CARE PLANNING AND THE NURSING PROCESS

Fiona Rich
Senior Lecturer
CARE PLANNING AND THE NURSING PROCESS

Aim

The aim of this resource pack is to provide you with a guide to care planning and use of the nursing process.

Learning Outcomes

On completion of this pack, you will have:

1. Discuss the implications of basing assessments on subjective and objective data.
2. State a nursing diagnosis for a client who has either profound/multiple learning disabilities or challenging behaviour
3. Discuss the ethical and legal dilemmas that the nurse must face in planning care
4. Write a goal statement for a client who has either profound/multiple learning disabilities (PMLD) or challenging behaviour

Instructions

You are required to work through the pack and complete ALL the activities indicated. You may work on your own, in pairs or in small groups when completing the formative activities.
What do we mean by the term Nursing Process?

“The Nursing process is a procedure for organising nursing care in which the first step (patient assessment) initiates the act of nursing.” (Stevens-Barnum, 1994, page. 152)

In its simplest form, the nursing process has 4 steps:

- Assessment
- Planning
- Implementation
- Evaluation

Other formulations might have any number of the following steps:

- Assessment
- Nursing diagnosis
- Patient prognosis
- Goal setting
- Therapeutic care planning
- Care implementation
- Evaluation of:
  a. Patient status (reassessment post care)
     b. Accuracy of prior assessment
     c. Goal achievement
     d. Accuracy of prognosis
     e. Appropriateness of therapeutic choices
     f. Effectiveness of care delivery
     g. Required alterations in the plan

The nursing process is very logical, “using a series of discrete components related to each other in unvaried sequence, prescribed and inflexible” (Stevens-Barnum, 1994, page. 152) for example; one would not implement care before making a therapeutic plan or make a nursing diagnosis before assessing.
Why as nurses, do we need to be bothered with the nursing process?

- Participation of the client in their care. The nursing process provides a mechanism for recording how clients are involved in the decision-making process – using the nursing process can encourage the client to participate in the following ways:
  a. In assessing their own needs
  b. In goal setting
  c. In agreeing care plans
  d. In evaluating progress

- Continuity of care – the nursing process offers a system for uniform practice. It is designed so that any nurse applying it correctly comes to the same conclusions as any other.

- Maintenance of professional standards. The nursing process provides a framework for documenting care, thus highlighting standards of care and professionalism. Stevens-Barnum (1994) suggests that the nursing process “resembles the medical model and can be used for professional parallelism” – in other words, it is a way to declare that the nursing profession is just as mature and professional as medicine.

- Assisting clients to maintain, regain or promote health.

- Demonstrates accountability and responsibility to client and family through effective planning, implementation, evaluation and documentation.

- It is the core method of nursing practice – it has been extensively adopted by the profession.

- It combines the inquiry and investigation of problem-solving methods – identifying needs and providing care to resolve the identified needs.

PHASES OF THE NURSING PROCESS

Assessment

The assessment strategy will depend on the framework or theory on which the assessment is based. For example, if the assessment is based on Roper et al’s (1990) theory of nursing, it will focus on the activities of living. If the assessment is based on Orem’s model of nursing, the assessment will focus on the client’s ability to be self-caring.

Whichever framework is used, the documentation of assessment must be:

- **Factual not inferred** – don’t let personal biases affect your assessment. For example, imagine that you had carried out an assessment of a client with profound, multiple learning disabilities and your assessment suggests that this person could not communicate verbally because of the nature of his/her disability. With this information, it might be easy to infer that the client is *unable* to communicate if the client’s form of
communication is not easily recognisable. The client may in fact have good communication skills that had not been evident at the time. You would need to provide factual evidence to correctly assess the client rather than make judgements without sufficient evidence to support these judgements.

- **Specific not general** – stating that a client has ‘behaviour problems’ is too general; you need to be more specific. For example, for a person whose challenging behaviour involves scratching other people, your assessment would need to state:

  “*when .......... [client] is in a room with another person, he will grab that person’s hands and scratch them until he is left alone again*”.

- **Accessible** – in order to utilise a multi-disciplinary approach or collaborative care, the nursing assessment must be accessible. Also, wading through reams of information before you can get to the assessment will not make the assessment accessible. A summary of the assessment is often useful.

**Sources of Assessment Data**

What sources of assessment data would you use to assess the client?

Answers could include:

- The client
- Family members
- Significant others

**Activity 1**

What other sources could be utilised?

1. ………………………………………………………………………………………………………………………………
   …..
2. ………………………………………………………………………………………………………………………………
   …..
3. ………………………………………………………………………………………………………………………………
   …..

**Methods of Data Collection**

What methods could be used to collect data to assess the client?

Answers could include:

- Informal conversations
• Observation
• Consultation

**Activity 2**

What other methods could be utilised?

1. ........................................................................................................................................
   ......
2. ........................................................................................................................................
   ......
3. ........................................................................................................................................
   ......

**Types of Data:**

**Objective:** Observable, detectable signs by use of the five senses
Records
Lab tests

**Subjective:** symptoms that the client can describe or validate

**Activity 3**

Examine the following data and determine which is objective and which is subjective data giving reasons for your answers:

- Cool skin:
  ........................................................................................................................................
  ........................................................................................................................................
  ........................................................................................................................................

- Rapid speech
  ........................................................................................................................................
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- Restless
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  ........................................................................................................................................
  ........................................................................................................................................

- Bites his arm when anxious
• Limited movement in right arm and leg

• States “my arm hurts”

• Echolalic speech

• Has challenging behaviour

**Activity 4**

Using an example from practice where you have worked with a service-user who presents with either challenging behaviour or PMLD consider the implications of basing your assessment on subjective data? (100 words approx)
Diagnosis Phase – Development of a Nursing Diagnosis

**Discussion Point:**

**What do we mean by a nursing diagnosis?**

* A process of data collection that leads to the identification of actual or potential health problems and the role of the nurse once these problems have been identified.

The emphasis here is that the nursing diagnosis refers to a problem that nurses can identify and treat. This is not a medical diagnosis.

How is a nursing diagnosis different to a medical diagnosis?

<table>
<thead>
<tr>
<th>Medical versus Nursing Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
</tr>
<tr>
<td>Describes specific disease process</td>
</tr>
<tr>
<td>Pathology oriented</td>
</tr>
<tr>
<td>Remains constant throughout illness</td>
</tr>
<tr>
<td>Guides medical management that is carried out by the nurse</td>
</tr>
</tbody>
</table>

**Advantages of a Nursing Diagnosis**

- Strengthens nursing process by providing direction for goals/outcomes and interventions
- Speeds communication among nurses
- Clarifies the nurses role and accountability
- Part of the unique body of knowledge of nursing
Components of a Nursing Diagnosis

There are 2 types of nursing diagnosis – “actual” and “high risk potential”. The “actual” diagnosis will consist of:

- Problem – a diagnostic statement of the actual problem
- Aetiology (probable cause, contributing/related factors)
- Signs and symptoms (manifestations of the problem, defining characteristics)

In other words, the diagnostic statement related to aetiology as evidenced by signs and symptoms

Using this format, the nursing diagnosis of impaired physical mobility would be:

"Impaired physical mobility related to decreased motor function of the left arm and leg as evidenced by compromised ability to move purposefully within the environment"

Consider one of the following case studies:

Case Study 1 (PMLD):

Miss Jane Roundtree is a 25 year old young lady with severe physical and learning disabilities who has no independent mobility. She was given a diagnosis of Cerebral Palsy and has spastic paralysis of all four limbs. As a consequence of this Jane also has problems with chewing and swallowing food. Jane is a very slender young lady, with the physique of a child and is prone to weight loss. Carers find feeding Jane a problem as she tends to clench her jaws together, making it impossible to put a spoon or other feeding implement into her mouth and therefore requires a soft, liquidised diet. This creates the additional problem of malnutrition and anaemia as the liquidised food is often softened with water, halving the nutritional content of the meal.

Jane is doubly incontinent and relies on others to meet all her hygiene needs. Her incontinence results in constant use of incontinence pads (which require changing frequently) and frequent washing to reduce perspiration and to maintain her personal hygiene.

Jane’s skin and pressure areas are frequently found to be red therefore frequent turning is required.

Example of a nursing diagnosis:

- Actual nursing diagnosis = Inability to chew food and difficulty in swallowing
- Aetiology = brain damage causing spastic paralysis
Signs and symptoms = inability to move limbs purposefully to feed self

Your nursing diagnosis would then read as follows:

Inability to chew food and difficulty in swallowing related to brain damage and spastic paralysis as evidenced by inability to move limbs purposefully to feed self

Case Study 2 (challenging behaviour):

Janet is a 19-year-old young lady with moderate to severe learning disabilities, some physical disabilities and challenging behaviour. Janet is able to walk for short distances, but is very unsteady and therefore uses a wheelchair when outside. Janet has no verbal communication, but has learnt that if she bangs her head on the floor, she can gain attention, or ‘get her own way’. For example, Janet attends a day service 3 mornings per week, but when it is time to return to her home, she refuses to sit in her wheelchair and bangs her head on the floor. Another example of where this behaviour is used is in getting out of tasks which she is unwilling to participate in.

Because of this behaviour, she has not learnt any self-help skills and requires help with all aspects of personal hygiene and dressing. She is able to feed herself, but refuses to feed herself with anything other than sweet desserts and often presents with challenging behaviour if she does not like the food presented to her. As a result of this behaviour, Janet is malnourished, underweight and anaemic. Staff are unable to ignore the behaviour presented because of the danger to Janet – if not stopped, Janet will continue to bang her head even if severe bleeding occurs and Janet has many scars as a result of these episodes.

Example of a nursing diagnosis:

Actual nursing diagnosis = Displays self-injurious behaviour to gain interactions from staff (attention) and/or to avoid demands

Aetiology = Learnt behaviour from reinforcement of incidents

Signs and symptoms = Bangs head on floor and sustains injury

Your nursing diagnosis would then read as follows:

Displays self-injurious behaviour to gain interactions from staff and/or avoid demands, related to learnt behaviour from reinforcement of incidents as evidenced by banging her head on the floor and sustaining injury

Select another problem of either Jane or Janet and identify the following:

- Problem – consider the actual diagnosis and the high-risk potential problems
- Aetiology (probable cause, contributing factors)
- Signs and symptoms (manifestations of the problem, defining characteristics
State the nursing diagnosis ………………………………………………………………………..
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Planning Phase

The planning phase includes:

- Setting priorities
- Establishing goals and outcome criteria
- Selecting nursing interventions
- Writing the plan of care

Setting priorities

Activity 6

When you prioritise your leisure time, what issues do you consider? Consider the following scenario:

Imagine you want to do the following 4 activities this Saturday between 08.30 and 12.30 hrs, but only have time to do 3.

1. Go to the gym at 10.00
2. Pick up your new glasses by 12.30 hrs
3. Watch your niece’s football game from 08.30 to 10.30
4. Take your elderly Aunt, who cannot drive, to the supermarket to do her weekly food shopping – this usually takes about 2 hours

What should you do?
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………

What strategies did you use to prioritise these activities?
…………………………………………………………………………………………………………
When deciding which of the nursing diagnoses are priorities, the following should be considered (not in any specific order):

1. Necessity for life

2. Maslow's hierarchy of needs:
   - Physiological needs
   - Safety needs
   - Love and belonging
   - Self esteem
   - Self actualisation

3. Client preferences as to what should be the priority

4. Overall treatment plan

5. Nursing resources

Without the appropriate information, it is difficult to set priorities that are appropriate to the client’s needs. It is also important to consider the legal and ethical issues surrounding each case.

**Activity 7**

Consider either Jane or Janet’s case study above and decide what is a priority and why. :

<table>
<thead>
<tr>
<th>Needs according to Priority</th>
<th>Reason for level of priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
</tbody>
</table>
Establishing goals and outcome criteria

When establishing goals, as far as possible, this should be done in conjunction with the client. Goals can be divided into long-term or short-term goals.

Long-term goals:
- are broader in scope
- are useful in long-term care settings
- may need to be broken down into shorter-term goals in order for achievement to occur

Short-term goals:
- focus on the immediate needs of the client
- can be used as a means to achieving longer term goals
- can help to track the client’s progress
- are used in acute care settings

Components of the Goal Statement:
1. Measurable verb – can you see it happen or hear the client report that it happened?
2. Qualifiers (explain under what conditions – how, what, or where the goal is achieved)
3. Time-frame for goal achievement – is it realistic

Activity 9

Examine the following goal statements and consider whether they are well-written or not – explain your decision:

The client will:

- Feel better each day
  ........................................................................................................................................
  ........................................................................................................................................
- Drink 800 ml of fluids between 0700 and 1900 hours
  ........................................................................................................................................
  ........................................................................................................................................
- Report decreased pain
  ........................................................................................................................................
  ........................................................................................................................................
- Demonstrate correct sequence of dressing each morning by the end of April 2006
  ........................................................................................................................................
  ........................................................................................................................................

Outcome Criteria

Goals should be stated as a reversal of the nursing diagnosis and written as:

*The client will........... [goal statement] as evidenced by ............... [outcome criteria]*

Goals should have an ‘outcome criterion’ – the criteria for a positive or negative outcome. In other words, how will we be able to know that the goal has or has not been achieved?

Outcome criteria must:

1. Have an action verb – e.g. ‘states’, ‘performs’, ‘identifies’
2. Be measurable

3. Have a time frame – a deadline for accomplishment

4. Have an indication of what to look for in order to know that the goal has/has not been achieved

5. Be linked to the signs and symptoms

**Characteristics of well-written outcome criteria:**

- Measurable
- Relevant
- Observable
- Attainable
- Mutually agreed
- Based on the nursing diagnosis
- Stated in the positive

For example – a nursing diagnosis of:

“Inability to feed self related to brain damage and spastic paralysis as evidenced by inability to move limbs purposefully to feed self”

… would have a goal/outcome criteria as follows:

“*By the end of April 2007, the client will feed self as evidenced by the ability to grip the spoon, load it with food and bring the spoon to her mouth*”

**Activity 10**

Consider the case studies of either Jane or Janet and write goal statements and outcome criteria for the needs that have the highest priority

By (date) …………………………………………………………………………………………………………………
the client will (goal statement)…………………………………………………………………………………….
as evidenced by (outcome criteria) …………………………………………………………………………………

By (date) …………………………………………………………………………………………………………………
the client will (goal statement)…………………………………………………………………………………….
as evidenced by (outcome criteria) …………………………………………………………………………………
Nursing Interventions

Nursing interventions are:

- Specific directions for nursing care
- Aimed to prevent, reduce or eliminate factors that prevent the client from attaining the goal
- Directly linked to the aetiology (probable cause)
- State who, what, when, where, how, how often, how long
- Based on rationale that reveals principles behind nursing care (in other words, it should be evidence-based)

Components of Nursing Interventions

Nursing interventions are written in the form of nursing plans (see Appendix 1) and should state the following:

- Date that the plan is written
  - Directive verb – e.g.: “explain”, “apply”, “measure”, “teach”, “review”
  - Content area: where, what, etc
  - Signature for accountability

Nursing interventions **may** include:

- Independent functions: as a result of the nurse’s judgement
- Dependent functions: under direction of medical officer
- Interdependent functions – a combination of both of the above

**Activity 11**

Consider the following nursing actions and decide whether they are independent, dependent or interdependent functions:
<table>
<thead>
<tr>
<th>Nursing Action</th>
<th>Type of Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administer Paracetamol for tooth ache</td>
<td></td>
</tr>
<tr>
<td>Elicit family member’s feelings re: resettlement</td>
<td></td>
</tr>
<tr>
<td>Complete a functional analysis of a challenging behaviour</td>
<td></td>
</tr>
<tr>
<td>Request that a specialist see the client</td>
<td></td>
</tr>
<tr>
<td>Reposition every 2 hours</td>
<td></td>
</tr>
<tr>
<td>Send a stool specimen to the lab</td>
<td></td>
</tr>
<tr>
<td>Explain ways to reduce dietary fat intake</td>
<td></td>
</tr>
<tr>
<td>Offer fluids every 2 hours</td>
<td></td>
</tr>
</tbody>
</table>

Example of nursing plan

The nursing diagnosis formulated for Jane in case study 1 was as follows:

*Inability to chew food and difficulty in swallowing related to brain damage and spastic paralysis as evidenced by inability to move limbs purposefully to feed self*

The nursing diagnosis formulated for Janet in case study 2 was as follows:

*Manipulates staff by using self-injurious behaviour to get her own way, related to learnt behaviour from reinforcement of incidents as evidenced by banging her head on the floor*

The nursing interventions to meet these needs are given in the next two pages:
# NURSING CARE PLAN

<table>
<thead>
<tr>
<th>CLIENT’S NAME</th>
<th>Jane</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>29th August 2006</td>
</tr>
<tr>
<td>LONG TERM GOAL</td>
<td>To feed self independently</td>
</tr>
</tbody>
</table>

## PROBLEM (Nursing Diagnosis)
Inability to feed self independently - related to brain damage and spastic paralysis as evidenced by difficulty in moving limbs purposefully to feed self

## SHORT TERM GOAL
By 30th September 2006, Jane will grip the spoon and load food from plate onto spoon

## NURSING ACTION
- At mealtimes, a designated carer must stand behind Jane and place the 'adapted' spoon in Jane’s hand. The carer must physically prompt her to load food from the plate using verbal prompts continuously. Bring the 'loaded' spoon to Jane’s mouth. As strength is increase and skill is developed, gradually reduce physical prompts where possible whilst maintaining gestural and verbal prompts.
- Review progress in 4 weeks

## EVALUATION
<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>SHORT TERM GOAL</th>
<th>NURSING ACTION (Including Rationale &amp; Evidence-base)</th>
<th>EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Displays self-injurious behaviour to avoid demands</td>
<td>By 30th September 2006, Janet will be able to perform the Makaton hand sign for 'no'</td>
<td>When Janet initiates head banging as an avoidance measure, staff will take Janet's hand and make the sign for 'no' then the activity that instigated the behaviour will be stopped. This will teach Janet that she can refuse an activity by signing 'no' rather than by banging her head.</td>
<td></td>
</tr>
<tr>
<td>Uses self-injurious behaviour to gain interactions with staff</td>
<td>By 30th November 2006, Janet will reduce her head-banging from 5 times per day to once per day</td>
<td>Staff will provide positive interactions for 5 minutes every half an hour when Janet is not displaying self-injurious behaviour</td>
<td></td>
</tr>
</tbody>
</table>
Activity 12

Refer back to the case study on either Jane or Janet. Using the form in Appendix 1, write a nursing intervention, which could be used to meet the need you gave the highest priority to, ensuring that you include all the components described above. You will need to research the area to provide evidence to support the intervention.

Evaluation

Discussion Point:

What do we mean by the term Evaluation? In its simplest form, Evaluation means:

“To determine the value of something” (Chambers English Dictionary)

What does evaluation mean when we apply it to nursing?

Alfaro-Lefevre (1994) suggests that when evaluating:

“You determine whether the patient has achieved the outcomes of the plan of care and decide whether to continue, modify or terminate the plan”
(Alfaro-Lefevre 1994)

Or looking at it another way, it is about:

“Reviewing the situation to see whether or not the problem still exists”
(Open University 1991)

or:

“Judging the effectiveness or otherwise of the nursing action towards goal achievement”
(Kemp and Richardson 1988)

Evaluation in nursing therefore is about reviewing the situation and judging the effectiveness of the care provided.

Outcomes of Evaluation

The question should be asked, what should be done following an evaluation? In nursing, evaluation has three outcomes. You can:

- **Continue the plan** if the client has not achieved outcomes, but you have not identified any factors that impeded or enhanced care.

- **Modify the plan** when outcomes have not been achieved and you have identified factors that enhanced or impeded care.

- **Terminate the plan** if the client has achieved the goals and demonstrates ability to care for him/herself.
Types of Evaluation

What types of evaluation are you likely to come across in nursing?

**Concurrent Outcome Evaluation** – used to determine whether clients have achieved expected outcomes for specific nursing problems.

‘Concurrent’ means simultaneous or as we go along, ‘outcome’ meaning what was expected.

**We evaluate the expected outcome of a situation – are we achieving what we want to achieve?**

- **Concurrent Process Evaluation** – used to determine whether care has reached an acceptable standard

  ‘Process’ means how did we get there, what was the approach used? You should evaluate the approach used – were the standards of care acceptable?

- **Retrospective Process Evaluation** – used to determine the extent to which care and records meet established standards

  ‘Retrospective' means looking back, or reflecting upon

  Did we do it properly? What could we have done better?

- **Retrospective Outcome Evaluation** – ascertaining from clients following discharge whether their goals were achieved

  This is done to overcome the problem of clients feeling that they will be labelled as “difficult" if they complain about the care they receive.

  This is a more client-centred approach and should involve an evaluation of the whole service including follow-up appointments

  For example:

  On resettling a client with learning disabilities into the community, we would look at the whole picture from the instigation of resettlement and preparing for change through to community support required to maintain independence
**Subjective and Objective Evaluation**

For evaluation to be effective, it must be objective and valid. Unfortunately, subjective evaluations are often seen in practice.

Subjective evaluations are the evaluations which are made, but which are subject to one’s own interpretation. Objective evaluations on the other hand are evaluations based on what is actually seen.

<table>
<thead>
<tr>
<th>Subjective Evaluation</th>
<th>Objective Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slept all night</td>
<td>Eyes closed, respirations regular</td>
</tr>
<tr>
<td>Quiet and co-operative</td>
<td>Did not display aggressive behaviour today</td>
</tr>
<tr>
<td>Appears restless</td>
<td>Pacing the floor 3 hours</td>
</tr>
<tr>
<td>Had a good day</td>
<td>No complaints of pain or discomfort</td>
</tr>
<tr>
<td>Diet – fair</td>
<td>Half of lunch consumed</td>
</tr>
<tr>
<td>Usual day, no seizures</td>
<td>Did not have any further epileptic seizures during the day.</td>
</tr>
</tbody>
</table>

When evaluating, make sure that you write what you see and not what you think happened.

**Formative and Summative Evaluation**

Evaluation may be formative or summative.

Formative evaluation is described as:

An on-going process where each intervention is judged as it is carried out, or just afterwards. For example, the goal for a child with learning disabilities who has difficulty self-feeding might be:

*Will be able to bring a spoon to her mouth independently by 30 April 2006*

Formative evaluation recorded might include such statements as:

01/02/06 Can scoop food onto her spoon, but needs maximum help to guide it to her mouth

Formative evaluation therefore evaluates the various stages that are accomplished in the task. These may be regarded as short-term goals, which need to be achieved in order to achieve the longer-term goal as in the example given.

Summative Evaluation on the other hand involves collecting information on the date indicated in the goal to ascertain whether or not the outcome has been achieved. In other words, it states whether the goal has been achieved or not. For example, on 30th April, can the child bring the spoon to her mouth independently? (Yes or No?)
Variables Affecting Goal Achievement

On evaluation there are many issues which would affect the achievement of goals. These include:

1. Were the goals and care realistic and appropriate for this individual?
   
   *Is it possible for this person to achieve this? Is achievement of this within his/her mental/physical capacity? For example it is unrealistic to expect a person who has had a cerebro-vascular accident to wash himself without help within say, one week*

2. Was the care implemented consistently as prescribed?
   
   *Was the care only carried out by a few staff. For example, in the case of the child with feeding difficulties, did some staff feed the child because it was quicker than encouraging the child to do this for herself?*

3. Was the care plan changed if adverse responses were detected?
   
   *For example, if a person with learning disabilities presented with self-injurious behaviour as a result of being taught a skill, was a different approach made?*

4. Was the client’s opinion about the goal and plan of care sought?
   
   *Did the client want to achieve the goal? For example, if you are caring for a person with an eating disorder, and the goal is to gain weight, does the patient want to achieve the goal?*

5. What were the factors that *impeded* progress?
   
   *Were there adequate resources to meet the goal?*

6. What were the factors that *enhanced* progress?

Achieving Goals

As we have seen, when we carry out an evaluation, one of the areas that we are evaluating is whether or not the goals have been achieved. To do this we need to decide whether the goals have been achieved

   *Have the Goals been achieved?*

   **Questions to consider:**

   1. *Can the client do everything described in the goal?*
   2. *Is further progress required or possible?*
Have the Goals been partly achieved?

*Questions to consider:*

1. *Is the client able to do only some of the activities described in the goal?*
2. *Is he/she able to do the activities but not with the level of proficiency described in the goal?*
3. *Does the client seem to be struggling to achieve the goals?*
4. *Was the time for evaluation unrealistic?*

Have the Goals not been met at all?

*Questions to ask:*

1. *Is the client completely unable to meet the criteria described in the goal?*
2. *Has the problem changed or ceased to exist?*
3. *Has the client's condition changed so that he/she does not need to reach the goal?*

**The Evaluation Procedure**

1. Check goal statement on review or target date
2. Collect information – consult the service-user and if necessary significant others
3. Compare the actual patient outcome with the expected outcome
4. Make an objective judgement about the service-user’s response based on what you actually observe:
   - Have the goals been achieved
   - Have the goals been partially achieved
   - Have the goals not been achieved
5. Feedback to and modification of the care plan – either continue, modify or terminate.

**Structure, Process and Outcome**

When evaluating, one needs to evaluate three specific areas:

1. The structure
2. The process
3. The outcome
What do we mean by these three areas?

1. **Structure** – is concerned with the evaluation of the conditions under which care and service are provided. *Ask – were the resources adequate?*

   For example, were there enough staff to carry out the care plan appropriately, was the equipment appropriate – e.g. hoists

2. **Process** – is when the evaluator looks at what the health carer does to and for the patient and how. *Ask – how did the nurse carry out the care?*

   For example, was the care carried out according to standards, codes of practice, policies etc? Did the nurse use evidence-based practice in an attempt to achieve the goal?

3. **Outcome** – is the result of the care on the patient. *Ask – what effect did it have on the patient?*

   Was the patient’s goal achieved? Did it make things worse?

**Tools and Skills used in Evaluation**

Consider some of the tools and skills used to evaluate success.

These can be broken into four categories:

1. Records
2. Measurements
3. Observation
4. Communications
Activity 13

From each category, discuss the usefulness of tools/skills have you seen used in the clinical area to evaluate success:

1. Records

2. Measurements

3. Observation

4. Communications

Conclusion

Having completed the activities above, you should now be in a position to start writing care plans. You should be able to state a nursing diagnosis for a service-user who has either profound/multiple learning disabilities or challenging behaviour and write clear, measurable goals for this need.

The information that you have gained from these activities will support you during modules GM5130 (PMLD) and GM5131 (Challenging Behaviour) and in writing your assignments for these modules. This information will be developed during the modules where you will be provided with knowledge of specific nursing interventions and an evidence base which will support you in writing your nursing interventions.
References


CARPENITO, C (2002) *Nursing Diagnosis- Application to Clinical Practice* Lippincott, Philadelphia

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>SHORT TERM GOAL</th>
<th>NURSING ACTION (Including Rationale &amp; Evidence-base)</th>
<th>EVALUATION</th>
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