SNS COLLEGE OF NURSING, COIMBATORE- 35

Department : Department of Nursing

Course Name : B. Sc. (Nursing) I Year II Semester

Subject : Nursing Foundation- II

Unit : II

Topic : Nursing Process- Interventions/ Rationale/ Implementation

Introduction

Patient Outcomes

The ultimate goal of nursing interventions

Collaborative Interventions

Actions requiring teamwork with other professionals

Dependent Interventions

Actions needing orders from healthcare providers

Independent Interventions

Actions nurses initiate autonomously

Types of Nursing Intervention

Types of Nursing Interventions

Independent Nursing Interventions

- Auscultate apical pulse, assess heart rate, rhythm.
- Document dysrhythmia if telemetry is available.

Dependent Nursing Interventions

- Administer diuretics as indicated.
- Administer IV solutions, restricting total amount as indicated.

Collaborative

- Refer to dietitian for counseling specific to individual dietary customs.

Nursing Actions Comparison

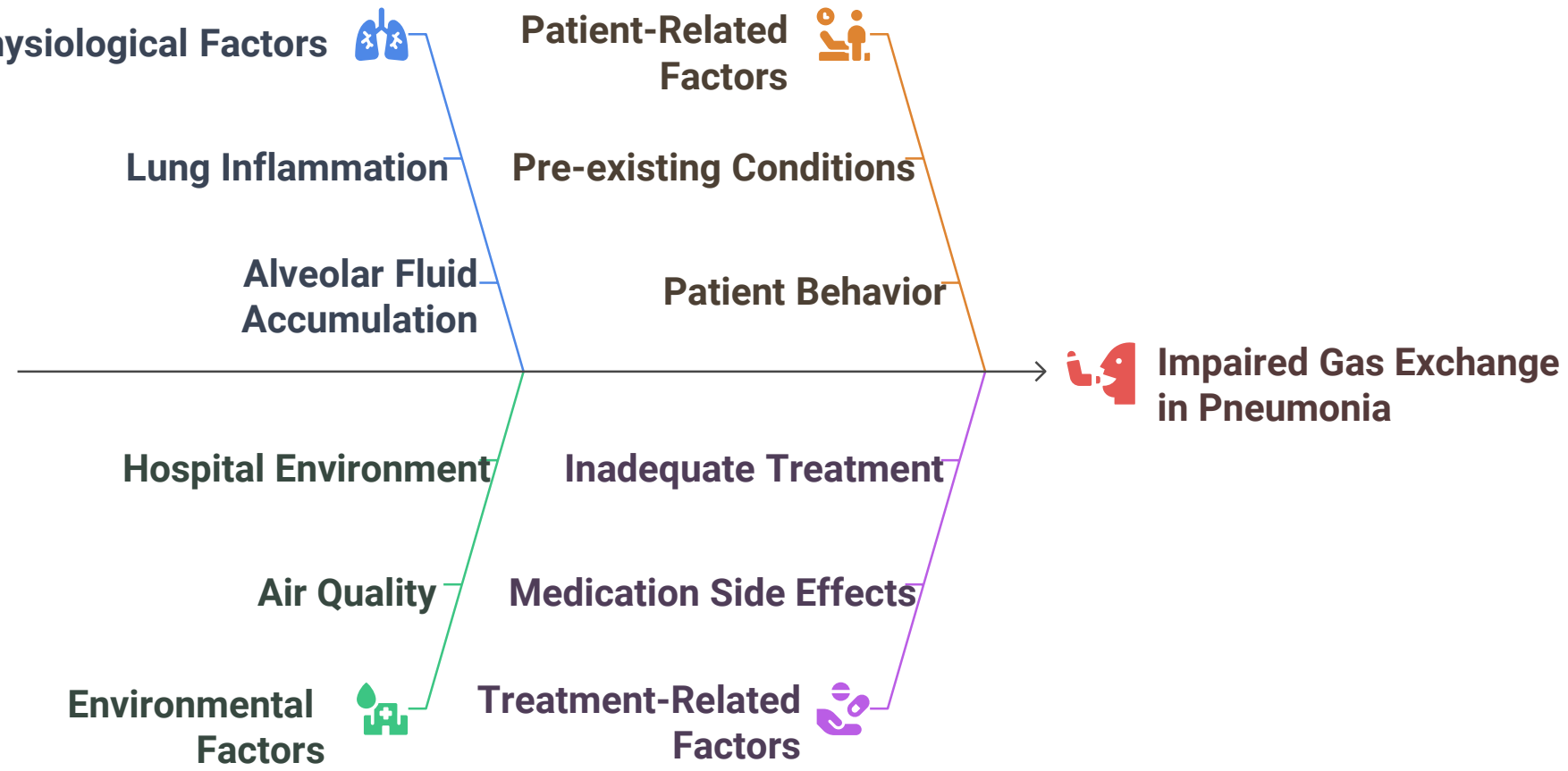
Characteristic	Independent	Dependent	Collaborative
Definition	Actions based on nurse's skills	Requires provider's order	Requires interprofessional teamwork
Examples	Patient education, positioning	Medication administration	Physical therapy, dietary consults

Rationale in Nursing Process:

Rationale in Nursing Practice

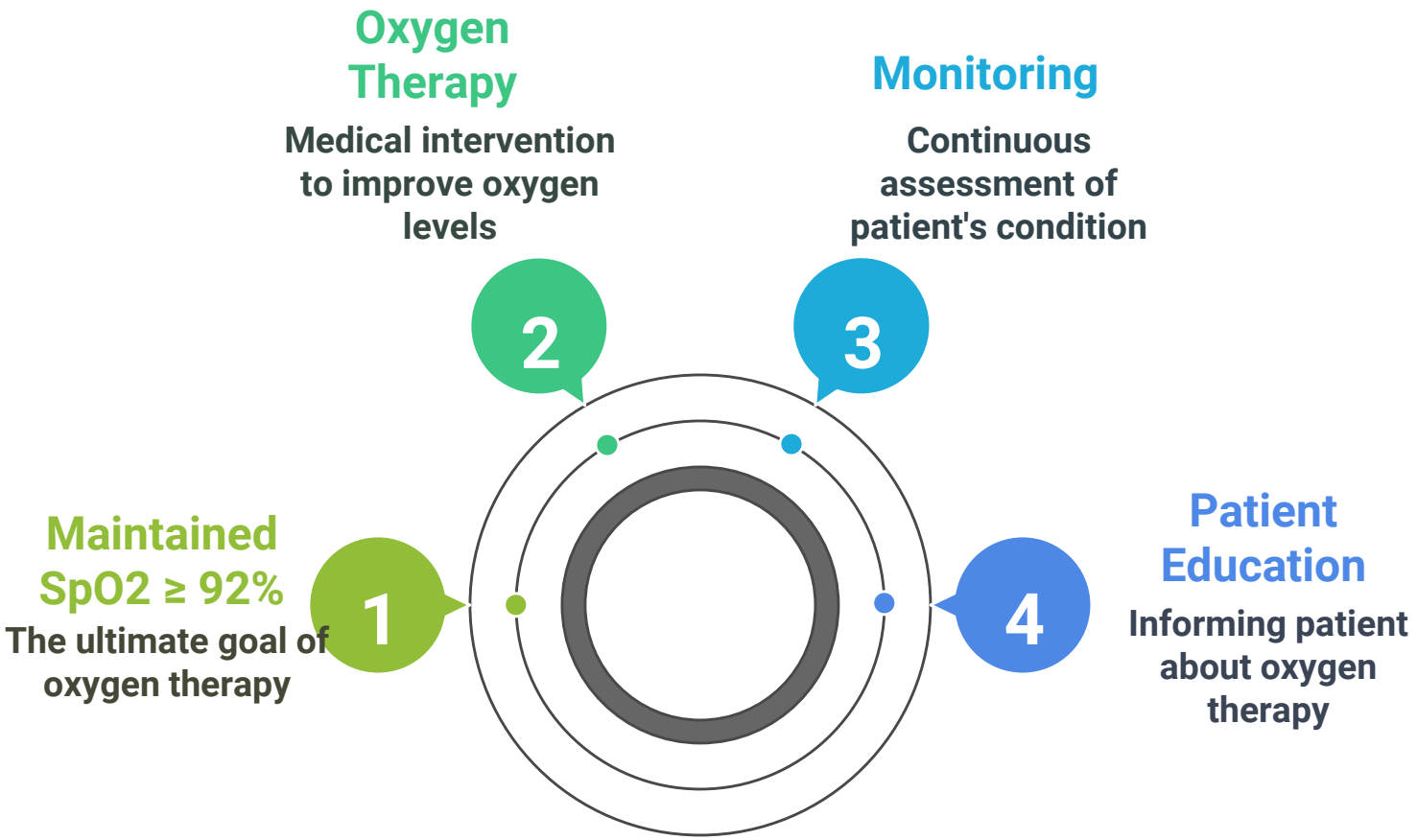
Example:

Analyzing Impaired Gas Exchange in Pneumonia

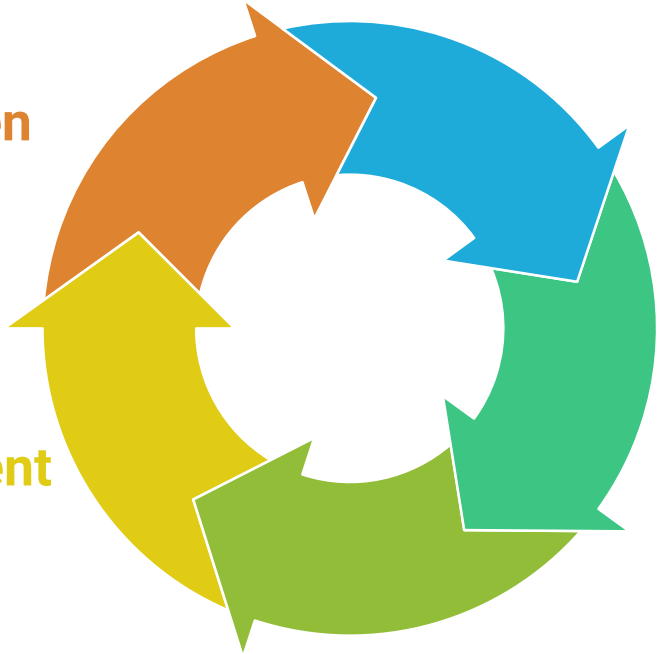


Goal:

Patient Oxygen Saturation Goal



Intervention: Cycle of Oxygen Administration



Assess Patient Condition
Evaluate respiratory status and oxygen needs.

Prescribe Oxygen
Determine the appropriate oxygen dosage.

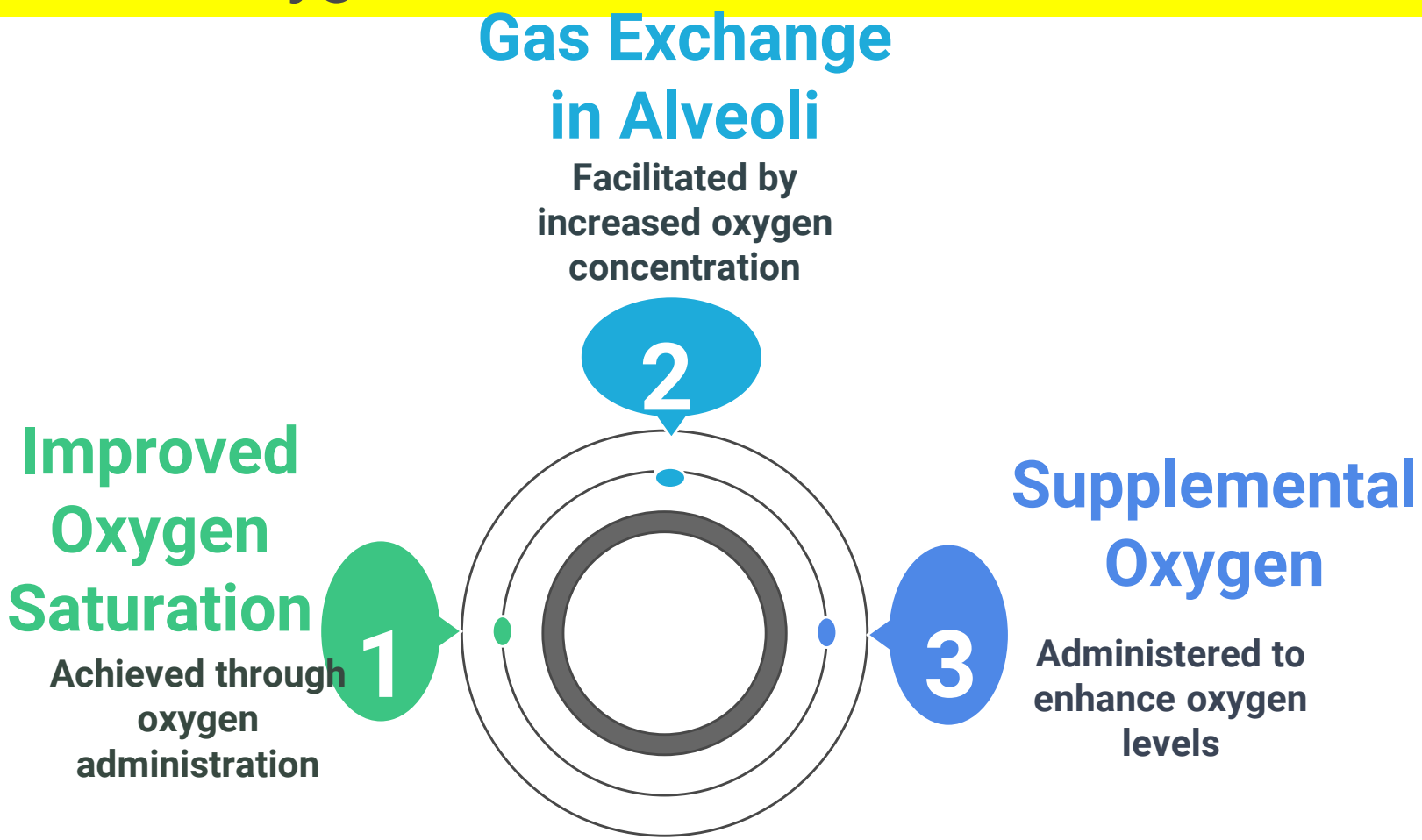
Administer Oxygen
Deliver oxygen via mask or cannula.

Monitor Patient Response
Observe for improvements in oxygen levels.

Adjust Oxygen Levels
Modify dosage based on patient response.

Rationale

Oxygen Administration Rationale



Components of Nursing Goals

Components of goals and desired outcomes

Client	will ambulate	unassisted with crutches	by discharge.
subject	verb	conditions or modifiers	criterion

Lets focus in detailed:

- **Subject.** The subject is the client, any part of the client, or some attribute of the client (i.e., pulse, temperature, urinary output).
- That subject is often omitted in writing goals because it is assumed that the subject is the client unless indicated otherwise (family, significant other).
- **Verb.** The verb specifies an action the client is to perform, for example, what the client is to do, learn, or experience.
- **Conditions or modifiers.** These are the "what, when, where, or how" that are added to the verb to explain the circumstances under which the behavior is to be performed.
- **Criterion of desired performance.** The criterion indicates the standard by which a performance is evaluated or the level at which the client will perform the specified behavior. These are optional.

Examples of nursing interventions and rationales

Sample nursing interventions and rationales for patients with acute pain

Nursing Interventions	Rationales
Perform a comprehensive assessment of pain. Determine the location, characteristics, onset, duration, frequency, quality, and severity of pain via assessment.	The patient experiencing pain is the most reliable source of information about their pain. Thus, assessment of pain by conducting an interview helps the nurse in planning optimal pain management strategies.
Provide cognitive-behavioral therapy (CBT) for pain management.	These methods are used to provide comfort by altering psychological responses to pain. Cognitive-behavioral interventions include: distraction, guided imagery, eliciting relaxation response, etc.

Sample nursing interventions and rationales for patients with heart failure

Nursing Interventions	Rationales
Auscultate apical pulse, assess heart rate.	Tachycardia is an early sign of heart failure. An increase in heart rate is the body's first response to compensate for reduced cardiac output (CO). Initially, this compensatory response has a favorable effect on cardiac output, but over time, persistent tachycardia is harmful and may worsen heart failure. Appropriate heart rate control has been associated with better clinical outcomes, including decreased hospitalizations and mortality (Yancy et al., 2017).
Give oxygen as indicated by the patient's symptoms, oxygen saturation, and ABGs.	Supplemental oxygen increases oxygen availability to the myocardium and can help relieve symptoms of hypoxemia, ischemia, and subsequent activity intolerance (Giordano, 2005; Haque et al., 1996). The need is based on the degree of pulmonary congestion and resulting hypoxia. Ongoing pulse oximetry monitors the need for and effectiveness of oxygen supplementation.

Last Step in Nursing Process

- **Evaluation** is a planned, ongoing, purposeful activity in which the client's progress towards achieving goals or desired outcomes is assessed, and the effectiveness of the nursing care plan (NCP).
- Evaluation is an essential aspect of the **nursing process** because the conclusions drawn from this step determine whether the nursing intervention should be terminated, continued, or changed

The FINAL DOCUMENTATION!

- **Step 9: Putting it on Paper**
- The client's care plan is documented according to hospital policy and becomes part of the client's permanent medical record, which may be reviewed by the oncoming nurse.
- Different nursing programs have different care plan formats.
- Most are designed so that the student systematically proceeds through the interrelated steps of the **nursing process**, and many use a five-column format.

FORMAT:

Cues	Inference	Nursing Diagnosis	Panning	Interventions	Rationale	Evaluation
S: 'sumasakit ang aking tyan" as verbalized by the client Pain Scale: 5/10 as 0 is the lowest and 10 is the highest With the pain characteristics of moderate pain O: • with facial grimace • verbal report of acute pain • guarding behavior on the left lower extremity	External and internal factor aggravates the nerve endings in the lower extremity causing production of prostaglandin, bradykinin, histamine and progesterone to react on the specific region causing pain sensation felt by the client	Acute pain related to post surgical as manifested by facial grimace, guarding behavior and verbal report of pain felt in the lower abdominal region	After series of nursing interventions the client should manifest a decrease in the pain scale of 5/10 to a manageable level of 0/10	• Assess the clients pain scale and perception • Encourage verbal report during and after the nursing interventions • Monitor V/S and pain scale • Teach client divertional activities • Advise breathing exercise • Administer Etoricoxib 120mg /tab as prescribed by the physician	• To identify the intensity, onset, duration, quality, and quality of the pain • Pain is highly subjective and to identify the effectiveness of the interventions • Obtain baseline V/S, V/S changes during onset of pain, for future comparison after interventions • To divert clients attention from pain • To allow proper O2 supply in the body, clients tend to stop breathing during pain • Relieve the client of pain using pharmacologic intervention	After series of nursing interventions goals are met as evident of the clients decrease in pain scale from 5/10 to 0/10 or with no pain and discomfort and positive verbal report of the client during the evaluation

University Question Paper – Frequently Asked Questions

5 Minutes Assessment :

- Which of the following is a primary purpose of a nursing intervention during the implementation phase of the nursing process?
  A. To collect patient data for diagnosis
  B. To carry out actions to achieve patient outcomes
  C. To evaluate the effectiveness of the care plan
  D. To revise the nursing diagnosis

- A patient with a nursing diagnosis of "Impaired Gas Exchange" is receiving oxygen therapy at 2 L/min via nasal cannula. What is the rationale for monitoring oxygen saturation levels during this intervention?
  A. To ensure the oxygen delivery device is comfortable
  B. To assess if the intervention improves respiratory function
  C. To determine the patient's pain level during breathing
  D. To confirm the patient's nutritional status

- A nurse is implementing a turning schedule every 2 hours for a bedridden patient. What is the primary rationale for this intervention?
  A. To reduce the risk of pressure injuries
  B. To improve the patient's nutritional intake
  C. To enhance the patient's emotional well-being
  D. To increase the patient's respiratory rate
- When implementing a fluid restriction intervention for a patient with heart failure, what is the nurse's priority action?
  A. Encourage the patient to drink more water
  B. Monitor daily weight and intake/output
  C. Administer oxygen therapy continuously
  D. Restrict all physical activity

- A nurse teaches a patient with diabetes about foot care to prevent complications. What is the rationale for this intervention?
  A. To improve the patient's respiratory status
  B. To prevent infections and promote early detection of issues
  C. To reduce the patient's blood glucose levels directly
  D. To enhance the patient's mobility immediately

- **Correct Answer**: B. To carry out actions to achieve patient outcomes
- **Correct Answer**: B. To assess if the intervention improves respiratory function
- **Correct Answer**: A. To reduce the risk of pressure injuries
- **Correct Answer**: B. Monitor daily weight and intake/output
- **Correct Answer**: B. To prevent infections and promote early detection of issues

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Thank you !!!