Imbalanced nutrition: Less than body requirements
- Ineffective breathing pattern
- Ineffective coping
- Risk for imbalanced body temperature
- Risk for impaired skin integrity

Hyperpituitarism
- Acute pain
- Disturbed body image
- Ineffective coping
- Risk for compromised human dignity
- Sexual dysfunction

Hypertension
- Decreased cardiac output
- Deficient knowledge (specify)
- Excess fluid volume
- Health-seeking behaviors
- Impaired resilience
- Ineffective denial
- Ineffective sexuality patterns
- Noncompliance (specify)
- Powerlessness
- Readiness for enhanced urinary elimination
- Risk for decreased cardiac output
- Risk for impaired cardiovascular function
- Risk for situational low self-esteem
- Risk-prone health behavior

Hyperthermia
- Deficient knowledge (specify)
- Hyperthermia
- Impaired oral mucous membrane
- Impaired comfort
- Ineffective thermoregulation

Hyperthyroidism
- Activity intolerance
- Decreased cardiac output
- Disturbed body image
- Disturbed thought processes
- Ineffective thermoregulation
- Insomnia
- Risk for decreased cardiac output
- Risk for imbalanced body temperature
- Risk for impaired cardiovascular function
- Sleep deprivation

Hypoparathyroidism
- Anxiety
- Compromised family coping
- Decreased cardiac output
- Imbalanced nutrition: Less than body requirements
- Ineffective coping
- Ineffective thermoregulation

- Risk for decreased cardiac output
- Risk for impaired cardiovascular function
- Risk for trauma

Hypopituitarism
- Risk for delayed development
- Risk for disproportionate growth

Hypothermia
- Deficient knowledge (specify)
- Hypothermia
- Impaired comfort
- Ineffective thermoregulation

Hypothyroidism
- Activity intolerance
- Chronic functional constipation
- Compromised family coping
- Constipation
- Decreased cardiac output
- Disturbed body image
- Functional urinary incontinence
- Ineffective coping
- Ineffective sexuality patterns
- Ineffective thermoregulation
- Risk for chronic functional constipation
- Risk for decreased cardiac output
- Risk for delayed development
- Risk for disproportionate growth
- Risk for hypothermia
- Risk for imbalanced body temperature
- Risk for impaired cardiovascular function
- Risk for overweight
- Disturbed sleep pattern

Ileostomy
- Anxiety
- Deficient fluid volume
- Deficient knowledge
- Diarrhea
- Disturbed body image
- Fear
- Imbalanced nutrition: Less than body requirements
- Impaired skin integrity
- Ineffective sexuality patterns
- Ineffective tissue perfusion (GI)
- Risk for infection
- Risk for dysfunctional gastrointestinal motility
- Risk for situational low self-esteem

Impotence
- Deficient knowledge (specify)
- Disturbed body image
- Risk for compromised human dignity
- Sexual dysfunction
- Situational low self-esteem
- Urinary retention

Incest
- Ineffective coping
- Interrupted family processes
- Moral distress
- Posttrauma syndrome

Infertility
- Chronic sorrow
- Complicated grieving
- Deficient knowledge (specify)
- Ineffective coping
- Risk for situational low self-esteem
- Stress overload

Inhalation injuries
- Ineffective thermoregulation
- Risk for injury
- Risk for suffocation

Interstitial pulmonary fibrosis
- Activity intolerance
- Anxiety
- Deficient knowledge (specify)
- Grieving
- Impaired gas exchange

- Impaired resilience
- Ineffective airway clearance
- Ineffective breathing pattern
- Ineffective coping
- Insomnia
- Spiritual distress

Intestinal obstruction
- Acute pain
- Chronic functional constipation
- Constipation
- Imbalanced nutrition: Less than body requirements
- Ineffective tissue perfusion (GI)
- Risk for aspiration
- Risk for chronic functional constipation
- Risk for deficient fluid volume
- Risk for dysfunctional gastrointestinal motility
- Risk for electrolyte imbalance
- Risk for imbalanced fluid volume
- Urinary retention

Intoxication
- Disturbed sensory perception
- Hypothermia
- Impaired verbal communication
- Ineffective community therapeutic regimen management
- Moral distress
- Risk for aspiration
- Risk for compromised human dignity
- Risk for falls
- Risk for hypothermia
- Risk for injury

Joint replacement
- Acute pain
- Compromised family coping
- Deficient knowledge (specify)
- Delayed surgical recovery
- Disturbed sensory perception (kinesthetic)
- Impaired physical mobility
- Ineffective peripheral tissue perfusion
- Risk for contamination
- Risk for falls
- Risk for infection
- Risk for injury

Juvenile rheumatoid arthritis
- Acute pain
- Caregiver role strain
- Compromised family coping
- Defensive coping
- Disturbed body image
- Disturbed sensory perception (tactile)
- Grieving
- Impaired resilience
- Impaired physical mobility
- Ineffective health maintenance
- Ineffective role performance
- Interrupted family processes
- Risk for unstable glucose level

Kidney transplantation
- Deficient fluid volume
- Deficient knowledge (specify)
- Delayed surgical recovery
- Disturbed body image
- Ineffective protection
- Interrupted family processes
- Risk for bleeding
- Readiness for enhanced decision-making
- Readiness for enhanced hope
- Readiness for enhanced resilience
- Risk for complicated grieving
- Risk for electrolyte imbalance
- Risk for infection

Labor and delivery
- Acute pain
- Anxiety
- Deficient knowledge (specify)
- Effective breastfeeding

- Impaired skin integrity
- Ineffective breastfeeding
- Ineffective coping
- Insufficient breast milk
- Labor pain
- Readiness for enhanced childbearing
- Risk for bleeding
- Risk for disturbed maternal–fetal dyad
- Risk for injury
- Urinary retention

Leukemia
- Acute pain
- Grieving
- Hopelessness
- Imbalanced nutrition: Less than body requirements
- Impaired gas exchange
- Impaired oral mucous membrane
- Impaired tissue integrity
- Ineffective protection
- Ineffective tissue perfusion (cardiopulmonary)
- Ineffective tissue perfusion (renal)
- Risk for bleeding
- Risk for contamination
- Risk for falls
- Risk for imbalanced body temperature
- Risk for infection
- Risk for injury

Liver transplantation
- Anxiety
- Compromised family coping
- Defensive coping
- Deficient knowledge (specify)
- Delayed surgical recovery
- Fear
- Ineffective coping
- Ineffective protection
- Ineffective tissue perfusion (cardiopulmonary)
- Ineffective tissue perfusion (GI)
- Ineffective tissue perfusion (renal)
- Moral distress
- Risk for impaired liver function
- Risk for electrolyte imbalance
- Risk for imbalanced fluid volume
- Risk for infection
- Risk for injury

Lung abscess
- Acute pain
- Anxiety
- Impaired gas exchange
- Ineffective airway clearance
- Ineffective breathing pattern
- Ineffective coping
- Ineffective tissue perfusion (cardiopulmonary)
- Risk for imbalanced body temperature

Lung cancer
- Activity intolerance
- Death anxiety
- Fear
- Grieving
- Hopelessness
- Imbalanced nutrition: Less than body requirements
- Impaired gas exchange
- Impaired tissue integrity
- Impaired verbal communication
- Ineffective airway clearance
- Ineffective breathing pattern
- Powerlessness
- Risk for infection

Lupus erythematosus
- Acute pain
- Decreased cardiac output
- Deficient knowledge
- Fatigue
- Hyperthermia

- Imbalanced nutrition: Less than body requirements
- Impaired oral mucous membrane
- Impaired physical mobility
- Impaired skin integrity
- Ineffective coping
- Ineffective tissue perfusion
- Risk for infection
- Risk-prone health behavior

Lyme disease
- Activity intolerance
- Acute pain
- Fatigue
- Hyperthermia
- Impaired skin integrity

Lymphomas
- Death anxiety
- Disturbed sleep pattern
- Grieving
- Hopelessness
- Impaired tissue integrity
- Ineffective protection
- Readiness for enhanced decision-making
- Risk for impaired religiosity
- Risk for infection

Macular degeneration
- Activity intolerance
- Deficient knowledge
- Disturbed sensory perception (visual)
- Ineffective denial
- Powerlessness
- Readiness for enhanced hope
- Risk for caregiver role strain
- Risk for low situational self-esteem
- Risk for falls
- Risk for trauma

Malnutrition
- Imbalanced nutrition: Less than body requirements
- Ineffective community coping
- Risk for electrolyte imbalance
- Risk for impaired oral mucous membrane
- Risk for injury

Maternal psychological stress
- Anxiety
- Deficient knowledge
- Ineffective breastfeeding
- Ineffective infant feeding pattern
- Ineffective role performance
- Interrupted breastfeeding
- Parental role conflict
- Risk for impaired attachment
- Risk for disturbed maternal–fetal dyad
- Risk for ineffective childbearing process
- Risk for sudden infant death syndrome
- Powerlessness

Meconium aspiration syndrome
- Ineffective breathing pattern
- Impaired gas exchange
- Impaired spontaneous ventilation
- Risk for aspiration
- Risk for injury

Melanoma
- Death anxiety
- Decisional conflict
- Defensive coping
- Disturbed body image
- Fatigue
- Hopelessness
- Impaired resilience
- Impaired oral mucous membrane
- Impaired skin integrity
- Powerlessness
- Spiritual distress

Ménière's disease
- Disturbed sensory perception (auditory)
- Impaired physical mobility
- Insomnia

- Nausea
- Risk for falls
- Risk for injury
- Risk for trauma

Meningitis
- Acute pain
- Bowel incontinence
- Deficient fluid volume
- Disturbed sensory perception
- Excess fluid volume
- Fatigue
- Fear
- Hyperthermia
- Ineffective airway clearance
- Ineffective breathing pattern
- Risk for imbalanced fluid volume
- Risk for infection
- Risk for injury

Menopause
- Ineffective sexuality patterns
- Insomnia
- Sexual dysfunction
- Situational low self-esteem
- Stress overload
- Risk for imbalanced body temperature

Metabolic acidosis
- Deficient knowledge (specify)
- Impaired airway clearance
- Impaired gas exchange
- Impaired oral mucous membrane
- Ineffective breathing pattern
- Risk for acute confusion
- Risk for electrolyte imbalance
- Risk for injury
- Risk for poisoning
- Risk for shock

Metabolic alkalosis
- Deficient fluid volume
- Disturbed thought processes
- Impaired oral mucous membrane
- Ineffective breathing pattern
- Risk for electrolyte imbalance
- Risk for injury

Mitral insufficiency
- Activity intolerance
- Decreased cardiac output
- Deficient knowledge (specify)
- Fatigue
- Ineffective tissue perfusion (cardiopulmonary)

Mitral stenosis
- Activity intolerance
- Decreased cardiac output
- Deficient knowledge (specify)
- Fatigue
- Ineffective tissue perfusion (cardiopulmonary)
- Risk for infection

Mood disorders
- Impaired religiosity
- Ineffective health management
- Ineffective community therapeutic regimen management
- Labile emotional control
- Powerlessness
- Readiness for enhanced health management
- Risk for impaired resilience
- Risk for suicide
- Self-mutilation
- Social isolation
- Spiritual distress

Multiple births
- Anxiety
- Deficient knowledge (specify)
- Impaired parenting
- Ineffective coping
- Interrupted family processes
- Risk for injury
- Risk for impaired parenting
- Risk for urinary tract injury
- Stress urinary incontinence

Multiple myeloma
- Activity intolerance
- Acute pain

- Excess fluid volume
- Fatigue
- Grieving
- Imbalanced nutrition: Less than body requirements
- Ineffective tissue perfusion (cerebral)
- Risk for infection

Multiple sclerosis
- Acute pain
- Bowel incontinence
- Caregiver role strain
- Chronic low self-esteem
- Death anxiety
- Deficient knowledge (specify)
- Disturbed sensory perception
- Dressing or grooming self-care deficit
- Fatigue
- Grieving
- Imbalanced nutrition: Less than body requirements
- Impaired bed mobility
- Impaired comfort
- Impaired memory
- Impaired physical mobility
- Impaired sitting
- Impaired spontaneous ventilation
- Impaired standing
- Impaired urinary elimination
- Impaired wheelchair mobility
- Ineffective airway clearance
- Ineffective health maintenance
- Ineffective sexuality patterns
- Ineffective therapeutic regimen management
- Readiness for enhanced family coping
- Readiness for enhanced spiritual well-being
- Risk for activity intolerance
- Risk for caregiver role strain
- Risk for infection
- Risk for spiritual distress
- Risk for urge urinary incontinence
- Risk-prone health behavior

Multisystem trauma
- Anxiety
- Bathing or hygiene self-care deficit
- Deficient fluid volume
- Dysfunctional ventilatory weaning response
- Ineffective tissue perfusion
- Impaired spontaneous ventilation
- Powerlessness
- Risk for electrolyte imbalance
- Risk for ineffective cardiac tissue perfusion
- Risk for ineffective cerebral tissue perfusion
- Risk for infection
- Risk for suffocation
- Risk for trauma

Muscular dystrophy
- Caregiver role strain
- Deficient knowledge (specify)
- Disturbed sensory perception (kinesthetic)
- Feeding self-care deficit
- Hopelessness
- Impaired physical mobility
- Impaired sitting
- Impaired standing
- Impaired swallowing
- Impaired transfer ability
- Ineffective health maintenance
- Readiness for enhanced family coping
- Risk for caregiver role strain
- Risk for pressure ulcer
- Risk for urge urinary incontinence
- Risk-prone health behavior

Myasthenia gravis
- Bowel incontinence
- Chronic low self-esteem
- Dressing or grooming self-care deficit

- Dysfunctional ventilatory weaning response
- Fatigue
- Fear
- Impaired gas exchange
- Impaired physical mobility
- Impaired verbal communication
- Ineffective airway clearance
- Readiness for enhanced self-care
- Risk for urge urinary incontinence

Myocardial infarction
- Activity intolerance
- Acute pain
- Anxiety
- Compromised family coping
- Death anxiety
- Decreased cardiac output
- Health-seeking behaviors
- Ineffective coping
- Ineffective denial
- Ineffective role performance
- Ineffective sexuality patterns
- Ineffective tissue perfusion
- Readiness for enhanced spiritual well-being
- Readiness for enhanced relationships
- Risk for decreased cardiac function
- Risk for impaired cardiovascular function
- Risk for ineffective cardiac tissue perfusion
- Risk for spiritual distress
- Risk-prone health behavior
- Sedentary lifestyle
- Sexual dysfunction
- Situational low self-esteem
- Sleep deprivation
- Spiritual distress

Neonatal asphyxia
- Compromised family coping
- Hypothermia
- Ineffective breathing pattern
- Risk for aspiration
- Risk for hypothermia
- Risk for injury
- Risk for sudden infant death syndrome
- Risk for suffocation
- Risk for sudden infant death syndrome

Neonatal hyperbilirubinemia
- Interrupted breastfeeding
- Neonatal jaundice
- Risk for neonatal jaundice

Neurologic impairment (neonatal)
- Compromised family coping
- Ineffective infant feeding pattern
- Disorganized infant behavior
- Readiness for enhanced organized infant behavior
- Risk for disorganized infant behavior

Neuromuscular trauma
- Impaired skin integrity
- Impaired swallowing
- Overflow urinary incontinence
- Posttrauma syndrome
- Risk for aspiration
- Risk for constipation
- Risk for disuse syndrome
- Unilateral neglect

Nutritional deficiencies
- Imbalanced nutrition: Less than body requirements
- Impaired skin integrity
- Risk for impaired parenting
- Risk for infection

Obesity
- Readiness for enhanced nutrition
- Readiness for enhanced self-concept
- Risk for constipation

- Risk for impaired skin integrity
- Risk for impaired tissue integrity
- Situational low self-esteem
- Stress urinary incontinence

Obsessive-compulsive disorder
- Anxiety
- Compromised family coping
- Decisional conflict
- Disturbed personal identity
- Impaired home maintenance
- Ineffective coping
- Ineffective denial
- Insomnia
- Risk for impaired religiosity
- Risk for injury
- Risk for spiritual distress
- Risk for self-directed violence
- Risk for other-directed violence
- Risk for suicide
- Self-mutilation
- Sleep deprivation
- Social isolation

Organic brain syndrome
- Frail elderly syndrome
- Impaired verbal communication
- Risk for deficient fluid volume
- Risk for frail elderly syndrome
- Wandering

Osteoarthritis
- Activity intolerance
- Acute pain
- Compromised family coping
- Deficient knowledge (specify)
- Disturbed body image
- Dressing or grooming self-care deficit
- Impaired home maintenance
- Impaired physical mobility
- Impaired wheelchair ability
- Ineffective health maintenance
- Ineffective health management
- Risk for falls
- Risk for injury

Osteomyelitis
- Acute pain
- Disturbed body image
- Impaired coping
- Impaired physical mobility
- Impaired skin integrity
- Impaired tissue integrity
- Ineffective coping
- Ineffective tissue perfusion (specify)
- Risk for infection
- Risk for injury
- Risk for falls

Osteoporosis
- Deficient knowledge (specify)
- Disturbed body image
- Fear
- Ineffective denial
- Ineffective health management
- Ineffective sexuality patterns
- Loneliness
- Nutrition imbalanced: Less than body requirements
- Powerlessness
- Risk for falls
- Risk for injury
- Risk for trauma
- Risk-prone health behaviors
- Self-neglect
- Social isolation

Ovarian cancer
- Constipation
- Death anxiety
- Fear
- Grieving
- Imbalanced nutrition: Less than body requirements
- Impaired tissue integrity
- Ineffective coping
- Ineffective protection
- Nausea
- Powerlessness

- Readiness for enhanced hope
- Readiness for enhanced resilience
- Readiness for enhanced spiritual well-being
- Risk for falls
- Spiritual distress
- Urinary retention

Panic disorder
- Anxiety
- Chronic low self-esteem
- Deficient knowledge (specify)
- Fear
- Impaired emancipated decision-making
- Impaired resilience
- Impaired mood regulation
- Ineffective coping
- Insomnia
- Powerlessness
- Risk for impaired emancipated decision-making
- Risk for posttrauma syndrome
- Sleep deprivation
- Risk for spiritual distress

Paralysis
- Autonomic dysreflexia
- Bowel incontinence
- Caregiver role strain
- Complicated grieving
- Compromised family coping
- Disuse syndrome
- Hopelessness
- Impaired bed mobility
- Impaired physical mobility
- Impaired sitting
- Impaired skin integrity
- Impaired standing
- Impaired walking
- Ineffective coping
- Ineffective health maintenance
- Ineffective role performance
- Ineffective sexuality patterns
- Powerlessness
- Reflex urinary incontinence
- Risk for caregiver role strain
- Risk for impaired skin integrity
- Risk for impaired tissue integrity
- Risk for pressure ulcer

Parkinson's disease
- Activity intolerance
- Bowel incontinence
- Caregiver role strain
- Chronic low self-esteem
- Compromised family coping
- Death anxiety
- Deficient knowledge (specify)
- Disturbed body image
- Disturbed sensory perception (tactile)
- Feeding self-care deficit
- Grieving
- Hopelessness
- Imbalanced nutrition: Less than body requirements
- Impaired home maintenance
- Impaired resilience
- Impaired physical mobility
- Impaired transfer ability
- Ineffective breathing pattern
- Ineffective coping
- Ineffective health maintenance
- Ineffective role performance
- Ineffective sexuality patterns
- Loneliness
- Powerlessness
- Readiness for enhanced therapeutic regimen management
- Risk for aspiration
- Risk for caregiver role strain
- Risk for compromised human dignity
- Risk for injury
- Risk for falls
- Risk for loneliness
- Risk for urge urinary incontinence
- Social isolation

Pelvic inflammatory disease
- Acute pain
- Deficient fluid volume
- Ineffective sexuality pattern
- Risk for infection
- Risk-prone health behavior
- Sexual dysfunction

Pericarditis
- Activity intolerance
- Acute pain
- Anxiety
- Decreased cardiac output
- Deficient knowledge
- Ineffective tissue perfusion (cardiopulmonary)
- Risk for decreased cardiac output
- Risk for impaired cardiovascular function
- Risk for ineffective cardiac tissue perfusion
- Risk for infection
- Risk for shock

Perinatal trauma
- Decisional conflict
- Hypothermia
- Impaired gas exchange
- Impaired spontaneous ventilation
- Risk for hypothermia
- Risk for injury
- Risk for ineffective cardiac tissue perfusion
- Risk for ineffective cerebral tissue perfusion
- Risk for ineffective renal tissue perfusion
- Risk for shock
- Risk for vascular trauma

Peripheral vascular disease
- Activity intolerance
- Acute pain
- Deficient diversional activity
- Deficient knowledge (specify)
- Impaired physical mobility
- Impaired skin integrity
- Impaired tissue integrity
- Ineffective health management
- Risk for falls
- Risk for impaired skin integrity
- Risk for ineffective peripheral tissue perfusion
- Risk for vascular trauma
- Risk for impaired tissue integrity
- Risk for infection
- Risk for injury
- Risk for peripheral neurovascular dysfunction
- Risk-prone health behavior

Peritoneal dialysis
- Caregiver role strain
- Defensive coping
- Deficient fluid volume
- Deficient knowledge (specify)
- Disabled family coping
- Disturbed body image
- Excess fluid volume
- Imbalanced nutrition: Less than body requirements
- Impaired resilience
- Interrupted family processes
- Risk for electrolyte imbalance
- Risk for infection
- Risk for injury

Peritonitis
- Acute pain
- Anxiety
- Decreased cardiac output
- Deficient fluid volume
- Nausea
- Risk for decreased cardiac output
- Risk for electrolyte imbalance
- Risk for ineffective gastrointestinal tissue perfusion
- Risk for ineffective cardiac tissue perfusion
- Risk for ineffective renal tissue perfusion

- Risk for imbalanced fluid volume
- Risk for impaired cardiovascular function
- Risk for infection
- Risk for shock

Personality disorders
- Decisional conflict
- Deficient knowledge
- Disturbed personal identity
- Impaired resilience
- Interrupted family processes
- Loneliness
- Risk for loneliness
- Risk for self-directed violence
- Risk for suicide
- Sexual dysfunction
- Social isolation

Phobic disorder
- Anxiety
- Disturbed personal identity
- Fear
- Hopelessness
- Ineffective coping
- Powerlessness
- Risk for impaired resilience
- Risk for loneliness
- Social isolation

Placenta previa
- Anxiety
- Fear
- Ineffective denial
- Risk for disturbed maternal–fetal dyad
- Risk for situational low self-esteem

Pleural effusion
- Acute pain
- Dysfunctional ventilatory weaning response
- Hyperthermia
- Impaired gas exchange
- Ineffective breathing pattern
- Risk for infection

Pleurisy
- Acute pain
- Fatigue
- Impaired gas exchange
- Ineffective breathing pattern

Pneumonia
- Bathing or hygiene self-care deficit
- Feeding and toileting self-care deficit
- Deficient fluid volume
- Imbalanced nutrition: Less than body requirements
- Impaired gas exchange
- Impaired physical mobility
- Impaired spontaneous ventilation
- Impaired verbal communication
- Ineffective airway clearance
- Ineffective breathing pattern
- Ineffective tissue perfusion (cardiopulmonary)
- Readiness for enhanced sleep
- Risk for aspiration
- Risk for electrolyte imbalance
- Risk for imbalanced fluid volume
- Risk for infection

Pneumothorax
- Anxiety
- Ineffective breathing pattern
- Fear
- Impaired gas exchange
- Acute pain
- Ineffective tissue perfusion (cardiopulmonary)
- Impaired spontaneous ventilation

Poisoning
- Contamination
- Disturbed sensory perception
- Ineffective tissue perfusion (renal)
- Nausea
- Risk for aspiration

- Risk for bleeding
- Risk for injury
- Risk for poisoning
- Risk for shock

Polycystic kidney disease
- Acute pain
- Anxiety
- Defensive coping
- Deficient knowledge (specify)
- Fear
- Ineffective tissue perfusion (renal)
- Interrupted family processes
- Moral distress
- Risk for infection
- Risk for urinary tract injury

Polycythemia vera
- Acute pain
- Disturbed sensory perception (visual)
- Fatigue
- Impaired gas exchange
- Impaired skin integrity
- Ineffective breathing pattern
- Risk for bleeding
- Risk for injury

Postpartum hemorrhage
- Anxiety
- Deficient fluid volume
- Ineffective tissue perfusion
- Risk for bleeding
- Risk for ineffective renal tissue perfusion
- Risk for shock

Posttraumatic stress disorder
- Ineffective impulse control
- Ineffective relationships
- Defensive coping
- Disabled family coping
- Disturbed personal identity
- Disturbed sensory perception
- Hopelessness
- Ineffective activity planning
- Interrupted family processes

Posttrauma syndrome
- Powerlessness
- Risk for loneliness
- Risk for posttrauma syndrome
- Risk for other-directed violence
- Risk for self-directed violence
- Risk for self-mutilation
- Risk for suicide
- Situational low self-esteem
- Sleep deprivation

Pregnancy
- Anxiety
- Deficient knowledge (specify)
- Impaired tissue integrity
- Ineffective coping
- Ineffective tissue perfusion (peripheral)
- Interrupted family processes
- Readiness for enhanced childbearing
- Readiness for enhanced fluid balance
- Readiness for enhanced relationships
- Risk for constipation

Premature labor
- Anxiety
- Deficient knowledge (specify)
- Effective breastfeeding
- Impaired parenting
- Ineffective coping
- Risk for disturbed maternal–fetal dyad
- Risk for infection
- Situational low self-esteem

Premature rupture of membranes
- Risk for infection

Prematurity
- Compromised family coping
- Disorganized infant behavior
- Hypothermia

- Imbalanced nutrition: Less than body requirements
- Impaired verbal communication
- Ineffective breastfeeding
- Ineffective breathing pattern
- Ineffective infant feeding pattern
- Ineffective thermoregulation
- Interrupted breastfeeding
- Readiness for enhanced parenting
- Risk for aspiration
- Risk for delayed development
- Risk for disorganized infant behavior
- Risk for disturbed maternal–fetal dyad
- Risk for hypothermia
- Risk for impaired parent–infant–child attachment
- Risk for sudden infant death syndrome

Pressure ulcers
- Imbalanced nutrition: Less than body requirements
- Impaired physical mobility
- Impaired skin integrity
- Impaired tissue integrity
- Ineffective protection
- Risk for deficient fluid volume
- Risk for infection

Prolapsed intervertebral disc
- Acute pain
- Impaired physical mobility
- Powerlessness
- Reflex urinary incontinence
- Urinary retention

Prostate cancer
- Acute pain
- Chronic sorrow
- Deficient knowledge
- Impaired skin integrity
- Impaired tissue integrity
- Risk for situational low self-esteem
- Risk for urinary tract injury
- Sexual dysfunction
- Urinary retention

Prostatectomy
- Acute pain
- Disturbed body image
- Ineffective protection
- Ineffective role performance
- Impaired skin integrity
- Risk for infection
- Urinary retention

Pseudomembranous colitis
- Deficient fluid volume
- Diarrhea
- Impaired skin integrity
- Ineffective tissue perfusion (cardiopulmonary)
- Ineffective tissue perfusion (GI)
- Ineffective tissue perfusion (renal)
- Risk for bleeding
- Risk for electrolyte imbalance

Psoriasis
- Deficient knowledge
- Disturbed body image
- Impaired skin integrity
- Powerlessness
- Risk for imbalanced body temperature
- Social isolation
- Risk for infection

Pulmonary edema
- Activity intolerance
- Bathing or hygiene self-care deficit
- Decreased cardiac output
- Dysfunctional ventilatory weaning response
- Excess fluid volume
- Fear
- Impaired gas exchange
- Impaired verbal communication

- Ineffective airway clearance
- Ineffective breathing pattern
- Ineffective tissue perfusion (cardiopulmonary)
- Risk for decreased cardiac output
- Risk for impaired cardiovascular function
- Risk for ineffective cardiac tissue perfusion
- Risk for ineffective cerebral tissue perfusion
- Risk for ineffective renal tissue perfusion

Pulmonary embolus
- Acute pain
- Anxiety
- Activity intolerance
- Decreased cardiac output
- Deficient fluid volume
- Impaired gas exchange
- Impaired verbal communication
- Ineffective breathing pattern
- Ineffective tissue perfusion (cardiopulmonary)
- Risk for decreased cardiac output
- Risk for impaired cardiovascular function
- Risk for ineffective cardiac tissue perfusion

Pyelonephritis
- Acute pain
- Excess fluid volume
- Impaired physical mobility
- Risk for infection
- Risk for electrolyte balance
- Risk for imbalanced fluid volume

Pyloric stenosis
- Acute pain
- Imbalanced nutrition: Less than body requirements
- Risk for aspiration
- Risk for imbalanced body temperature

Radiation therapy
- Acute pain
- Deficient fluid volume
- Diarrhea
- Imbalanced nutrition: Less than body requirements
- Impaired oral mucous membrane
- Impaired physical mobility
- Impaired tissue integrity
- Ineffective protection
- Nausea
- Risk for impaired oral mucous membrane
- Risk for impaired tissue integrity
- Sexual dysfunction
- Rape
- Anxiety
- Complicated grieving
- Fear
- Posttrauma syndrome
- Rape-trauma syndrome
- Risk for compromised human dignity
- Risk for thermal injury
- Situational low self-esteem
- Social isolation

Raynaud's disease
- Deficient knowledge (specify)
- Disturbed sensory perception (tactile)
- Impaired tissue integrity
- Ineffective tissue perfusion (peripheral)
- Risk for impaired skin integrity
- Risk for ineffective peripheral tissue perfusion

Renal calculi
- Acute pain
- Ineffective denial
- Risk for infection

- Risk for urinary tract injury
- Urinary retention

Renal cancer
- Acute pain
- Deficient fluid volume
- Risk for electrolyte balance
- Risk for imbalanced fluid volume

Renal disease: End-stage
- Caregiver role strain
- Chronic low self-esteem
- Decisional conflict
- Defensive coping
- Excess fluid volume
- Grieving
- Hopelessness
- Ineffective coping
- Ineffective denial
- Ineffective role performance
- Ineffective sexuality patterns
- Risk for caregiver role strain
- Risk for disuse syndrome
- Risk for infection
- Risk for poisoning
- Risk for spiritual distress
- Spiritual distress

Respiratory distress syndrome
- Dysfunctional weaning response
- Impaired gas exchange
- Impaired spontaneous ventilation
- Ineffective airway clearance
- Ineffective breathing pattern
- Ineffective thermoregulation
- Risk for infection

Reye's syndrome
- Decreased intracranial adaptive capacity
- Hyperthermia
- Impaired physical mobility
- Ineffective thermoregulation

Rheumatoid arthritis
- Activity intolerance
- Acute pain
- Deficient knowledge (specify)
- Disturbed body image
- Dressing or grooming self-care deficit
- Impaired physical mobility
- Impaired skin integrity
- Impaired transfer ability
- Ineffective coping
- Ineffective denial
- Ineffective health maintenance
- Ineffective protection
- Ineffective therapeutic regimen management
- Insomnia
- Risk for disuse syndrome
- Risk for falls
- Risk for ineffective activity planning
- Risk for injury
- Risk-prone health management
- Sexual dysfunction

Salmonella
- Constipation
- Diarrhea
- Hyperthermia
- Nausea
- Risk for dysfunctional gastrointestinal motility
- Risk for electrolyte imbalance
- Risk for imbalanced fluid volume
- Risk for infection
- Urinary retention

Sarcoidosis
- Activity intolerance
- Acute pain
- Decreased cardiac output
- Disturbed body image
- Impaired gas exchange
- Ineffective breathing pattern

Schizophrenia
- Anxiety

- Bathing or hygiene self-care deficit
- Caregiver role strain
- Disturbed personal identity
- Disturbed sensory perception
- Dysfunctional family processes
- Functional urinary incontinence
- Hopelessness
- Impaired emancipated decision-making
- Impaired home maintenance
- Impaired mood regulation
- Impaired social interaction
- Interrupted family processes
- Ineffective coping
- Ineffective therapeutic family regimen management
- Ineffective health maintenance
- Ineffective relationships
- Ineffective role performance
- Interrupted family processes
- Insomnia
- Labile mood control
- Risk for caregiver role strain
- Risk for impaired emancipated decision-making
- Risk for injury
- Risk for poisoning
- Risk for self-directed violence
- Risk for suicide
- Sexual dysfunction
- Social isolation

Seizure disorders
- Anxiety
- Chronic low self-esteem
- Disturbed sensory perception (tactile)
- Impaired memory
- Ineffective airway clearance
- Ineffective breathing pattern
- Ineffective coping
- Ineffective therapeutic management
- Risk for delayed development
- Risk for falls
- Risk for impaired oral mucous membrane
- Risk for injury
- Risk for spiritual distress
- Risk for trauma
- Risk-prone health behavior
- Social isolation
- Self-neglect

Self-destructive behavior
- Anxiety
- Chronic low self-esteem
- Ineffective denial
- Risk for poisoning
- Risk for self-directed violence
- Risk for self-mutilation

Sepsis
- Acute confusion
- Acute pain
- Diarrhea
- Dysfunctional ventilatory weaning response
- Hyperthermia
- Hypothermia
- Nausea
- Imbalanced nutrition: Less than body requirements
- Impaired spontaneous ventilation
- Ineffective thermoregulation
- Risk for hypothermia
- Risk for ineffective cardiac tissue perfusion
- Risk for ineffective renal perfusion
- Risk for shock

Sexual assault
- Posttrauma syndrome
- Rape-trauma syndrome
- Risk for self-directed violence
- Risk for suicide

Shaken baby syndrome
- Disabled family coping
- Impaired parenting
- Interrupted family processes
- Risk for impaired parenting

- Risk for ineffective cerebral tissue perfusion
- Risk for impaired attachment
- Risk for injury
- Risk for other-directed violence

Shock
- Decreased cardiac output
- Deficient fluid volume
- Impaired gas exchange
- Impaired oral mucous membrane
- Impaired spontaneous ventilation
- Ineffective airway clearance
- Ineffective tissue perfusion (cardiopulmonary)
- Ineffective tissue perfusion (cerebral)
- Ineffective tissue perfusion (renal)
- Risk for decreased cardiac output
- Risk for electrolyte imbalance
- Risk for impaired cardiovascular function
- Risk for infection

Sickle cell anemia
- Acute pain
- Impaired gas exchange
- Impaired physical mobility
- Ineffective protection
- Ineffective tissue perfusion (peripheral)
- Ineffective tissue perfusion (renal)

Sjögren's syndrome
- Acute pain
- Disturbed sensory perception (gustatory)
- Risk for corneal injury
- Risk for dry eye
- Impaired oral mucous membrane

Spina bifida
- Bowel incontinence
- Impaired skin integrity
- Latex allergy response
- Risk for physical immobility
- Risk for latex allergy response
- Urinary incontinence

Spinal cord defects
- Chronic low self-esteem
- Impaired urinary elimination
- Overflow urinary incontinence
- Readiness for enhanced family coping
- Risk-prone health behavior
- Total urinary incontinence

Spinal cord injury
- Activity intolerance
- Autonomic dysreflexia
- Bathing or hygiene self-care deficit
- Bowel incontinence
- Chronic functional constipation
- Chronic pain
- Chronic sorrow
- Complicated grieving
- Constipation
- Deficient diversional activity
- Deficient knowledge (specify)
- Disturbed body image
- Disturbed sensory perception
- Fear
- Hopelessness
- Impaired physical mobility
- Impaired sitting
- Impaired spontaneous ventilation
- Impaired standing
- Impaired transfer ability
- Impaired urinary elimination
- Ineffective airway clearance
- Ineffective health maintenance
- Ineffective sexuality patterns
- Ineffective therapeutic regimen management

- Moral distress
- Posttrauma syndrome
- Powerlessness
- Readiness for enhanced communication
- Readiness for enhanced therapeutic regimen management
- Reflex urinary incontinence
- Risk for autonomic dysreflexia
- Risk for chronic functional constipation
- Risk for constipation
- Risk for delayed development
- Risk for disuse syndrome
- Risk for impaired skin integrity
- Risk for impaired tissue integrity
- Risk for infection
- Risk for pressure ulcer
- Risk for trauma
- Risk for urge urinary incontinence
- Risk-prone health behavior
- Sleep deprivation
- Social isolation
- Total urinary incontinence
- Urinary retention

Spinal tumor
- Autonomic dysreflexia
- Bowel incontinence
- Chronic low self-esteem
- Disturbed sensory perception (kinesthetic)
- Dressing or grooming self-care deficit
- Impaired physical mobility
- Impaired urinary elimination
- Ineffective breathing pattern
- Reflex urinary incontinence
- Risk for autonomic dysreflexia
- Risk for impaired skin integrity
- Risk for injury
- Risk for urge urinary incontinence
- Sexual dysfunction
- Situational low self-esteem
- Total urinary incontinence

Spouse abuse
- Anxiety
- Defensive coping
- Deficient knowledge (specify)
- Fear
- Hopelessness
- Impaired emancipated decision-making
- Posttrauma syndrome
- Powerlessness
- Rape-trauma syndrome
- Readiness for enhanced hope
- Readiness for enhanced knowledge
- Readiness for enhanced parenting
- Readiness for enhanced power
- Readiness for enhanced self-concept
- Readiness for enhanced health management
- Risk for impaired emancipated decision-making
- Risk for other-directed violence
- Risk for suicide
- Stress overload

Streptococcal throat
- Acute pain
- Hyperthermia
- Impaired oral mucous membrane
- Risk for infection

Stroke
- Acute confusion
- Bathing or hygiene self-care deficit
- Bowel incontinence
- Caregiver role strain
- Chronic confusion

- Chronic functional constipation
- Chronic sorrow
- Compromised family coping
- Constipation
- Death anxiety
- Decreased intracranial adaptive capacity
- Deficient knowledge (specify)
- Disturbed body image
- Disturbed sensory perception (tactile)
- Fatigue
- Frail elderly syndrome
- Functional urinary incontinence
- Hopelessness
- Imbalanced nutrition: Less than body requirements
- Impaired bed mobility
- Impaired gas exchange
- Impaired home maintenance
- Impaired memory
- Impaired physical mobility
- Impaired sitting
- Impaired social interaction
- Impaired standing
- Impaired swallowing
- Impaired urinary elimination
- Impaired verbal communication
- Impaired walking
- Ineffective airway clearance
- Ineffective breathing pattern
- Ineffective health maintenance
- Ineffective sexuality patterns
- Ineffective thermoregulation
- Ineffective tissue perfusion (cerebral)
- Interrupted family processes
- Powerlessness
- Readiness for enhanced family processes
- Risk for activity intolerance
- Risk for aspiration
- Risk for caregiver role strain
- Risk for chronic functional constipation
- Risk for compromised human dignity
- Risk for disuse syndrome
- Risk for frail elderly syndrome
- Risk for impaired skin integrity
- Risk for injury
- Risk for poisoning
- Risk for pressure ulcer
- Situational low self-esteem
- Sleep deprivation
- Social isolation
- Stress urinary incontinence
- Total urinary incontinence
- Unilateral neglect

Suicidal behavior
- Anxiety
- Chronic low self-esteem
- Disturbed personal identity
- Ineffective denial
- Readiness for enhanced spiritual well-being
- Risk for poisoning
- Risk for self-directed violence
- Risk for self-mutilation

Tendinitis
- Acute pain
- Activity intolerance
- Impaired physical mobility
- Ineffective role performance

Testicular cancer
- Acute pain
- Death anxiety
- Disturbed body image
- Fear
- Hopelessness
- Powerlessness
- Sexual dysfunction
- Risk for situational low self-esteem

Thoracic surgery
- Acute pain
- Deficient fluid volume
- Fatigue
- Fear

- Impaired gas exchange
- Ineffective airway clearance
- Ineffective breathing pattern
- Risk for bleeding
- Risk for delayed surgical recovery
- Risk for infection
- Risk for perioperative position injury

Thrombophlebitis
- Acute pain
- Impaired gas exchange
- Impaired skin integrity
- Ineffective tissue perfusion (peripheral)
- Risk for impaired skin integrity
- Risk for infection
- Risk for injury
- Risk for vascular trauma

Tracheoesophageal fistula
- Imbalanced nutrition: Less than body requirements
- Risk for aspiration

Tracheostomy
- Imbalanced nutrition: Less than body requirements
- Impaired skin integrity
- Impaired verbal communication

Transient ischemic attacks
- Acute confusion
- Disturbed sensory perception (tactile)
- Impaired memory
- Ineffective tissue perfusion (cerebral)
- Risk for bleeding
- Risk for ineffective cerebral tissue perfusion

Trauma
- Death anxiety
- Disabled family coping
- Disturbed sensory perception (auditory)
- Risk for bleeding
- Risk for corneal injury
- Risk for self-directed violence
- Risk for shock
- Risk for urinary tract injury

Trigeminal neuralgia
- Acute pain
- Anxiety
- Deficient knowledge (specify)
- Imbalanced nutrition: Less than body requirements

Tuberculosis
- Deficient community health
- Deficient knowledge
- Fatigue
- Fear
- Impaired dentition
- Impaired gas exchange
- Ineffective airway clearance
- Ineffective breathing pattern
- Ineffective community coping
- Risk for infection
- Risk for loneliness
- Social isolation

Urinary calculi
- Acute pain
- Anxiety
- Impaired urinary elimination
- Ineffective tissue perfusion (renal)
- Readiness for enhanced urinary elimination
- Risk for infection
- Risk for urinary tract injury

Urinary diversion
- Acute pain
- Constipation
- Disturbed personal identity
- Grieving
- Impaired skin integrity
- Ineffective breathing pattern
- Ineffective sexuality patterns
- Risk for infection
- Sexual dysfunction

Urinary incontinence
- Anxiety
- Functional urinary incontinence
- Impaired skin integrity
- Overflow urinary incontinence
- Reflex urinary incontinence
- Social isolation
- Stress urinary incontinence
- Total urinary incontinence

Urinary tract infection
- Acute pain
- Impaired urinary elimination
- Readiness for enhanced urinary elimination
- Risk for infection
- Risk for urge urinary incontinence
- Stress urinary incontinence
- Urge urinary incontinence

Uterine prolapse
- Disturbed body image
- Stress urinary incontinence
- Risk for situational low self-esteem

Uterine rupture
- Acute pain
- Deficient fluid volume
- Ineffective tissue perfusion (cardiopulmonary)
- Ineffective tissue perfusion (cerebral)
- Ineffective tissue perfusion (renal)
- Risk for bleeding
- Risk for electrolyte imbalance
- Risk for shock

Vascular insufficiency
- Impaired tissue integrity
- Risk for peripheral neurovascular dysfunction

Viral hepatitis
- Deficient fluid volume
- Imbalanced nutrition: Less than body requirements
- Impaired skin integrity
- Risk for impaired skin integrity
- Risk for infection
- Social isolation

APPENDIX

Table A: Assessment Parameters© Based on Taxonomy of Nursing Practice*

CLASS	OBJECTIVE DATA
Functional Domain	
Activity/exercise	Functional mobility status: 0 = completely independent 1 = requires use of equipment or device 3 = requires help from another person and equipment or device 4 = dependent, doesn't participate in activity
Comfort	Muscle tone: listless to rigid Autonomic responses: pulse rate, diaphoresis, blood pressure, respiratory rate. Behavior changes: loss of consciousness (LOC), increased irritability, lethargy, or aggression; elderly and young children can manifest pain in behavior changes.
Growth and development	Height/weight—compare to pediatric growth grid: concern if child has ↑↓ 2 SD on the CDC Growth Chart Bone/Tooth development Developmental Exam (DDS II)
Nutrition	Weight (compare to normal chart) Laboratory studies: Serum albumin, glucose: infant, 60–105; children and adults, 70–115. Bilirubin total: Normal adults: 0.1–1.2 mg/dL 0- to 1-day-old: <6 mg/dL 1- to 2-day-old: <12 mg/dL 3- to 5-day-old: <12 mg/dL Breast exam: sore or bleeding nipples, engorgement, signs of infection, signs of oxytocin release
Self-care	Self-care status: score separately for bathing, hygiene, dressing, grooming, feeding, and toileting 0 = completely independent 1 = requires use of equipment or device 3 = requires help from another person and equipment or device 4 = dependent, doesn't participate in activity
Sexuality	Use of antihypertensives, neuroleptics, sedatives, tranquilizers, or sexual enhancing drugs
Sleep/rest	
Values/beliefs	

*Ralph, S. (2009). *Assessment Parameters Based on Taxonomy of Nursing Practice*. Copyright by Author, Hamilton, VA. Dochterman, J. M., & Jones, D. A. (Eds.). (2003). *Unifying nursing languages: The harmonization of NANDA, NIC, and NOC*. Washington, DC: NursesBooks.org.

SUBJECTIVE DATA
Usual activity level, daily schedule, usual exercise patterns Reports of inability to carry out activities of daily living (ADLs) or instrumental activities of daily living (IADLs); overwhelming lack of energy (thyroid studies: abnormalities in thyroid hormone levels can manifest in decreased energy levels)
Characteristics of pain: location, duration, time of day when pain is most severe, sources of relief Placement on pain scale 1–10, with 10 being most severe; for children: faces scale Use of pain medications (including prescription and over the counter/illegal)
Growth history; genetic factors, lead screening, Sexual Maturation Index Scale for Adolescents Signs of puberty for girls as early as 8 and boys 9; concern if no signs of puberty in girls 13 and boys 14
Daily food intake, usual dietary patterns, food preferences, food allergies, changes in weight, dentures (proper fit). Report of difficulty breast-feeding or incomplete emptying (normal weight gain key in assessing nutritional status for infants and children). Infants should reach birth weight by 2 wk, double birth weight by 6 mo, triple birth weight by 1 yr, and 4 × birth weight by 2.5 yr; slow weights gain 2–3 lb a year normal until adolescence. BMI: concern if greater than 18 kg/m^2
Report of difficulty or inability to carry out one or more ADLs
Perception of sexual identity; sexuality status: changes in sexual behavior, usual patterns of sexuality, sexual dysfunction, impotence, vaginismus, decreased or increased libido, dyspareunia, premature ejaculation
Description of sleep patterns, usual sleep routines, expression of tiredness or lack of being rested after sleep, use of sleep-disturbing drugs, usual activity and work patterns, sleep environment Pain: medications, alcohol consumption, depression, caffeine intake, and stress affect sleep Sleep apnea: enlarged tonsils in young children; in older children and adults, obesity may be a finding for sleep apnea
Spiritual status, including religious affiliation, current perception of faith and religious practices, spiritual beliefs linked to current distress, change in usual spiritual practices, relationship between spiritual beliefs and everyday living, unmet spiritual needs (meaning and purpose, love and relatedness, forgiveness)

(*continued*)

Table A: Assessment Parameters© Based on Taxonomy of Nursing Practice* (*continued*)

CLASS	OBJECTIVE DATA
Physiologic Domain	
Cardiac function	Cardiovascular status: heart rate and rhythm; skin color, temperature, and turgor; jugular vein distension, hepatojugular reflux, heart sounds, blood pressure, peripheral pulses, electrocardiogram, results of echocardiogram
Elimination	Gastrointestinal (GI) status: stool characteristics, bowel sounds, abdominal distension Genitourinary status: characteristics of urine, palpation of bladder, results of intravenous pyelogram, electrolytes, blood urea nitrogen (BUN), creatinine level, urinalysis, intake and output, mucous membranes, urine specific gravity
Fluid and electrolytes	Fluid and electrolyte status, weight, intake and output, urine specific gravity, skin turgor, mucous membranes, results of laboratory studies (hemoglobin [Hgb]/hematocrit [Hct]—overhydration or dehydration; Hct ↑dehydration, ↓if the person has been rehydrated too rapidly or is retaining fluid. Hct should be 3 times the Hgb. Serum electrolytes, BUN, urinalysis, arterial blood gas [ABG]), characteristics of stool, vomiting, nasogastric drainage, blood loss
Neurocognition	Neurologic status, LOC, orientation to person, place, and time, pupillary response, sensory status, motor status. Mental status, abstract thinking, insight, judgment, recent and remote memory; Mini-Mental Status Examination
Pharmacologic function	
Physical regulation	Vital signs (blood pressure, temperature, pulse, respirations); signs of inflammation or allergic responses; skin status, color, temperature, and turgor. Tactile sensations in upper and lower extremities, motor nerve function, peripheral pulses (compare bilaterally using the following scale: 0 = absent; 1 = weak, barely palpable; 2 = weak, diminished; 3 = slightly weak, easily located; 4 = normal, easily located), vascular status (capillary refill time, blanching, skin temperature, and skin color)
Reproduction	
Respiratory function	Respiratory status, rate and depth of respirations, symmetry of chest expansion, use of accessory muscles, palpation for fremitus, percussion of lung fields, auscultation for breath sounds, ABG levels: When the P_{CO_2} and HCO_3 increase and decrease together, the imbalance is metabolic. When the P_{CO_2} and HCO_3 move in opposite directions, think respiratory: metabolic together respiratory apart; pulse oximetry; results of chest x-ray, cough, characteristics of sputum; results of pulmonary function studies and sputum cultures; presence or absence of gag and swallow reflexes; artificial airway, ventilator settings

History of valvular disorder, congenital heart disease or myopathy, myocardial infarction, congestive heart failure, shortness of breath, frequent respiratory infections red flag for undiagnosed cardiac conditions in children

Bowel: usual elimination patterns, change in bowel patterns, reports of constipation or diarrhea, history of laxative, suppositories, or enema use, history of GI disorder
Urinary: history of urinary tract disorder (renal calculi, infection, trauma, surgery), elderly and infants may only have behavioral changes to indicate urinary tract infection (UTI); nighttime bed-wetting in an older or previously toilet-trained child can indicate UTI, usual voiding pattern, report of urine leakage or retention, use of incontinence aids, perception of bladder fullness

History of renal, cardiac, GI disorders, burns, diabetes mellitus, use of diuretics or rehydration fluid instead of water for imbalances when indicated

History of spinal cord trauma, head trauma, alcoholism delirium, stroke, transient ischemic attacks; description of symptoms, headache, nasal congestion, blurred vision, chest pain, diaphoresis and flushing above the level of the spinal cord injury

List all medications (prescribed, over-the-counter, and illicit drugs) and responses. Changes in LOC, balance, and behavior can indicate drug toxicity.

History of allergic responses to food, drugs, or other irritants (especially latex). Facial and extremity swelling, difficulty breathing, and rashes may indicate reaction.
Elevated eosinophils indicate allergic response; exposure to heat or cold. History of burns, fractures or trauma, mechanical (cast, brace, etc.) or vascular obstruction

Maternal history. Number of pregnancies, live births, abortions, or miscarriages. History of contraceptive use, sterilization procedures, fertility problems

History of respiratory disorder, use of respiratory medications (for asthma, bronchitis, emphysema, interstitial lung disease, pneumonia); smoking history

Table A: Assessment Parameters© Based on Taxonomy of Nursing Practice* (*continued*)

CLASS	OBJECTIVE DATA
Sensation/ perception	Auditory status, ear position, size and symmetry, tympanic membrane (cerumen, color of canal, deformities, intactness or tension, landmarks), results of audiometric evaluation (Rinne, Weber, Schwabach, and speech and noise tests), use of hearing aid Gustatory: taste sensation, including change from baseline, ability to differentiate sweet, salty, sour, and bitter tastes; changes in weight or smell Kinesthetic: motor coordination and muscular strength, flaccidity or atrophy; perception of body part location and changes in position Olfactory: olfactory status, nosebleeds, foul taste in mouth, sneezing, postnasal drip, dry or sore mouth or throat, excessive tearing, facial pain, eye pain Tactile: impaired tactile perception (tingling, pain, numbness; response to sharp and dull stimuli, signs of bruises, cuts, scrapes, or other injury) Visual: visual status, corneal reflex, extraocular movements, fields of gaze, inspection of lid and eyeball, ophthalmoscopy, palpation of lid and eyeball, pupil size and accommodation, tonometry, use of glasses, contact lenses or intraocular implants, visual acuity (near and distant), visual fields
Tissue integrity	Oral: oral status, gums, lips, tongue, mucous membranes, signs of salivary dysfunction, teeth Skin: integumentary status, color, elasticity, hygiene, lesions, moisture, sensation, quantity and distribution of hair, texture, turgor, pressure ulcer (place, stage, size, characteristics), CBC, Hgb/Hct, serum albumin, blood coagulation studies, serum electrolytes, mobility status, urinary or bowel incontinence
Psychosocial Domain	
Behavior	
Communication	Speech patterns, judgment, thoughts, perception of reality, memory, characteristics of speech (coherence of topics, logic and relevance of responses, volume, voice tone and modulation, presence of speech defects such as stuttering, fast or slow speech, slurred speech, dysarthria, garbled speech, echolalia, aphasia, dysphasia), orientation, mood, affect, gender and age; use of communication aids

SUBJECTIVE DATA

Auditory: history of ear disorders, trauma, surgery; perception of auditory ability; use of adaptive auditory aids (lip reading, gestures, signing). Delayed development of speech and language may indicate hearing loss. Gentamycin and aspirin toxicity can lead to hearing loss. Bacterial meningitis strong link to hearing loss. Tip of the ears not matching the outer canthus of the eye; equal low set ears can be indicative of mental retardation and congenital syndromes. Skin tags and sinus on the auricle may be linked to kidney structural defects.

Gustatory: history of vitamin or mineral deficiency, neurologic or oral disorders, chemotherapy, or radiation therapy; medication history (antidepressants such as clomipramine, antineoplastic agents, penicillamine, captopril, lithium, interferon alfa-2a, levamisole, zidovudine)

Kinesthetic: history of cerebral palsy, multiple sclerosis, muscular dystrophy, spinal disorders; use of safety devices

Olfactory: history of nasal disease or allergy, intranasal drug abuse, surgery or trauma; use of phenothiazines, estrogen, metronidazole, antineoplastics, prolonged use of nasal decongestants or topical anesthetics. Frequent sinus infections and colds can alter sense of smell. Altered sense of smell can also indicate CNS damage.

Tactile: history of chemotherapy, alcohol use, medications such as clomipramine, ceftizomine, amiodarone hydrochloride, dichlorphenamide, guanadrel, anistreplase, interferon alfa-2b, zidovudine

Visual: history of eye disorders, trauma, surgery. Strabismus normal up to 6 mo of age. Children's vision is about 20/30 until 7–8 yr of age. May develop near sightedness after puberty due to physiologic change in the lens shape.

Oral: dental health history, tooth development, frequency of dental visits, frequency of brushing and flossing; history of malnutrition, anorexia, bulimia, infections, allergies, lead poisoning, rubella, caries, extractions, bridges, braces, dentures

Skin: history of skin problems, trauma, lesions (color, borders, elevation, and bleeding), surgery, chronic metabolic or systemic disease, immunocompromised, renal or hepatic disease, radiation or chemotherapy

Trauma that does not fit history may indicate abuse.

Bruises that are on soft tissue areas, in a pattern, may indicate abuse.

Anticoagulants and antiseizure medications may cause bruising.

Patient's understanding of health problem and treatment plan, past history with health care providers, participation in health care planning and decision making; recognition and realization of potential growth, health, autonomy

Developmental history of communication patterns, knowledge of difference among passive, assertive, and aggressive responses. Infants through nonverbal cues. Direct communication at parent.

Toddlers: direct communication at parents initially, talk at eye level with the child, use play and simple speech

School-age: concrete thinkers, take speech literally. Direct the communication at them. Simple language with few analogies.

Adolescents: communicate with them in private and with parent. Want honesty. Expect both childlike and adult-like behavior. Don't use adolescent's language. May resist authority figures.

Need to use appropriate interpreter; do not use untrained personnel or family members to communicate.

Allow elderly people time to reminisce about past.

Speak slowly to allow for auditory processing.

Do not yell at a hearing impaired patient.

Face patient when speaking.

(*continued*)

Table A: Assessment Parameters© Based on Taxonomy of Nursing Practice* (*continued*)

CLASS	OBJECTIVE DATA
Coping	Evidence of physical injuries, laboratory studies (pregnancy test, tests for sexually transmitted diseases)
Emotional	Symptoms of anxiety, depression (Depression Screening tool) HEADSS screening tool for adolescents
Knowledge	Learning ability (affective, cognitive, and psychomotor domains), developmental stage, demonstrated skills in managing health problems, memory, mental status, orientation
Roles/relationships	Family genogram, caregiver's age, sex, level of education, occupation, general health, nationality, area of residence Infant's status: muscle tone, reflexes, lethargy, irritability, seizures, tremors; Brazelton Neonatal Behavioral Assessment Scale, Dubowitz Maturity Scale, Bayley Scales of Infant Development
Self-perception	Musculoskeletal status, contractures, subluxation, muscle atrophy, pain, deformity
Environmental Domain	
Health care system	
Populations	Community demographics, including age and sex distribution, ethnic groups, racial groups, education and income level Prevalence of health problems, availability of health care services Other data: drug and alcohol abuse, automobile accidents, homicides, suicides, domestic violence, burglaries, teenage pregnancy, sexually transmitted diseases, low-birth-weight infants, incidence of congenital abnormalities
Risk management	Toxicology results, LOC, mental status, presence of dangerous products

SUBJECTIVE DATA
Patient's perception of health problem, coping mechanisms, problem-solving ability, decision-making competencies, relationships, family system, self-worth, patterns of coping with loss, experiences with relocation
Health status, support systems, expressed concerns about impending death, history of loss, changes in appetite, sleep and eating patterns, alcohol consumption Changes in work or school performance, activity level or libido, expression of emptiness, loneliness, low self-esteem, overwhelmed
Health status, educational level, cultural status, requests for information; demonstrated understanding of material
Family status, including roles of family members, effects of illness on patient's family, family's understanding of patient's illness, ability to meet needs of patient, quality of relationships Cultural status, including affiliation with racial, ethnic, or religious groups Parental status, including level of education, knowledge of growth and development, stability of relationship Infant's status, including sleep patterns, prematurity, developmental disorder Parent–child interaction
Verbal and nonverbal responses to actual (burns, surgery-amputation, mastectomy, laryngectomy) or perceived change in body structure and function
Patient's experiences with the health care system
Health history: accidents, adolescents most at risk for injury. 2- to 5-year-olds most at risk for poisoning and drowning. Allergies, exposure to pollutants, falls, hyperthermia, hypothermia, poisoning, seizures, trauma, sensory–perceptual changes, support systems, financial resources

Table B: Taxonomy of Nursing Practice: A Common Unified Structure for Nursing Language

DOMAIN	
I. Functional domain includes diagnoses, outcomes, and interventions to promote basic needs.	II. Physiologic domain includes diagnoses, outcomes, and interventions to promote optimal biophysical health.
Classes include diagnoses, class outcomes, and interventions that pertain to:	
Activity/exercise: physical activity, including energy conservation and expenditure	Cardiac function: cardiac mechanisms used to maintain tissue profusion
Comfort: a sense of emotional, physical, and spiritual well-being and relative freedom from distress	Elimination: process related to secretion and excretion of body wastes
Growth and development: physical, emotional, and social growth and development milestones	Fluid and electrolyte: regulation of fluid/electrolytes and acid–base balance
Nutrition: processes related to taking in, assimilating, and using nutrients	Neurocognition: mechanisms related to the nervous system and neurocognitive functioning, including memory, thinking, and judgment
Self-care: ability to accomplish basic and instrumental ADLs	Pharmacologic function: effects (therapeutic and adverse) of medications or drugs and other pharmacologically active products
Sexuality: maintenance or modification of sexual identity and patterns	Physical regulation: body temperature, endocrine, and immune system responses to regulate cellular processes
Sleep/rest: the quantity and quality of sleep, rest, and relaxation patterns	Reproduction: processes related to human procreation and birth
Values/beliefs: ideas, goals, perceptions, spiritual, and other beliefs that influence choices or decisions	Respiratory function: ventilation adequate to maintain ABGs within normal limits Sensation/perception: intake and interpretation of information through the senses, including seeing, hearing, touching, tasting, and smelling Tissue integrity: skin and mucous membrane protection to support secretion, excretion, and healing

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III. Psychosocial domain includes diagnoses, outcomes, and interventions to promote optimal mental and emotional health and social functioning.	IV. Environmental domain includes diagnoses, outcomes, and interventions to promote and protect the environmental health and safety of individuals, systems, and communities.

Behavior: actions that promote, maintain, or restore health	Health care system: social, political, and economic structures and processes for the delivery of health care services
Communication: receiving, interpreting, and expressing spoken, written, and nonverbal messages	Populations: aggregates of individuals, or communities having characteristics in common
Coping: adjusting or adapting to stressful events	Risk management: avoidance or control of identifiable health threats
Emotional: a mental state or feeling that may influence perceptions of the world	
Knowledge: understanding skill in applying information to promote, maintain, and restore health	
Roles/relationships: maintenance and/or modification of expected social behaviors and emotional connectedness with others	
Self-perception: awareness of one's body and personal identity	

Table C: Action Intervention Types

TYPE	DEFINITION	EXAMPLES
Determine	Finding out or establishing	Assess, monitor, observe, evaluate
Perform	Doing a task	Hygiene, insert, position, change, feed
Inform	Telling about something	Describe, explain, teach
Attend	Being concerned about	Assist, relate
Manage	Being in charge of or bringing order	Organize, refer, obtain

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READINESS FOR ENHANCED ORGANIZED INFANT BEHAVIOR

DEFINITION

A pattern of modulation of the physiological and behavioral systems of functioning (i.e., autonomic, motor, state-organizational, self-regulatory, and attentional–interactional systems) in an infant, which can be strengthened

DEFINING CHARACTERISTICS

- Parent expresses desire to enhance cue recognition
- Parent expresses desire to enhance recognition of infant's self-regulatory behaviors

RELATED FACTORS

- Pain
- Immaturity

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Elimination
- Neurocognition
- Nutrition
- Physical regulation
- Role/relationships
- Sensation/perception
- Sleep/rest

EXPECTED OUTCOMES

- The parents will express understanding of their role in infant's behavioral development.
- The parents will express confidence in their ability to interpret infant's behavioral cues.
- The parents will identify means to promote infant's behavioral development.
- The parents will express positive feelings about their ability to care for infant.
- The parents will identify resources for help with infant.
- The infant will maintain physiologic stability.
- The infant will maintain an organized motor system.
- The infant will respond to information in an adaptive way.

SUGGESTED NOC OUTCOMES

Knowledge: Child Development: 1, 2, 4, 6, and 12 Months; Infant Care; Neurological Status; Sleep; Family Coping; Family Functioning; Parenting Performance

INTERVENTIONS AND RATIONALES

Determine: Monitor infant's responses *to ensure effectiveness of preventive measures*.

Perform: Demonstrate appropriate ways of interacting with the infant, such as moderate stimulation, gentle rocking, and quiet vocalizations, *to help the parents identify the most effective methods of interacting with their child.*
Inform: Explain to parents that infant maturation is a developmental process. Further explain that infants exhibit three behavioral states: sleeping, crying, and being awake and alert. Also explain that infants provide behavioral cues that indicate their needs. *Education will help parents understand the importance of nurturing the infant and prepare them to respond to the infant's behavioral cues.*

Explain to parents that their actions can help promote infant development. Make it clear, however, that infant maturation isn't completely within their control. *Explanation may decrease feelings of anxiety and incompetence and help prevent unrealistic expectations.*

Help parents interpret behavioral cues from their infant, *to foster healthy parent–child interaction.* For example, help them recognize when the infant is awake and alert, and point out to them that this is a good time to provide stimulation.

Help parents identify ways they can promote the infant's development, such as providing stimulation by shaking a rattle in front of the infant, talking to the infant in a gentle voice, and looking at the infant when feeding. *This encourages practices that promote the infant's development. Sensory experiences promote cognitive development.*
Attend: Explore with parents ways to cope with stress caused by the infant's behavior, *to increase their coping skills.*

Praise parents for their attempts to enhance their interaction with the infant, *to provide positive reinforcement.*
Manage: Provide parents with information on sources of support and special infant services *to encourage them to continue to foster their infant's development.*

SUGGESTED NIC INTERVENTIONS

Attachment Promotion; Developmental Care; Environmental Management: Attachment Process; Family Integrity Promotion; Infant Care; Sleep Enhancement; Teaching: Infant Stimulation 0–12 Months

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Greener, M. (2015). Bath time: More than good clean fun. *British Journal of Midwifery, 23*(6), 402–405.

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READINESS FOR ENHANCED BREASTFEEDING 3

DEFINITION

A pattern of providing milk to an infant or young child directly from the breasts, which may be strengthened

DEFINING CHARACTERISTICS

- Mother expresses desire to enhance ability to provide breast milk for child's nutritional needs
- Mother expresses desire to enhance ability to exclusively breast-feed

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Communication
- Roles and relationships
- Values and beliefs

EXPECTED OUTCOMES

- The mother will breast-feed neonate successfully and will experience satisfaction with breast-feeding process.
- The mother will continue breast-feeding neonate after early postpartum period.
- The infant will feed successfully on both breasts and appear satisfied.
- The infant will grow and develop in pace with accepted standards.

SUGGESTED NOC OUTCOMES

Breastfeeding Establishment: Infant; Breastfeeding Establishment: Maternal; Breastfeeding Maintenance; Breastfeeding Weaning; Hydration; Knowledge: Breastfeeding

INTERVENTIONS AND RATIONALES

Determine: Assess factors that influence mother's decision to breast-feed. *Assessment information will be used to develop interventions.*

Assess the mother's knowledge and experience of breast-feeding *to focus teaching on specific learning needs.*

Monitor mother's breast-feeding technique. *Improper technique, which impedes feeding, will cause the mother to experience anxiety.*

Perform: Position mother in Fowler's position *to enhance mother's relaxation during feeding.* Place infant in proper position for optimal feeding, *to produce proper sucking motion.*

Inform: Educate the mother and selected support person about breast-feeding techniques: Clean hands and breasts before nursing; position the neonate for feeding (the neonate should be able to grasp most of the areola); change positions to decrease nipple tenderness, and use both breasts at each feeding; remove the neonate from the breast by breaking suction; avoid setting time limits in the early stage. *Greater understanding of techniques improves chances for success.*

Teach the mother how to use warm showers and compresses, relaxation and guided imagery, infant suckling, holding the infant close to breasts, and listening to the infant cry *to stimulate letdown.*

Educate the mother about nutritional needs. She requires a well-balanced diet plus an additional 500 calories and two extra glasses of fluid each day *to maintain an adequate milk supply.* She should limit caffeine and avoid foods that make her uncomfortable.

Teach mother techniques (e.g., lying on her side, positioning the infant correctly, holding the nipple with C position, talking to and cuddling the infant) *that will help the infant latch on to the breast.*

Instruct mother to remove infant from the breast to be burped midway during the feeding, *to allow for expulsion of air that is swallowed.*

Attend: Assist the mother and family in planning for home care. The mother needs to rest when the neonate sleeps, practice self-care, learn techniques for expressing and storing breast milk, and recognize signs of engorgement and infection. Family members should understand the importance of helping and supporting the mother in her desire to breast-feed. *A mother who stops breast-feeding after she returns home and resumes work usually does so because of fatigue.*

Provide quiet environment and privacy *to enhance development of breast-feeding skills.*

Encourage mother to express concerns about breast-feeding *to reduce anxiety.*

Manage: Offer mother information about breast-feeding support groups *to help meet emotional and learning needs.*

Refer to home health nurse *for a follow-up visit in the home.*

Refer to a nutritionist *for information on good nutrition and fluid management.*

SUGGESTED NIC INTERVENTIONS

Breastfeeding Assistance; Family Support; Lactation Counseling; Nutrition Management; Parent Education: Infant

REFERENCES

Brown, C. L., Dodds, L., Legge, A., Bryanton, J., & Semenic, S. (2014). Factors influencing the reasons why mothers stop breastfeeding. *Canadian Journal of Public Health, 105*(3), e179–e185.

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6 READINESS FOR ENHANCED CHILDBEARING PROCESS

DEFINITION

A pattern of preparing for and maintaining a healthy pregnancy, childbirth process, and care of the newborn for ensuring well-being, which can be strengthened

DEFINING CHARACTERISTICS

During pregnancy

- Expresses desire to enhance knowledge of childbearing process
- Expresses desire to enhance management of unpleasant pregnancy symptoms
- Expresses desire to enhance prenatal lifestyle (e.g., elimination, exercise, nutrition, personal hygiene, sleep)
- Expresses desire to enhance preparation for newborn

During labor and delivery

- Expresses desire to enhance lifestyle appropriate for stage of labor (e.g., elimination, exercise, nutrition, personal hygiene, sleep)
- Expresses desire to enhance proactivity during labor and delivery

After birth

- Expresses desire to enhance attachment behavior
- Expresses desire to enhance baby care techniques
- Expresses desire to enhance baby feeding techniques
- Expresses desire to enhance breast care
- Expresses desire to enhance safety for the baby
- Expresses desire to enhance postpartum lifestyle (e.g., elimination, exercise, nutrition, personal hygiene, sleep)
- Expresses desire to enhance use of support system

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Behavior
- Knowledge
- Roles/relationships

EXPECTED OUTCOMES

- The patient/childbearing family will demonstrate a willingness to maintain/modify lifestyle for optimal prenatal health.
- The patient/childbearing family will convey confidence and knowledge of pregnancy, the labor and delivery process, and newborn care.
- The patient/childbearing family will express appropriate self-control and readily cooperate with recommendations of the health care team during labor and delivery.

- The patient/childbearing family will exhibit parent–newborn attachment after delivery.
- The patient/childbearing family will meet the newborn's physical, social, and nutritional needs.

SUGGESTED NOC OUTCOMES

Prenatal Health Behavior; Knowledge: Pregnancy; Knowledge: Labor & Delivery; Knowledge: Newborn Care; Parent-Infant Attachment

INTERVENTIONS AND RATIONALES

Determine: Assess baseline knowledge of prenatal self-care, labor and delivery process, and newborn care *to identify and resolve knowledge deficits.*

Perform: Provide written literature on prenatal wellness, labor and delivery expectations, and newborn care. *Providing written materials allows adequate time to synthesize and understand new information.*

Inform: Teach self-care for common prenatal discomforts *to promote patient autonomy.*

Teach childbearing family labor and delivery process and newborn care. *Understanding expectations improves confidence and reduces anxiety.*

Attend: Assist childbearing family with development of a birth plan. *This allows childbearing family to participate in managing the birth experience and promotes communication with the health care team.*

Encourage and support childbearing family throughout the course of the pregnancy *to improve self-confidence and promote patient compliance with health recommendations.*

Manage: Refer to certified childbirth educator for classes on prenatal care, labor and delivery (to include cesarean birth), breast-feeding, and newborn care. *Advanced knowledge of the childbearing process promotes empowerment and positive maternal outcomes.*

SUGGESTED NIC INTERVENTIONS

Anticipatory Guidance; Childbirth Preparation; Emotional Support; Parent Education: Infant, Prenatal Care

REFERENCES

Daniels, M., & Wedler, J. A. (2015). Enhancing childbirth education through technology. *International Journal of Childbirth Education*, *30*(3), 28–32.

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8 READINESS FOR ENHANCED COMFORT

DEFINITION

A pattern of ease, relief, and transcendence in physical, psychospiritual, environmental, and/or social dimensions, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to enhance comfort
- Expresses desire to enhance feeling of contentment
- Expresses desire to enhance relaxation
- Expresses desire to enhance resolution of complaints

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Behavior
- Communication
- Coping

EXPECTED OUTCOMES

The patient will

- The patient will express positive perception of nursing assistance to perform activities that promote comfort.
- The patient will experience physical and psychological ease.
- The patient will develop plans to optimize level of comfort.
- The patient will report an increase in relaxation.

SUGGESTED NOC OUTCOMES

Coping Enhancement; Client Satisfaction: Caring; Comfort Status; Environmental Management; Comfort Status: Environment, Physical, Sociocultural, and Psychospiritual

INTERVENTIONS AND RATIONALES

Determine: Assess patient's satisfaction with the amount of assistance the nurse is presently offering, *to determine whether the patient perceives self as performing physical, psychosocial, and spiritual activities at a level that is comfortable for self-changes in status.*

Determine what enhancements to care can be made *to provide the patient a greater degree of comfort.*

Ask for feedback from the patient at least once a day *to evaluate progress.*

Perform: Adjust environmental factors, where possible, *to enhance the patient's feeling of a safe and comfortable environment.*

Assist patient with bathing, feeding, and toileting *to ensure that patient's needs are met.*

Turn and reposition patient every 2 hours *to promote comfort.*

Inform: Teach patients when they are ready about their disease. Present only what patient is able and willing to absorb, *to prevent the patient from becoming overwhelmed.*

Avoid insisting that the patient accept information. *Readiness is an important factor in adult education.* Provide both patient and family with written information such as pamphlets and so forth.

Teach the patient and family techniques for relaxation, such as guided imagery, *to promote comfort and reduce anxiety.*

Attend: Provide emotional support and encouragement *to help improve ability of patient to cope with the diagnosis.*

Involve patient in planning and decision making. *Having the ability to participate will encourage greater compliance with the plan and enhance comfort.*

Encourage patient to communicate with others, asking questions and clarifying concerns based on readiness. *This will enhance the patient's learning ability.*

Manage: Maintain frequent communication with physicians and other staff *to determine what the patients are being told about their condition.*

Collaboration will foster consistency in what the patient is being told.

Refer patient to a mental health professional/grief counselor *if denial interferes with ability of patient to function within limits.*

SUGGESTED NIC INTERVENTIONS

Anxiety Reduction; Calming Techniques; Counseling; Health Education; Reality Orientation; Truth Telling; Environmental Management: Comfort

REFERENCES

de Azevedo Ponte, K. M., & de Fátima da Silva, L. (2015). Comfort as a result of nursing care: An integrative review. *Revista De Pesquisa: Cuidado E Fundamental*, *7*(2), 2603–2614. doi:10.9789/2175-5361.2015.v7i2.2603-2614

Serrano, B., Baños, R. M., & Botella, C. (2016). Virtual reality and stimulation of touch and smell for inducing relaxation: A randomized controlled trial. *Computers in Human Behavior*, *55*, 1–8. doi:10.1016/j.chb.2015.08.007

Slatyer, S., Williams, A. M., & Michael, R. (2015). Seeking empowerment to comfort patients in severe pain: A grounded theory study of the nurse's perspective. *International Journal of Nursing Studies*, *52*(1), 229–239. doi:10.1016/j.ijnurstu.2014.06.010

10 READINESS FOR ENHANCED COMMUNICATION

DEFINITION

A pattern of exchanging information and ideas with others, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to enhance communication

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Communication
- Coping
- Roles and relationships
- Values and beliefs

EXPECTED OUTCOMES

- The patient will express message clearly as evidenced by feedback that receiver understood message.
- The patient will express an increased sense of confidence in communicating thoughts and feelings.
- The patient will report enhanced ability to respond assertively to individuals.
- The patient will report feelings of confidence in social encounters.
- The patient will gain practice in applying enhanced communication techniques with individuals, family, and groups.
- The patient will enhance communication by nonverbal means, such as use of electronic mail and Internet connections, pictures, and drawings.
- The patient will use enhanced communication skills to negotiate and advocate for self.

SUGGESTED NOC OUTCOMES

Communication: Expressive; Communication: Receptive; Health-Seeking Behaviors

INTERVENTIONS AND RATIONALES

Determine: Listen for themes presented during nurse–client interactions, *because themes can provide areas of focus for patient discussions with caregiver.*

Establish a clear purpose for interaction. *This provides the patient with goals and a time frame for interaction.*

Perform: Provide an environment that diminishes space between the patient and the nurse, *to eliminate barriers to communication, such as noise and lack of privacy.*

Incorporate questions that are open-ended and start with such words as "what," "how," and "could," rather than "why." *Open-minded, nonthreatening questioning encourages patient to discuss issues of concern and improve communication skills.*

Schedule frequent interdisciplinary treatment team meetings regarding communication skill development with patient. *Team meetings with the patient can ensure continuity of care.*

Inform: Educate patient and family members about the aging process. *Educating the patient and family will help them anticipate processes that will naturally occur again.*

Teach theory of assertive behavior and role-play assertive communication approaches. *Assertive training can decrease passive or aggressive communication patterns.*

Include role-playing as a teaching strategy *to model methods of enhanced verbal and nonverbal communication skills. Role-playing in a nonthreatening, safe environment can enhance communication skills.*

Attend: Encourage patient verbally and nonverbally to explore strategies to enhance self-advocacy communication skills with health care providers. *Self-advocacy communication can guide a patient toward autonomy, confidence, and independence.*

Provide support through active listening, appropriate periods of silence, reflection on feelings, and paraphrasing and summarizing comments. *Active listening techniques encourage patient participation in communication.*

Provide patient with clear explanations for everything that will happen to the patient. Ask for feedback *to ensure that the patient understands. Anxiety may impair patient's cognitive abilities.*

Manage: Identify appropriate social agencies and support groups for the patient and provide referrals, *to ensure ongoing opportunities for the patient to increase social interaction.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Anticipatory Guidance; Assertiveness Training; Behavior Modification; Social Skills; Relationship-Building Enhancement; Guided Imagery; Support Group

REFERENCES

Clochesy, J. M., Dolansky, M. A., Hickman, R. L., Jr., Gittner, L. S., & Hickman, R. J. (2015). Enhancing communication between patients and healthcare providers: SBAR3. *Journal of Health & Human Services Administration*, *38*(2), 237–252.

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Weis, J., Zoffmann, V., & Egerod, I. (2015). Enhancing person-centred communication in NICU: A comparative thematic analysis. *Nursing in Critical Care*, *20*(6), 287–298. doi:10.1111/nicc.12062

12 READINESS FOR ENHANCED COPING

DEFINITION

A pattern of cognitive and behavioral efforts to manage demands related to well-being, which can be strengthened

DEFINING CHARACTERISTICS

- Awareness of possible environmental change
- Expresses desire to enhance knowledge of stress management strategies
- Expresses desire to enhance management of stressors
- Expresses desire to enhance social support
- Expresses desire to enhance use of emotion-oriented strategies
- Expresses desire to enhance use of problem-oriented strategies
- Expresses desire to enhance use of spiritual resource

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Behavior
- Communication
- Coping
- Roles/relationships
- Self-perception

EXPECTED OUTCOMES

- The patient will identify major issues that require ongoing enhancement of coping strategies.
- The patient will express feelings associated with coping strategies.
- The patient will demonstrate readiness to develop enhanced strategies.
- The patient will identify support persons and activities that will assist in goal attainment.

SUGGESTED NOC OUTCOMES

Coping; Quality of Life; Personal Autonomy

INTERVENTIONS AND RATIONALES

Determine: Assess patient's usual coping mechanisms, roles and responsibilities, social support, spiritual resources, and use of alcohol and tobacco, *to decide on a focus for interventions.*

Perform: Establish a trusting relationship with patient by spending time with the patient each shift, *which will encourage the patient to be more honest and open.*

Begin discussions at patient's level of comfort. *If patient wants to express anger or other emotion, listen carefully. Until the patient has had an opportunity to talk, you will not be able to move the patient to a place where the issue can be discussed logically.*

Inform: Provide information on informed consent *because parents will be making decisions for the child's care.*

Teach additional skills that enhance coping strategies. Help the patient develop a program by using relaxation strategies (i.e., meditation, guided imagery, yoga, exercise); *these strategies will help to reduce anxiety and allow the patient to concentrate.*

Teach problem-solving skills. Have patient role-play *to demonstrate how to set up options and choose from among them.*

Attend: Encourage patient to continue adhering to plan for enhanced coping strategies. *Compliance with the plan will produce results for the patient. It will also help patient measure success.*

Encourage patient to continue involvement in a wide range of activities. *More activities will involve more choices.*

Encourage patient to look for volunteer opportunities in the *community* as a way of keeping the patient involved with others.

Offer to meet with patient regularly, if desired, *to help patient continue developing enhanced coping skills.*

Manage: Refer patients to support groups and offer ideas about educational opportunities in the community.

SUGGESTED NIC INTERVENTIONS

Active Listening; Coping Enhancement; Guided Imagery; Massage; Meditation Facilitation

REFERENCES

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14 READINESS FOR ENHANCED COMMUNITY COPING

DEFINITION

A pattern of community activities for adaptation and problem-solving for meeting the demands or needs of the community, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to enhance availability of community recreation programs
- Expresses desire to enhance availability of community relaxation programs
- Expresses desire to enhance communication among community members
- Expresses desire to enhance communication between aggregates and larger community
- Expresses desire to enhance community planning for predictable stressors
- Expresses desire to enhance community resources for managing stressors
- Expresses desire to enhance community responsibility for stress management
- Expresses desire to enhance problem-solving for identified issue

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Communication
- Coping
- Populations
- Risk management

EXPECTED OUTCOMES

- Community members will express understanding of problems associated with failure to immunize population and will recognize the needs to reduce the number of adults and children who are not immunized.
- Community members will initiate a plan to increase the number of immunizations in population and provide adequate protection from communicable diseases.
- Community members will work to reduce spread of communicable diseases and increase the number of immunizations.
- Community members will evaluate established plans for ensuring that all children become immunized and will make changes to plans as needed.

SUGGESTED NOC OUTCOMES

Community Competence; Community Health Status: Immunity; Community Risk Control: Communicable Disease

INTERVENTIONS AND RATIONALES

Determine: Assess community member's level of understanding of the importance of immunization. If level of compliance is low, survey community needs to determine why. Determine ease of access in the community for members to comply with immunization requirements/needs. Identify new members of the community, such as immigrants or refugees. *This assessment will assist in identifying appropriate intervention.*

Perform: Collect statistical data from community health sources, such as the health department and schools, *to continue to identify children who have not been immunized*. Recruit local agencies with an adequate number of professionals able to deliver the immunization services.

Contact parents personally or by handwritten note about children who have not been immunized. *Make it clear to the parents that your purpose is to protect the children.*

Inform: Provide extensive educational opportunities in the community about communicable diseases and the importance of immunization. *Educate persons in the community in their first language to ensure adequate understanding.*

Attend: Encourage community members to implement a program to disseminate information about problems associated with inadequate immunization, *to educate residents and promote the community's established immunization program.*

Encourage health departments, clinics, and practitioners' offices to provide information on the recommended childhood immunization schedule to the public, *to foster understanding about the importance of educating the public.*

Conduct a follow-up survey on immunization rates *to measure the effectiveness of educational initiatives.*

Manage: Supply a list of referrals for the parents of children who are not immunized. Include information on low-cost health insurance, city health centers, and well-baby clinics to encourage compliance. *Helping the parents by giving referrals will empower them to meet their child's health care needs.*

SUGGESTED NIC INTERVENTIONS

Communicable Disease Management; Community Health Development; Health Education; Health Policy Monitoring; Immunization/Vaccination Management

REFERENCES

Craig, S. L., Betancourt, I., & Muskat, B. (2015). Thinking big, supporting families and enabling coping: The value of social work in patient and family centered health care. *Social Work in Health Care*, *54*(5), 422–443. doi:10.1080/00981389.2015.1017074

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16 READINESS FOR ENHANCED FAMILY COPING

DEFINITION

A pattern of management of adaptive tasks by primary person (family member, significant other, or close friend) involved with the client's health change, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to acknowledge growth impact of crisis
- Expresses desire to choose experiences that optimize wellness
- Expresses desire to enhance connection with others who have experienced a similar situation
- Expresses desire to enhance enrichment of lifestyle
- Expresses desire to enhance health promotion

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Behavior
- Coping
- Emotional status
- Roles/responsibilities

EXPECTED OUTCOMES

- Family members will discuss the impact of patient's illness and feelings about it with health care professional.
- Family members will participate in treatment plan.
- Family members will establish a visiting routine beneficial to the patient.
- Family members will demonstrate the care needed to maintain patient's health status.
- Family members will identify and use available support systems.

SUGGESTED NOC OUTCOMES

Caregiver–Patient Relationship; Caregiver Well-Being; Family Coping; Family Normalization; Health-Promoting Behavior

INTERVENTIONS AND RATIONALES

Determine: Assess normal pattern of communication among family members; understanding and knowledge of family members about patient's condition; family's past response to crises; patient's perception of health problem. Assess patient and family's spiritual needs, including religious beliefs and affiliation. *Assessment of these factors will assist in selecting appropriate interventions.*

Perform: Schedule time to meet with family and patient *in order to listen to ways in which they plan to enhance their coping skills in the present situation.*

Provide comfort measures such as bathing, massage, regulation of environmental temperature, and mouth care, according to the patient's needs and preferences. *Comfort can promote ability to cooperate with the plan.*

Establish a visiting schedule that will not tax patient's or family's resources. Use patient's daily routine to aid in planning (e.g., no visiting during treatments or during periods of uninterrupted rest). *Establishing a routine will allow the patient to have consistency and a measure of control.*

Inform: Teach self-healing techniques to patient and family, such as meditation, guided imagery, yoga, and prayer. *These strategies promote anxiety reduction.*

Teach patient how to incorporate the use of self-healing techniques in carrying out usual daily activities, *to encourage ongoing use of the strategies.*

Demonstrate procedures and encourage participation in patient's care in a way that maximizes patient's comfort. *Both patient and family need to work together to implement the plan with patient's comfort in mind.*

Provide patient with concise information about condition. Be aware of what family members already know. *Honesty is important when conveying information.*

Attend: Reinforce family's efforts to care for patient. Let family know they are doing well *to ease adaptation to new caregiver roles.*

Ensure privacy for patient and family visits, *to foster open communication.*

Encourage family to support patient's independence. Encourage patient's cooperation as you continue with healing techniques, such as therapeutic touch. *There is a need to allow for as much independence on the part of the patient as possible. At times, the family will try to promote dependency to the detriment of the patient.*

Provide emotional support to family by being available to answer questions. *Availability will communicate to the family that you are concerned for them and the patient.*

Manage: Refer family to community resources and support groups available *to assist in managing patient's illness and providing emotional and financial assistance to caregivers.*

Refer to a member of the clergy or a spiritual counselor, according to the patient's preference, *to show respect for the patient's beliefs and provide spiritual care.*

SUGGESTED NIC INTERVENTIONS

Coping Enhancement; Family Process Management

REFERENCES

Bademli, K., & Duman, Z. Ç. (2014). Effects of a family-to-family support program on the mental health and coping strategies of caregivers of adults with mental illness: A randomized controlled study. *Archives of Psychiatric Nursing*, *28*(6), 392–398. doi:10.1016/j.apnu.2014.08.011

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addiction. *Journal of Groups in Addiction & Recovery*, *10*(4), 313–336. doi:10.1080/1556035X.2015.1099125

Rossetto, K. R. (2015). Developing conceptual definitions and theoretical models of coping in military families during deployment. *Journal of Family Communication*, *15*(3), 249–268. doi:10.1080/15267431.2015.1043737

READINESS FOR ENHANCED DECISION-MAKING 19

DEFINITION

A pattern of choosing a course of action for meeting short- and long-term health-related goals, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to enhance congruency of decisions with sociocultural goals
- Expresses desire to enhance congruency of decisions with sociocultural values
- Expresses desire to enhance congruency of decisions with goals
- Expresses desire to enhance congruency of decisions with values
- Expresses desire to enhance decision making
- Expresses desire to enhance risk–benefit analysis of decisions
- Expresses desire to enhance understanding of choices for decision making
- Expresses desire to enhance understanding of the meaning of choices
- Expresses desire to enhance use of reliable evidence for decisions

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Coping
- Communication
- Knowledge
- Values and beliefs

EXPECTED OUTCOMES

- The patient will express the desire to make effective decisions.
- The patient will verbalize decision-making goals and concerns.
- The patient will discuss measures used to evaluate decisions.
- The patient will make decisions that promote maximal physical, mental, social, and psychological well-being.
- The patient will involve family, friends, and clergy in health care decision making when appropriate.

SUGGESTED NOC OUTCOMES

Decision Making; Participation in Healthcare Decisions; Self-Care: IADLs; Coping

INTERVENTIONS AND RATIONALES

Determine: Assess usual coping strategies employed by the patient when making decisions; determine how the patient goes about making difficult decisions; have the patient describe several challenging decisions the patient made in the past year. *Assessment information will help identify appropriate interventions.*

Evaluate support systems available to the patient when it is necessary to make decisions. *Patients often need support of families or other support systems when they are faced with major decisions.*

Perform: Provide assistance with activities of daily living, as required. *As the patient receives assistance, it is important to allow the patient to be as independent as possible.*

Make changes in the environment *to reduce unnecessary stimulation and promote a sense of calm.*

Inform: Teach patient simple decision-making techniques and role-play the same. *Return demonstration from the patient will give him or her confidence that he or she can choose wisely among options.*

Educate family about the importance of allowing the patient to think and act for self, *to give the patient a sense of control over the present situation.*

Attend: Provide emotional support and encouragement *to help improve patients' confidence in their ability to make logical decisions.*

Provide patient with all necessary support during hospitalization, *to prepare the patient and family to continue the process of having the patient make decisions about patient's own care.*

Involve patient in planning and decision making. *Having the ability to participate will encourage greater compliance with the treatment plan.*

Manage: If patient continues to have difficulty, refer to case manager/social worker/mental health professional *for continued follow-up.*

Provide appropriate assistance to the family members when they are trying to provide; it might be helpful in working with the patient.

SUGGESTED NIC INTERVENTIONS

Decision-Making Support; Health System Guidance; Self-Responsibility Facilitation; Self-Efficacy Enhancement

REFERENCES

Ali, S. F., & Muhammad, M. P. (2014). Patient preference regarding their role in clinical decision making process: A systematic review. *International Journal of Nursing Education*, *6*(2), 192–195. doi:10.5958/0974-9357.2014.00632.1

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READINESS FOR ENHANCED EMANCIPATED DECISION-MAKING 21

DEFINITION

A process of choosing a health care decision that includes personal knowledge and/or consideration of social norms, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to enhance ability to choose health care options that best fit current lifestyle
- Expresses desire to enhance ability to enact chosen health care option
- Expresses desire to enhance ability to understand all available health care options
- Expresses desire to enhance ability to verbalize own opinion with constraint
- Expresses desire to enhance comfort to verbalize health care options in the presence of others
- Expresses desire to enhance confidence in decision making
- Expresses desire to enhance confidence to discuss health care options openly
- Expresses desire to enhance decision making
- Expresses desire to enhance privacy to discuss health care options

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Behavior
- Communication
- Coping
- Emotional
- Neurocognition
- Risk management
- Self-care
- Sensation/perception

EXPECTED OUTCOMES

- The patients will engage with the nurse to meet needs for privacy.
- The patients will openly seek information and verbalize that their information needs are met.
- The patients will assertively communicate their own opinions regarding their health care choices.
- The patients will self-select a health care choice that meets their lifestyle needs and reflects their values, beliefs, and preferences.
- The patients will verbalize satisfaction with their health care decision given the choices available to them.

SUGGESTED NOC OUTCOMES

Decision-Making; Information Processing; Participation in Health Care Decisions

INTERVENTIONS AND RATIONALES

Determine: Ask the patient to verbalize what lifestyle, social, and other factors they need to consider in their decision and how these would impact or be impacted by the health care choices available to them. *To promote consideration of the context of their decision making.*

Ask the patient about strategies they have used in the past to make decisions. Validate their past choices in strategies. Engage the patient in realistic appraisal of the applicability of past strategies to current situation. *To identify and draw on personal experiences and strengths in decision making.*

Perform: Ensure that communications and information provided are at a level consistent with the patient's cognitive abilities, *to ensure understanding.*

Promote self-esteem through active listening, validation of concerns, knowledge and feelings, conveyance of respect for the patient's values, beliefs, and preferences. *To promote psychological readiness to make a decision and to strengthen the therapeutic relationship.*

Use active listening to identify and reflect back to the patients their opinions of the choices available to them. *To promote autonomous consideration of options by the patient and confidence in own opinions.*

Inform: Provide information proactively in anticipation of the patient's needs, as well as upon request by the patient. Encourage the patient to ask questions, and provide meaningful answers to the patient. *To promote psychological readiness to make a decision, self-esteem, and confidence in knowledge.*

Teach the patient about the utility of problem-solving frameworks to assist in decision making. *Use of a problem-solving framework in consideration of health care choices encourages the patients to consider health care options from the context of their own experience and to identify their own best choices given their life situation.*

Attend: Role-playing assertive expression of opinions may be helpful to prepare the patient to do so in real-life situations. *Role-play can be an effective strategy toward the development of skill mastery.*

As needed, assist the patient to practice assertive expression of opinions. Encourage the patient to communicate in a way that is authentic, and simultaneously respectful of the patient's own feelings, values, beliefs, and wishes as well as those of others. *Assertive expression of opinions promotes self-esteem within and after interpersonal interactions.*

Collaborate with the patient to determine strategies to meet patient's needs for privacy. *To promote self-care, self-esteem, and decision making.*

Manage: Refer for professional support, if needed. *Counselling maybe required to assist the patient to work through distorted thoughts and determine own best course of action.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Assertiveness Training; Decision-Making Support; Learning Facilitation; Mutual Goal Setting

REFERENCES

Kayser, J. W., Cossette, S., & Alderson, M. (2014). Autonomy-supportive intervention: An evolutionary concept analysis. *Journal of Advanced Nursing, 70*(6), 1254–1266.

Linehan, M. (2014). *DBT skills training manual* (2nd ed.). New York: Guilford Press.

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Welzel, C., & Delhey, J. (2015). Generalizing trust: The benign force of emancipation. *Journal of cross-Cultural Psychology, 46*(7), 875–896.

24 READINESS FOR ENHANCED FAMILY PROCESSES

DEFINITION

A pattern of family functioning to support the well-being of family members, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to enhance balance between autonomy and cohesiveness
- Expresses desire to enhance communication pattern
- Expresses desire to enhance energy level of family to support activities of daily living
- Expresses desire to enhance family adaptation to change
- Expresses desire to enhance family dynamics
- Expresses desire to enhance family resilience
- Expresses desire to enhance growth of family members
- Expresses desire to enhance interdependence with community
- Expresses desire to enhance maintenance of boundaries between family members
- Expresses desire to enhance respect for family members
- Expresses desire to enhance safety of family members

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Roles/relationship
- Communication
- Coping
- Values/beliefs

EXPECTED OUTCOMES

- Family members will identify family goals and structured directions.
- Family members will express enjoyment and satisfaction with their roles in the family.
- Family members will express a willingness to enhance roles in family dynamics.
- Family members will participate regularly in traditional family activities.
- Family members will maintain open and positive communication.
- Family members will maintain a safe home environment.
- Family members will seek regular health screenings and immunizations.
- Family members will identify and acknowledge family risk factors.
- Family members will make plans to deal with life changes and events.

SUGGESTED NOC OUTCOMES

Family Coping; Family Functioning; Family Health Status; Family Integrity; Family Normalization; Family Social Climate

INTERVENTIONS AND RATIONALES

Determine: Assess family composition, roles within the family, communication patterns, family developmental stages, developmental tasks, health patterns, coping mechanisms, socioeconomics, educational levels, ethnicity, and cultural and religious beliefs. *Assessment information helps identify appropriate interventions.*

Perform: Establish an environment in which family members can openly share their issues and concerns in *comfort to reduce anxiety and develop their ability to resolve problems.*

Inform: Explain importance of setting goals as a method of establishing boundaries that will be respected by all family members. *Family functioning with structural direction will enhance the potential to meet physical, social, and psychological needs.*

Show family how to develop a genogram to identify genetic risk factors. *Information from the genogram will highlight things that can modify a family's health patterns, lead to early identification of genetically related diseases, and may delay onset of disease.*

Teach value of daily exercise, well-balanced diet, and use of proven holistic strategies *to improve health.*

Provide family with information on recommended health screenings and immunization schedules. *It is essential to keep immunizations given according to schedule to prevent loss of immunity.*

Attend: *Encourage family members to identify individual and* family goals and a structured direction toward sound health habits for the entire family. *Developing a structured plan will assist in having everyone work together toward goals set by the family for themselves.*

Involve family in planning and decision making. *Having the ability to participate encourages greater compliance with the plan.*

Encourage family to spend time together enjoying traditional activities that everyone likes doing, *to promote a healthy lifestyle and encourage strong family unity.*

Manage: Refer, where requested, for follow-up for a family member who needs exercise, weight management, diet assistance, health screenings, and so forth. *Providing referrals will help to provide continuity of care for the patient.*

SUGGESTED NIC INTERVENTIONS

Family Support; Family Integrity Promotion; Family Maintenance

REFERENCES

Alhusen, J. L., Bullock, L., Sharps, P., Schminkey, D., Comstock, E., & Campbell, J. (2014). Intimate partner violence during pregnancy and adverse neonatal outcomes in low-income women. *Journal of Women's Health, 23*(11), 920–926. doi:10.1089/jwh.2014.4862

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READINESS FOR ENHANCED FLUID BALANCE 27

DEFINITION

A pattern of equilibrium between the fluid volume and chemical composition of body fluids, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to enhance fluid balance

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Activity/exercise
- Cardiac function
- Elimination
- Fluid and electrolytes
- Neurocognition
- Respiratory function

EXPECTED OUTCOMES

- The patient will have stable vital signs within normal ranges; electrocardiograph shows no abnormality in rhythm.
- The patient will have normal skin temperature, moistness, turgor, and color.
- The patient will have moist and intact mucous membranes.
- The patient will have stable weight.
- The patient will have adequate fluid volume intake and thirst satiety.
- The patient will produce adequate urine volume (approximately equal to fluid intake) of light to straw-colored urine.
- The patient will maintain a urine specific gravity between 1.015 and 1.025.
- The patient will have normal values for plasma and serum for electrolytes, osmolarity, glucose, blood urea nitrogen, hematocrit (HCT), and hemoglobin (Hb).
- The patient will be alert and will respond to demands of living, react appropriately to reflex needs (i.e., thirst), and have normal muscle reflexes, strength, and tone.
- The patient will express understanding of factors that contribute to normal fluid and electrolyte balance.
- The patient will adhere to prescribed therapies to manage such coexisting disease processes.

SUGGESTED NOC OUTCOMES

Fluid Balance; Hydration; Nutritional Status: Food & Fluid Intake; Tissue Integrity: Skin & Mucous Membranes; Vital Signs; Knowledge: Health Promotion

INTERVENTIONS AND RATIONALES

Determine: Assess usual fluid intake and desire to improve fluid status *to establish a baseline.*

Inform: Teach patient to read and interpret labels on beverage and food containers. For example, humans require 0.5 g (500 mg) of sodium per day; typical intake is 3,500 mg daily. *Reducing the amount of sodium reduces the amount of fluid volume in the vascular system.*

Encourage adequate water intake (1,200 to 2,000 mL) during exercise or high environmental temperatures; *unmeasured fluid losses through diaphoresis and lung evaporation can be significant.*

Teach signs and symptoms of dehydration (dry mouth and mucous membranes), light-headedness (blood pressure and vital sign changes), scant urine output (glycosuria and polyuria), and overhydration (cough, increased weight gain, dependent edema, and jugular vein distention). *Teaching prevents severe complications.*

Attend: Encourage patient to select healthy beverages such as water and limit beverages such as soda or sports drinks that have high sugar content *(which increase the osmolar content of the body, causing greater thirst and increased load on the renal system and diuresis)* and caffeine *(which causes diuresis and may cause an increased fluid loss)* and alcoholic beverages during hot weather *because these can cause fluid and electrolyte disturbances through excess diuresis.*

SUGGESTED NIC INTERVENTIONS

Electrolyte Management; Fluid/Electrolyte Management; Fluid Management; Fluid Monitoring

REFERENCES

Maughan, R. J., Watson, P., Cordery, P. A., Walsh, N. P., Oliver, S. J., Dolci, A., . . . Galloway, S. R. (2016). A randomized trial to assess the potential of different beverages to affect hydration status: Development of a beverage hydration index. *American Journal of Clinical Nutrition*, *103*(3), 717–723. doi:10.3945/ajcn.115.114769

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READINESS FOR ENHANCED HEALTH MANAGEMENT 29

DEFINITION

A Pattern of regulating and integrating into daily living a therapeutic regimen for the treatment of illness and its sequelae, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to enhance choices of daily living for meeting goals
- Expresses desire to enhance management of illness
- Expresses desire to enhance management of prescribed regimens
- Expresses desire to enhance management of risk factors
- Expresses desire to enhance management of symptoms
- Expresses desire to enhance immunization/vaccination status

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Self-care
- Behavior
- Knowledge

EXPECTED OUTCOMES

- The patient will acknowledge responsibility to manage own health condition.
- The patient will identify any barriers to optimal self-health management and determine plan to address them.
- The patient will refine problem-solving skills over time.
- The patient will increase self-efficacy, the confidence that one can carry out a behavior necessary to reach a desired goal.

SUGGESTED NOC OUTCOMES

Adherence Behavior; Compliance Behavior; Decision-Making; Health Orientation; Health Promoting Behavior; Personal Health Status; Self-Direction of Care; Knowledge: Health Promotion

INTERVENTIONS AND RATIONALES

Determine: Monitor patient's self-efficacy and use of problem-solving skills as patient manages own health. *These concepts reflect a new paradigm in health management that acknowledges that patients need many skills and confidence to carry out plan of care.*

Perform: Assist patient in setting goals and making informed choices. *This patient–nurse collaborative relationship helps patient and nurse identify barriers to optimal health management and overcome them.*

Inform: Teach patients about their disease states and regimens, but, more importantly, teach patients problem-solving skills *to ensure that they actively participate in their self-health management despite any setbacks that they might experience.*

Attend: Provide encouragement to help motivate patient to maximize healthy behaviors. *This highlights that behavior is best changed by internal motivation rather than by external motivation.*

Manage: Coordinate with social services and colleagues in other disciplines *to ensure that family, economic, and social barriers to optimal self-health management have been addressed.*

SUGGESTED NIC INTERVENTIONS

Behavior Modification; Complex Relationship Building; Decision-Making Support; Health Education; Learning Facilitation; Mutual Goal-Setting; Self-Awareness Enhancement

REFERENCES

Carneiro Cde, S., Oliveira, A. P., Lopes Jde, L., Bachion, M. M., Herdman, T. H., Moorhead, S. A., & Barros, A. L. (2016). Outpatient clinic for health education: Contribution to self-management and self-care for people with heart failure. *International Journal of Nursing Knowledge, 27*(1), 49–55. doi:10.1111/2047-3095.12071

Risendal, B., Dwyer, A., Seidel, R., Lorig, K., Katzenmeyer, C., Coombs, L., . . . Ory, M. (2014). Adaptation of the chronic disease self-management program for cancer survivors: feasibility, acceptability, and lessons for implementation. *Journal of Cancer Education, 29*(4), 762–771. doi:10.1007/s13187-014-0652-8

Zaldonis, J., Alrawashdeh, M., Atman, K. S., Fatigati, A., Dabbs, D., & Bermudez, C. A. (2015). Predictors and influence of goal orientation on self-management and health-related quality of life after lung transplant. *Progress in Transplantation, 25*(3), 230–242. doi:10.7182/pit2015189

DEFINITION

A pattern of expectations and desires for mobilizing energy on one's own behalf, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to enhance ability to set achievable goals
- Expresses desire to enhance belief in possibilities
- Expresses desire to enhance congruency of expectation with goal
- Expresses desire to enhance connectedness with others
- Expresses desire to enhance hope
- Expresses desire to enhance problem-solving to meet goal
- Expresses desire to enhance sense of meaning to life
- Expresses desire to enhance spirituality

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Behavior
- Coping
- Emotional status
- Roles/responsibilities
- Self-perception

EXPECTED OUTCOMES

- The patient will express desire for positive health outcomes.
- The patient will share personal goals to increase autonomy and personal satisfaction.
- The patient will increase quality of life.
- The patient will plan to promote maximal physical, mental, social, and psychological abilities.
- The patient will share strategies to live a meaningful life.
- The patient will express awareness of the need for developing and maintaining a positive attitude of hope.
- The patient will seek spiritual support, as needed.

SUGGESTED NOC OUTCOMES

Hope; Personal Well-Being; Quality of Life; Will to Live; Role Performance

INTERVENTIONS AND RATIONALES

Determine: Assess patient's perception of ability to set personal goals.

Assess expression of desire to build on possibilities for the future, and ability to align desires and expectations. Assess ability of patient to maintain and enhance relationships with others. Assess patient's and family's spiritual needs, including religious beliefs and affiliation. *Information from assessment will assist in determining appropriate interventions.*

Perform: Schedule time to meet with family and patient *to listen to ways in which they plan to enhance their coping skills in the present situation.*

Facilitate opportunities for spiritual nourishment and growth *to address patient's holistic needs for maximal therapeutic environment.*

Inform: Teach self-healing techniques to both the patient and family, such as meditation, guided imagery, yoga, and prayer, *to promote relaxation.*

Teach patient how to incorporate the use of self-healing techniques in carrying out usual daily activities. *Practicing will increase the chance that the patients will themselves use these techniques.*

Teach caregivers to assist patient with self-care activities in a way that maximizes patient's comfort. *Comfort will reduce anxiety and help patient cooperate with treatment.*

Demonstrate procedures and encourage participation in patient's care.

Provide patient with concise information about patient's condition. Be aware of what the family members have already been told.

Attend: Reinforce family's efforts to care for the patient. Let them know they are doing well, *to ease adaptation to new caregiver roles.* Encourage family to support patient's independence.

Encourage patient's cooperation as you continue with healing techniques, such as therapeutic touch. *Cooperation will enhance the effect of the therapy.*

Provide emotional support to family and be available to answer questions. *Being available to answer questions and listen builds trust of the family.*

Manage: Refer family to community resources and support groups *to assist in managing patient's illness and providing emotional and financial assistance to caregivers.*

Refer to a member of the clergy or a spiritual counselor, according to the patient's preference, *to show respect for the patient's beliefs and provide spiritual care.*

SUGGESTED NIC INTERVENTIONS

Hope Facilitation; Self-Esteem Enhancement; Spiritual Growth Facilitation; Guided Imagery; Meditation Facilitation; Relaxation Therapy; Therapeutic Touch

REFERENCES

Paley, J. (2014). Hope, positive illusions and palliative rehabilitation. *Progress in Palliative Care*, *22*(6), 358–362. doi:10.1179/1743291X14Y.0000000084

Waynor, W. R., & Gill, K. J. (2015). The role of hope in predicting supported employment success. *Journal of Rehabilitation*, *81*(2), 26–31.

Yarcheski, A., & Mahon, N. E. (2016). Meta-analyses of predictors of hope in adolescents. *Western Journal of Nursing Research*, *38*(3), 345–368. doi:10.1177/0193945914559545

READINESS FOR ENHANCED KNOWLEDGE

DEFINITION

A pattern of cognitive information related to a specific topic or its acquisition, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to enhance learning

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Communication
- Knowledge
- Risk management
- Values and beliefs

EXPECTED OUTCOMES

- The patient will identify new sources for enhancing knowledge in the topic of interest.
- The patient will make use of all relevant resources to enhance knowledge.
- The patient will ask questions where new information needs clarification.
- The patient will begin practicing new behaviors gleaned from enhanced knowledge.

SUGGESTED NOC OUTCOMES

Knowledge: Health Promotion; Client Satisfaction: Teaching; Health Promoting Behavior; Health Seeking Behavior

INTERVENTIONS AND RATIONALES

Determine: Assess current health status; problems, restrictions, limitations; personal habits, such as the use of tobacco, drugs, alcohol consumption, level of knowledge about disease process; communication skills (verbal and written), degree of motivation to maintain health; familiarity with technology as a source of learning. *Assessment information will help identify appropriate interventions.*

Perform: Plan a health maintenance program for the patient and family members addressing current problems. *Developing a plan with the family will increase the probability of compliance by giving them information to review each day.* Provide the family and patient with a written copy. *A written copy can be posted in the patient's home where it is always available for review.*

Inform: Provide books and videos that will help the patient's quest for enhanced knowledge. *Supplying some materials directly may be a motivation for the patient to search further.*

Direct patient and family to use other sources such as libraries, the Internet, or professional organizations. *An independent search results*

in the patients developing confidence in their ability to go much deeper into the area of interest.

Attend: Encourage patient and family to verbalize feelings and concerns related to the knowledge and skills that patient needs. *This promotes greater ease in managing challenging situations.*

Demonstrate willingness to repeat instruction and demonstrations of skills needed by the patient. *Repetition will reinforce learning and give the patient added confidence in ability to comply.*

Be available to answer questions and correct misconceptions for the patient/family *to enhance the effectiveness of learning.*

Introduce the patient and/or family to individuals who may have had experience with the health problems in question if that is advisable. *In many cases, having the opportunity to talk to another person who has coped well with the same problem will provide support and encouragement to the patient.*

Manage: Refer to social worker/case manager early in the patient's hospitalization. *This person will begin identifying the types of support and resources the family and patient will need to prepare for follow on care.*

Refer to social and community resources, such as stroke support group, and Alzheimer's family support group, American Cancer Society. *The patient can contact these sources for additional information, as needed.*

SUGGESTED NIC INTERVENTIONS

Discharge Planning; Teaching: Individual; Learning Readiness Enhancement; Learning Facilitation; Referral; Teaching

REFERENCES

Bannister, S. L., Hanson, J. L., Maloney, C. G., & Dudas, R. A. (2015). Practical framework for fostering a positive learning environment. *Pediatrics*, *136*(1), 6–9. doi:10.1542/peds.2015-1314

Hume, K., & Tomsik, E. (2014). Enhancing patient education and medication reconciliation strategies to reduce readmission rates. *Hospital Pharmacy*, *49*(2), 112–114. doi:10.1310/hpj4902-112

Price, B. (2015). Helping patients to learn about self-management. *Nursing Standard*, *30*(2), 51–57. doi:10.7748/ns.30.2.51.e10145

DEFINITION

A pattern of nutrient intake, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to enhance nutrition

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Knowledge
- Nutrition
- Risk management
- Values/beliefs

EXPECTED OUTCOMES

- The patient will articulate present understanding of factors that enable and hinder enhanced nutritional status.
- The patient will evaluate each of the barriers to enhancing nutritional status.
- The patient will articulate the personal value of practicing positive behaviors.
- The patient will plan modifications of environment to reinforce change in eating habits.
- The patient will express positive feelings about self.

SUGGESTED NOC OUTCOMES

Adherence Behavior: Healthy Diet; Knowledge: Diet; Knowledge: Weight Management; Nutritional Status: Fluid and Food Intake; Health Promoting Behavior

INTERVENTIONS AND RATIONALES

Determine: Assess height, weight, body mass index; self-esteem, attitude toward food and eating; moral or health concerns about eating; financial status; cultural background and influences of same on food; ability to read food labels, numbers of take-out meals per week; cost of food in particular geographic area. *Assessment information about these factors will help identify appropriate interventions.*

Perform: Help patient list the internal and external barriers to improving nutritional status. *Lack of understanding of the patient's individual barriers, such as unclear goals, lack of skill, or lack of motivation, will prevent change from occurring.*

Inform: Provide materials that are intellectually and culturally appropriate for enhancing nutritional knowledge. *It is important to engage the patient in information gathering before beginning to develop a plan to change behavior.*

Teach patient to read food labels, to plan meals using a standard method such as the meals in the Food Guide (American Diabetic Association), and to stop and stock the refrigerator and pantry with smart food choices. *New behaviors require practice in a practical sense for the kind of reinforcement that will produce the desired change.*

Teach patient about the importance of exercise. Assist patient to outline a realistic program that provides adequate exercise on a weekly basis. *Having a schedule that is realistic for the individual will assist the patient with personal compliance.*

Attend: Encourage patient to list realistic goals with target dates for meeting. *Goal-directed behavior will increase the chance of positive outcomes.*

Have patient make a list of the positive outcomes of changing behaviors (e.g., wearing smaller size clothing, feeling better about being with others who are health conscious, enjoying feelings of physical and emotional well-being). *Positive reinforcers make changes more appealing.*

Manage: Refer patient to a nutrition group and an exercise group in the community, and community resources that may offer assistance to the patient when needed. *Patients often do better when they are participating with others who are working toward similar goals.*

Offer written information that can be referred to when needed. *Having written instructions reinforces learning.*

SUGGESTED NIC INTERVENTIONS

Nutrition Management; Nutritional Monitoring; Nutritional Counseling; Weight Management; Teaching: Prescribed Diet

REFERENCES

Better nutrition when cooking for one. (2016). *Harvard Health Letter*, *41*(4), 5.

Kamphuis, C. M., de Bekker-Grob, E. W., & van Lenthe, F. J. (2015). Factors affecting food choices of older adults from high and low socioeconomic groups: A discrete choice experiment. *American Journal of Clinical Nutrition*, *101*(4), 768–774. doi:10.3945/ajcn.114.096776

Sobow, T. (2014). Healthy cognitive ageing with a healthier diet and better nutrition? *European Journal of Clinical Nutrition*, *68*(11), 1177–1178. doi:10.1038/ejcn.2014.179

READINESS FOR ENHANCED PARENTING 37

DEFINITION

A pattern of providing an environment for children or other dependent person(s) to nurture growth and development, which can be strengthened

DEFINING CHARACTERISTICS

- Children express desire to enhance home environment
- Expresses desire to enhance parenting
- Parent expresses desire to enhance emotional support of children
- Parent expresses desire to enhance support of other dependent person

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Communication
- Coping
- Knowledge
- Roles/responsibilities
- Values/beliefs

EXPECTED OUTCOMES

- The parents will express satisfaction with and confidence in parental role.
- The parents will discuss signs of safe and functional environment in the home setting and state or demonstrate an understanding of teaching.
- The parents will demonstrate consistency and effectiveness related to discipline.
- The family will appear to be physically and emotionally healthy.
- The family will express belief in a higher spiritual power.
- The family will express enjoyment of spending time together.
- The family will express confidence in social and community resources available related to family needs.

SUGGESTED NOC OUTCOMES

Parent–Infant Attachment; Parenting: Psychosocial Safety; Family Health Status; Family Social Climate; Knowledge: Parenting; Parenting Performance

INTERVENTIONS AND RATIONALES

Determine: Assess age and maturity of the parents; parental role-models during childhood; role satisfaction; social support; educational needs of parents, present parenting skills, coping mechanism utilized, knowledge of child growth and development, disciplinary methods used by parents; family status, including relationship between parents and parents to children, sibling relationships, and spirituality; psychological status, including financial, educational level, and consistency and reliability of parenting techniques. *A thorough assessment will help identify appropriate interventions for this diagnosis.*

Perform: Explore family's value systems as well as their spiritual beliefs and practices. *Spirituality and values provide a basis for ethical and moral reasoning and an enhanced meaning to life.*

Explore parents' idea of social support and community resources available to the family, *to prepare for later referrals.*

Establish an environment of mutual trust and respect *to enhance learning. Consistency between action and words combined with the parents' self-awareness forms the basis of a trusting relationship.*

Inform: Select teaching strategies that will enhance teaching/learning effectiveness, such as discussion, demonstration, role-playing, and visual materials. Teach those skills that the patient must incorporate into daily living. Have patient do return demonstration of each skill, *to aid in gaining confidence.*

When teaching, go slowly and repeat frequently. Offer small amounts of information and present it in various ways. *By building cognition, parents will be better prepared to cope.* Include family members in teaching. Demonstrate to family members how each coping strategies can be used, *to deal with challenging incidents.*

Attend: Engage parents in a discussion of discipline practices and offer suggestions *to enhance their present skills.* Discipline needs to be consistent and loving and have reasonable guidelines. *Children want and need to have limits to feel safe.*

Encourage family to "play" together. *Laughter and joy increase enjoyment and bonding as well as growth as a family unit.*

Praise family for activities and traditions they honor together. *Sharing meaningful activities increases loyalty, security, and a sense of belonging for family members.* Encourage family members to participate in patient's learning process *to help create a therapeutic environment after discharge.*

Demonstrate patience in helping the patient repeat new skills multiple times. Offer parents opportunities to express their doubts or convictions about the adequacy of their parenting skills. *An open and receptive attitude provides an atmosphere for increased trust and enhanced learning.*

Manage: Have patient incorporate learned skills into care while still in the hospital, *to allow practice and time for feedback.*

Provide patient and/or family with names and telephone numbers of resource people or community agencies *so that care is continuous and follow-up is possible after discharge.*

If financial hardship interferes with the family's ability to provide equipment and supplies, offer a referral to a social worker *to improve the family's access to financial assistance.*

SUGGESTED NIC INTERVENTIONS

Attachment Promotion; Developmental Enhancement: Child and Adolescent; Family Integrity Promotion: Childbearing Family; Environmental Management: Attachment Process; Family Integrity Promotion; Role Enhancement

REFERENCES

Collins, C., Duncanson, K., & Burrows, T. (2014). A systematic review investigating associations between parenting style and child feeding behaviours. *Journal of Human Nutrition & Dietetics, 27*(6), 557–568. doi:10.1111/jhn.12192

Seay, A., Freysteinson, W. M., & McFarlane, J. (2014). Positive parenting. *Nursing Forum, 49*(3), 200–208. doi:10.1111/nuf.12093

Wright, D. (2015). Supporting transitions to parenthood: Bonding with a baby that has down's syndrome. *Midwifery Matters,* (147), 9–12.

40 READINESS FOR ENHANCED POWER

DEFINITION

A pattern of participating knowingly in change for well-being, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to enhance awareness of possible changes
- Expresses desire to enhance identification of choices that can be made for change
- Expresses desire to enhance independence with actions for change
- Expresses desire to enhance involvement in change
- Expresses desire to enhance knowledge for participation in change
- Expresses desire to enhance participation in choices for daily living
- Expresses desire to enhance participation in choices for health
- Expresses desire to enhance power

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Behavior
- Coping
- Knowledge
- Roles/responsibilities
- Values/beliefs

EXPECTED OUTCOMES

- The patient will express perceived control in influencing health outcomes.
- The patient will participate in choices that enhance self-care and well-being.
- The patient will develop a plan for adjusting to significant life changes.

SUGGESTED NOC OUTCOMES

Family Resiliency; Health Beliefs; Perceived Control; Personal Autonomy; Psychosocial Adjustment: Life Change; Knowledge: Health Promotion; Health Promoting Behavior

INTERVENTIONS AND RATIONALES

Determine: Assess patient's perception of present state of power; perception of ability to enhance power; support systems; patient's ability to identify choices; readiness for change to occur; reliance on the health care system to resolve problems; level of knowledge for positive decision making. *Assessment information will help identify appropriate interventions.*

Perform: Work with the patient to list those areas of health-related issues in which the patient needs to take greater responsibility and control. *The patients may feel the need to be in greater control without being able to articulate the specifics themselves.*

List questions in writing that a patient may want to ask primary caregiver and suggest strategies for further clarifying information that

seems unclear. *The patient's anxiety may cause to forget important point the patient needs clarified unless the patient is prepared for the visit.*

Inform: Keep patient informed about what to expect and when to expect it. *Accurate information reduces anxiety.*

Teach self-healing techniques to both the patient and the family, such as meditation, guided imagery, yoga, and prayer. Teach patient how to incorporate the use of self-healing techniques in carrying out usual daily activities. *Repeatedly performing these techniques throughout the day will help further reduce anxiety.*

Attend: Encourage patient to talk about personal assets and accomplishments and improvements in patient's condition, no matter how small they may seem. Give positive feedback. *Conversation assists you to evaluate the patient's self-concept and adaptive abilities.*

Direct the patient's focus beyond the present state.

Manage: Help patient involve the family, community, clergy, and friends with changes to the care plan, *to increase the potential of the patient's control over self-care outcomes.*

Refer patient and family to other professional caregivers, for example, dietitian, social worker, clergy, and mental health professional. *Support groups such as Ostomy clubs, I Can Cope, and Reach for Recovery can be helpful to the patient and the family.*

Assist patient to utilize appropriate resources by contacting family and scheduling follow-up appointments. *This helps give the patient a sense of direction and control over future care.*

SUGGESTED NIC INTERVENTIONS

Assertiveness Training; Coping Enhancement; Self-Modification Assistance; Self-Responsibility Facilitation; Support Group; Guided Imagery; Meditation; Religious Ritual Enhancement

REFERENCES

Irving, P. (2015). Self-empowerment in later life as a response to ageism. *Generations*, *39*(1), 72–77.

Mazzoni, D., Cicognani, E., Laghi, M., Sgarlato, V., & Mosconi, G. (2014). Patients' direction, empowerment and quality of life in haemodialysis. *Psychology, Health & Medicine*, *19*(5), 552–558. doi:10.1080/13548506.2013.855316

Stoffel, V. (2015). Engagement, exploration, empowerment. *American Journal of Occupational Therapy*, *69*(6), 1–8. doi:10.5014/ajot.2015.696002

42 READINESS FOR ENHANCED RELATIONSHIP

DEFINITION

A pattern of mutual partnership to provide each other's needs, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to enhance autonomy between partners
- Expresses desire to enhance collaboration between partners
- Expresses desire to enhance communication between partners
- Expresses desire to enhance emotional need fulfillment for each partner
- Expresses desire to enhance mutual respect between each partner
- Expresses desire to enhance satisfaction with complementary relationship between partners
- Expresses desire to enhance satisfaction with emotional need fulfillment for each partner
- Expresses desire to enhance satisfaction with idea sharing between partners
- Expresses desire to enhance satisfaction with information sharing between partners
- Expresses desire to enhance satisfaction with physical need fulfillment for each partner
- Expresses desire to enhance understanding of partner's functional deficit (e.g., physical, psychological, social)

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Sexuality
- Emotional
- Roles/relationships

EXPECTED OUTCOMES

- The patient will communicate effectively with partner and family members.
- The patient will articulate ways to mutually meet physical and emotional needs of partner and self.
- The patient will participate in appropriate counseling (premarital, preconceptual, sexual), as needed.
- The patient will verbalize that relationships are characterized by well-balanced autonomy and self-efficacy.

SUGGESTED NOC OUTCOMES

Family Functioning; Role Performance; Sexual Functioning; Social Interaction Skills

INTERVENTIONS AND RATIONALES

Determine: Assess communication techniques and effectiveness of couple and family *to be able to counsel and/or refer appropriately as needed.*

Perform: Suggest that patient and partner/family members attend counseling sessions, as appropriate, for their life-cycle stage. *Patients may need permission from a health care professional to feel comfortable seeking relationship assistance.*
Inform: Teach patient and family members normal family life-cycle stages *so that they can better understand what is normal and are able to anticipate challenges.*
Attend: Encourage patient and family members to share information and ideas *to enhance their communication.*
Manage: Refer, as needed, to colleagues in other disciplines such as social workers or counselors *to facilitate enhanced communication.*

SUGGESTED NIC INTERVENTIONS

Family Integrity Promotion; Family Support; Preconception Counseling; Sexual Counseling; Socialization Enhancement; Support System Enhancement

REFERENCES

Fortune-Britt, A. G., Nieuwsma, J. A., Gierisch, J. M., Datta, S. K., Stolldorf, D. P., Cantrell, W. C., . . . Jackson, G. L. (2015). Evaluating the implementation and sustainability of a program for enhancing veterans' intimate relationships. *Military Medicine*, *180*(6), 676–683. doi:10.7205/MILMED-D-14-00336

Kemp, D. (2016). Improving mental health through social support: Building positive and empowering relationships. *Mental Health Nursing*, *36*(1), 21.

Lundy, B. L., & Drouin, M. (2016). From social anxiety to interpersonal connectedness: Relationship building within face-to-face, phone and instant messaging mediums. *Computers in Human Behavior, 54*, 271–277. doi:10.1016/j.chb.2015.08.004

44 READINESS FOR ENHANCED RELIGIOSITY

DEFINITION

A pattern of reliance on religious beliefs and/or participation in rituals of a particular faith tradition, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to enhance belief patterns used in the past
- Expresses desire to enhance connection with a religious leader
- Expresses desire to enhance forgiveness
- Expresses desire to enhance participation in religious experiences
- Expresses desire to enhance participation in religious practices (e.g., ceremonies, regulations, clothing, prayer, services, holiday observances)
- Expresses desire to enhance religious customs used in the past
- Expresses desire to enhance religious options
- Expresses desire to enhance use of religious material

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Communication
- Coping
- Knowledge
- Roles/responsibilities
- Values/beliefs

EXPECTED OUTCOMES

- The patient will articulate what gives the patient strength and hope.
- The patient will discuss important aspects of religion to work with the patient to establish a trusting relationship.
- The patient will list how staff can facilitate patient's participation in religious practices.
- The patient will request or agree to talk to a religious professional.
- The patient will express a feeling of peace with provided religious opportunities.

SUGGESTED NOC OUTCOMES

Health Beliefs; Health Promoting Behavior; Hope; Motivation; Quality of Life; Spiritual Health

INTERVENTIONS AND RATIONALES

Determine: Assess support system; involvement in religion; religious affiliation; religious practices and/or spiritual practices that are meaningful to the patient; perceptions of faith, life, death, and suffering. *Information from assessment helps identify appropriate interventions.*

Perform: Obtain for the patient objects of religious significance that the patient requests, for example, a cross, a copy of the Bible or Koran, a menorah. *Patients often find comfort in having religious objects at the bedside.*

Attend: Listen attentively to the patient. Do not argue about the patient's beliefs or perceptions of faith. Ask for clarification when it is needed. Honest communication is important to gain the patient's trust.

Offer to provide whatever things can easily be found to support the patient's spiritual needs, such as reading material, pictures, music, and so forth. *This may promote comfort.*

Explore with the patient to what extent the patient wishes to incorporate religious beliefs into daily life. *This would introduce the idea of making a plan to enhance religiosity.*

Help patient list the religious practices that are most important to the patient, *to comfort the patient while planning much more complex support.*

Manage: Evaluate to what extent the patient perceives that patient's spiritual needs are being met. *This way, modifications can be made, if indicated.*

Arrange a referral to a member of the clergy or person designated by the patient as a spiritual guide *so the patient may discuss deeper spiritual issues.*

SUGGESTED NIC INTERVENTIONS

Presence; Religious Ritual Enhancement; Spiritual Growth Facilitation; Spiritual Support; Values Clarification

REFERENCES

Cervelin, A. F., & Luce Kruse, M. H. (2015). Spirituality and religiosity in palliative care: Proposing a good death. *Journal of Nursing UFPE/Revista De Enfermagem UFPE, 9*, 7615–7624. doi:10.5205/reuol.7049-61452-1-ED.0903supl201515

Kim, N. Y., Huh, H. J., & Chae, J. H. (2015). Effects of religiosity and spirituality on the treatment response in patients with depressive disorders. *Comprehensive Psychiatry, 60*, 26–34. doi:10.1016/j.comppsych.2015.04.009

Snider, A., & McPhedran, S. (2014). Religiosity, spirituality, mental health, and mental health treatment outcomes in Australia: A systematic literature review. *Mental Health, Religion & Culture*, *17*(6), 568–581. doi:10.1080/13674676.2013.871240

46 READINESS FOR ENHANCED RESILIENCE

DEFINITION

A pattern of positive responses to an adverse situation or crisis, which can be strengthened

DEFINING CHARACTERISTICS

- Demonstrates positive outlook
- Exposure to crisis
- Expresses desire to enhance available resources
- Expresses desire to enhance communication skills
- Expresses desire to enhance environmental safety
- Expresses desire to enhance goal-setting
- Expresses desire to enhance involvement in activities
- Expresses desire to enhance own responsibility for action
- Expresses desire to enhance progress toward goal
- Expresses desire to enhance relationship with others
- Expresses desire to enhance resilience
- Expresses desire to enhance self-esteem
- Expresses desire to enhance sense of control
- Expresses desire to enhance support system
- Expresses desire to enhance use of conflict management strategies
- Expresses desire to enhance use of coping skills
- Expresses desire to enhance use of resource

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Thought process
- Perception of self
- Stability of relationships

EXPECTED OUTCOMES

- The patient will acknowledge readiness for increased resilience.
- The patient will verbalize the feeling of resilience.
- The patient will identify impact of resilience toward growth.

SUGGESTED NOC OUTCOMES

Self-Esteem; Knowledge: Health Behavior; Personal Resiliency

INTERVENTIONS AND RATIONALES

Determine: Explore with patients their process and growth in mastering a situation or crisis that enhanced their resilience. *Mastery of responses in crisis situations can generalize to future situations.*

Monitor attainment of goals *to assess need for further intervention.*

Perform: Listen therapeutically to patient's self-exploration and mastery. *Active listening is the key to the therapeutic alliance and accurate assessment.*

Demonstrate conflict resolution principles through role-playing, *to be able to practice in a controlled environment.*

Inform: Instruct the patient to journal experiences for future reflection. *Journaling is a therapeutic tool for self-exploration and expansion.*

Attend: Guide patient to review life goals that might now be attainable. *Personal potential is maximized in an environment of resilience.*

Manage: Encourage patient to assist others or get involved to enrich the lives of others. *Humans benefit from shared positive experiences.*

SUGGESTED NIC INTERVENTIONS

Coping Enhancement; Conflict Mediation; Journaling; Resiliency Promotion

REFERENCES

Ellis, L., Gergen, J., Wohlgemuth, L., & Nolan, M. T. (2016). Empowering the "cheerer": Role of surgical intensive care unit nurses in enhancing family resilience. *American Journal of Critical Care*, *25*(1), 39–45. doi:10.4037/ajcc2016926

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Wong, P. S., Fong, K. W., & Lam, T. L. (2015). Enhancing the resilience of parents of adults with intellectual disabilities through volunteering: An exploratory study. *Journal of Policy & Practice in Intellectual Disabilities*, *12*(1), 20–26. doi:10.1111/jppi.12101

48 READINESS FOR ENHANCED SELF-CARE

DEFINITION

A pattern of performing activities for oneself to meet health-related goals, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to enhance independence with health
- Expresses desire to enhance independence with life
- Expresses desire to enhance independence with personal development
- Expresses desire to enhance independence with well-being
- Expresses desire to enhance knowledge of self-care strategies
- Expresses desire to enhance self-care

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Behavior
- Coping
- Emotional
- Self-care

EXPECTED OUTCOMES

- The patient will demonstrate positive decision making toward maximizing potential for self-care.
- The patient will express satisfaction with independence in assuming responsibility for planning self-care.
- The patient will involve staff, family, and community in developing strategies for self-care.
- The patient will seek out health-related information, as needed.
- The patient will monitor self-care measures taken for effectiveness and make alterations, as needed.

SUGGESTED NOC OUTCOMES

Adherence Behavior; Client Satisfaction: Functional Assistance; Decision-Making; Health Beliefs: Perceived Ability to Perform

INTERVENTIONS AND RATIONALES

Determine: Assess patient's satisfaction with level of self-care, *to support general well-being.*

Assess current ability to provide self-care, *to establish a baseline.*

Assess effectiveness of self-care measures, *to identify the need for adjustments.*

Perform: Assist patient to develop plan *to promote autonomous decision making to increase patient's responsibility for facilitating care.*

Inform: Provide information that supports implementation of a program to sustain health-seeking behavior, *to promote patient autonomy in self-care.*

Attend: Encourage health team, family, and community efforts to participate in patient's self-care initiatives, *to promote satisfactory mutual goal-setting and group efforts.*

Encourage patient and family to participate in support networks that promote patient independence, where possible, *to promote patient and family resilience.*

Manage: Develop a referral list for community resources to promote patient's enhanced self-care.

SUGGESTED NIC INTERVENTIONS

Mutual Goal-Setting; Resiliency Promotion; Self-Responsibility Facilitation; Self-Efficacy Enhancement

REFERENCES

Basak, T., Unver, V., & Demirkaya, S. (2015). Activities of daily living and self-care agency in patients with multiple sclerosis for the first 10 years. *Rehabilitation Nursing, 40*(1), 60–65. doi:10.1002/rnj.153

Frost, Y., Weingarden, H., Zeilig, G., Nota, A., & Rand, D. (2015). Self-care self-efficacy correlates with independence in basic activities of daily living in individuals with chronic stroke. *Journal of Stroke & Cerebrovascular Diseases, 24*(7), 1649–1655. doi:10.1016/j.jstrokecerebrovasdis.2015.03.054

Sechoaro, E. J., Scrooby, B., & Koen, D. P. (2014). The effects of rehabilitation on intellectually-disabled people – a systematic review. *Health SA Gesondheid*, *19*(1), 1–9. doi:10.4102/hsag.v19i1.693

50 READINESS FOR ENHANCED SELF-CONCEPT

DEFINITION

A pattern of perceptions or ideas about self, which can be strengthened

DEFINING CHARACTERISTICS

- Acceptance of limitations
- Acceptance of strengths
- Actions congruent with verbal expressions
- Confidence in abilities
- Expresses desire to enhance role performance
- Expresses desire to enhance self-concept
- Satisfaction with body image
- Satisfaction with personal identity
- Satisfaction with sense of worth
- Satisfaction with thoughts about self

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Coping
- Emotional
- Growth and development
- Roles/relationships
- Self-perception
- Values/beliefs

EXPECTED OUTCOMES

- The patient will articulate long- and short-term goals.
- The patient will express motivation necessary to achieve goals.
- The patient will develop realistic plan to achieve stated goals.
- The patient will practice self-management strategies needed to be successful.
- The patient will evaluate progress and modify behavior, as needed.

SUGGESTED NOC OUTCOMES

Adherence Behavior; Health Beliefs: Perceived Ability to Perform: Health Promoting Behavior: Knowledge: Health Promotion; Motivation; Personal Well-Being; Risk Control; Body Image; Personal Autonomy; Self-Esteem

INTERVENTIONS AND RATIONALES

Determine: Assess patient's satisfaction with level of self-concept, *to support general well-being.*

Perform: Provide patient with materials and resources on health-related issues that affect patient's attitude. *Knowledge will enhance patient's motivation or resolve.*

Have patient list one or two realistic, practical behaviors that will facilitate achieving goals. *The more positive the patient's behaviors are, the greater the chance patient has of being successful.*

Inform: Answer questions related to written material *so patient is adequately prepared to establish realistic goals.*

Attend: Assist patient in writing long- and short-term goals. *These goals can serve as tools for self-evaluation as new behaviors are being practiced.*

Assist patient to determine positive rewards for successful behavior changes. *Reinforcers are needed for new behavior to continue.*

Manage: Develop a referral list for community resources *to promote patient's enhanced self-concept.*

SUGGESTED NIC INTERVENTIONS

Hope Inspiration; Journaling; Self-Awareness Enhancement; Self-Responsibility Facilitation; Self-Efficacy Enhancement; Self-Esteem Enhancement

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52 READINESS FOR ENHANCED SLEEP

DEFINITION

A pattern of natural, periodic suspension of relative consciousness to provide rest and sustain a desired lifestyle, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to enhance sleep

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Activities
- Knowledge
- Pharmacologic function
- Sleep/rest

EXPECTED OUTCOMES

- The patient will identify factors that enhance readiness for sleep.
- The patient will demonstrate readiness for enhanced sleep through the use of appropriate sleep hygiene measures.
- The patient will express feeling rested after sleep.
- The patient will have an appropriate amount of sleep and rapid eye movement sleep that is congruent with developmental needs.

SUGGESTED NOC OUTCOMES

Anxiety Level; Rest; Sleep

INTERVENTIONS AND RATIONALES

Determine: Assess daytime activity and work patterns; cognitive status; daytime consequences of sleeplessness; sleep environment; quality and duration of sleep; recent changes in health status or lifestyle; and dietary and drug history, including ingestion of caffeine or other stimulants.

Assessment information will help identify appropriate outcomes and interventions.

Perform: Give warm, light snacks containing protein at bedtime and small amounts of liquid *to promote a sense of comfort.*

Provide a cup of water close to bedtime *to avoid dry mouth and help return to sleep after awakening.*

Inform: Educate patient about normal age-related changes to sleep and strategies that are specific to the patient's health status, lifestyle, and environment, *to decrease anxiety about sleeplessness.*

Teach patient to relax before going to bed, using music, reading, meditation, or other soothing or comforting activities, *to enhance ability to sleep.*

Instruct patient to avoid dietary substances and drugs that may influence sleep, including ingestion of caffeine or other stimulants, nicotine, alcohol, sedatives, hypnotics, and fluid intake, *to enhance the ability to sleep.*

Attend: Encourage patient to make a log of sleep and wake times, number of awakenings, total time asleep, quality of sleep, and any precipitating factors that may influence sleep, *to determine sleep efficiency.*

Manage: If patient begins having difficulties in sleeping, recommend a behavior modification plan based on assessment of condition, patient's history, and precipitating factors, *to enhance compliance*.

SUGGESTED NIC INTERVENTIONS

Comfort; Sleep Enhancement; Environmental Management: Comfort; Progressive Muscle Relaxation; Journaling

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54 READINESS FOR ENHANCED SPIRITUAL WELL-BEING

DEFINITION

A pattern of experiencing and integrating meaning and purpose in life through connectedness with self, others, art, music, literature, nature, and/or a power greater than oneself, which can be strengthened

DEFINING CHARACTERISTICS

Connections to self

- Expresses desire to enhance acceptance
- Expresses desire to enhance coping
- Expresses desire to enhance courage
- Expresses desire to enhance hope
- Expresses desire to enhance joy
- Expresses desire to enhance love
- Expresses desire to enhance meaning in life
- Expresses desire to enhance meditative practice
- Expresses desire to enhance purpose in life
- Expresses desire to enhance satisfaction with philosophy of life
- Expresses desire to enhance self-forgiveness
- Expresses desire to enhance serenity (e.g., peace)
- Expresses desire to enhance surrender

Connections with others

- Expresses desire to enhance forgiveness from others
- Expresses desire to enhance interaction with significant other
- Expresses desire to enhance interaction with spiritual leaders
- Expresses desire to enhance service to others

Connections with art, music, literature, and nature

- Expresses desire to enhance creative energy (e.g., writing, poetry, music)
- Expresses desire to enhance spiritual reading
- Expresses desire to enhance time outdoors
- Expresses desire to enhance mystical experiences
- Expresses desire to enhance participation in religious activity
- Expresses desire to enhance prayerfulness
- Expresses desire to enhance reverence

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Coping
- Emotional
- Knowledge
- Self-perception
- Values/beliefs

EXPECTED OUTCOMES

- The patients will discuss spiritual conflicts.
- The patients will have opportunity to meet with chosen religious figure.
- The patients will receive support in their efforts to pursue enhanced spiritual well-being.
- The patients will pursue religious or spiritual practices to the extent they feel comfortable.
- The patients will openly discuss effects of illness on their beliefs and other spiritual issues.
- The patients will describe plan to continue to enhance spiritual well-being.
- The patients will receive referrals for continued support.

SUGGESTED NOC OUTCOMES

Hope; Quality of Life; Spiritual Health; Comfort Status: Psychospiritual; Knowledge: Health Resources; Motivation; Personal Well-Being

INTERVENTIONS AND RATIONALES

Determine: Assess personal religion and church affiliation; perceptions of faith, life, death, suffering; support networks; beliefs opposed by family, friends, and health care providers. *Assessment of spiritual status will provide information that will assist in identifying expected outcomes and interventions for this diagnosis.*

Perform: Monitor the patient for signs of spiritual distress that might harm the patient's well-being (altered self-care, sleep pattern disturbance, and change in eating and exercise habits). *This information will provide insight into changes in goals and interventions.*

Assess the significance of spirituality in the patient's life and in coping with illness. *Before the nurse can intervene in spiritual matters, she must determine whether spirituality is significant for the patient.*

Inform: Provide the patient with resources for coping with spiritual distress (such as referrals to religious or spiritual organizations or books on prayer or meditation) *to enhance the opportunity to attend to spiritual beliefs.*

If the nurse lacks knowledge about the patient's beliefs or practices, consult an authority on the patient's particular religion *to have accurate information when endeavoring to meet patient's individual needs.*

Discuss importance of maintaining a healthy diet, regular exercise, adequate sleep, and healthy interaction with family members and friends. *A patient who is predisposed to spiritual distress may neglect day-to-day well-being.*

Attend: Demonstrate to the patients that you are willing to discuss issues related to spirituality, such as the patient's view of God, how illness has affected their life, or how the hospital stay has affected their spiritual practices, *to bring spiritual issues into the open.*

Praise patients' efforts to attend to their spiritual needs and encourage them to continue to develop spirituality after they leave the health care setting, *to reinforce the progress the patients have already made.*

Manage: Provide patient with referrals to appropriate religious groups, spiritually centered organizations, and social service organizations *to help provide additional support and to ensure continuity of care.*

Consider resources such as faith community nurses, home visiting services, and computer networks *to help provide continued opportunity for spiritual development and ensure continuity of care.*

SUGGESTED NIC INTERVENTIONS

Active Listening; Emotional Support; Hope Instillation; Presence; Spiritual Growth Facilitation; Spiritual Support; Referral

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READINESS FOR ENHANCED URINARY ELIMINATION

DEFINITION

A pattern of urinary functions for meeting eliminatory needs, which can be strengthened

DEFINING CHARACTERISTICS

- Expresses desire to enhance urinary elimination

ASSESSMENT FOCUS

(Refer to comprehensive assessment parameters.)

- Coping
- Elimination
- Fluid and electrolytes
- Nutrition
- Reproduction

EXPECTED OUTCOMES

- The patient will maintain urine output that is clear and straw colored with no odor.
- The patient will drink 64 oz of noncaffeinated, nonalcoholic beverages per day (unless contraindicated).
- The patient will maintain blood pressure in normal range.
- The patient will avoid use of nonsteroidal anti-inflammatory drugs (NSAIDs), analgesics, and anticholinergics.
- The patient will express understanding of health promotion activities to enhance urinary elimination.

SUGGESTED NOC OUTCOMES

Urinary Continence; Urinary Elimination; Fluid Balance

INTERVENTIONS AND RATIONALES

Determine: Assess that weight is within established norms *to prevent pressure on bladder, which contributes to incontinence.*

Assess that blood pressure is within norms; *elevated ranges contribute to renal failure.*

Perform: Discuss voiding and fluid intake patterns to *provide a baseline for introducing new activities.*

Discuss foods that increase acidity in the urine (cranberries, meats, eggs, whole grains, and prunes) and foods that are low in sodium. *Increased acidity in the urine impedes bacterial growth. Foods high in sodium cause fluid retention and decreased urine output.*

Discuss hygiene practices, including hand hygiene, wiping and cleaning from front to back, and taking showers rather than baths (females). *Cleaning from front to back prevents transferring microorganisms from the bowel to the urinary meatus. Showering flushes microorganisms away from the urinary meatus, preventing urinary tract infections (UTIs).*

Inform: Teach female patient to perform Kegel exercises *to strengthen pelvic muscles and prevent development of incontinence (which occurs in 20% to 40% of elderly women).*

Teach stress management techniques. *Stress stimulates release of antidiuretic hormones and interferes with sphincter relaxation, which causes urine retention.*

Explain reasons for activities that enhance urinary elimination *to patient, to promote understanding and compliance.*

Attend: Encourage patient to drink six to eight glasses of noncaffeinated, nonalcoholic, noncarbonated liquid, preferably water, per day (unless contraindicated). *1,500 to 2,000 mL/day promotes optimal renal function and flushes bacteria and solutes from the urinary tract. Caffeine and alcohol promote diuresis and may contribute to excess fluid loss. Caffeine, alcohol, and carbonation are irritating to the bladder wall.*

Encourage patient to respond to the urge to void in a timely manner. *Ignoring the urge to urinate may cause incontinence.*

For female patient, encourage her to void before and after intercourse *to flush microorganisms away from the urinary meatus, preventing UTI*; to avoid bubble baths *that may cause chemical irritation to urinary meatus, increasing the risk of UTI*; and to wear cotton underpants, *as cotton is an absorbent fabric that prevents perineal moisture retention.*

Encourage patient to participate in regular exercise, including walking and modified sit-ups (unless contraindicated). *Weak abdominal and perineal muscles weaken bladder and sphincter control.*

Encourage patient to avoid NSAIDs, analgesics, and anticholinergics. *NSAIDs and analgesics impair renal blood flow. Anticholinergic drugs inhibit relaxation of urinary sphincter and cause urine retention.*

Encourage patient to stop smoking (if applicable) or refrain from starting. *Smoking contributes to renal and bladder cancer. Nicotine is a potent vasoconstrictor.*

Encourage patient to avoid exposure to petroleum, heavy metals, asbestos, dyes, rubber, leather, ink, and paint. *Exposure to carcinogens increases the risk of renal and bladder cancer.*

Manage: Advise patient to report presence of sore throat to primary care provider. *Sore throat may be indicative of streptococcal infection, which may cause renal failure.*

SUGGESTED NIC INTERVENTIONS

Urinary Elimination Management; Smoking Cessation Assistance

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