NIC
Nursing Intervention Classification
Definition and Activities

INTRODUCTION

Quality school nursing documentation depends upon the individual school nurse accurately recording his/her nursing assessments, plans, interventions and client outcomes. Use of the nursing process assures that all aspects of care are considered, addressed and written in a uniform manner. The challenge is to document in an efficient way that is easily comprehended by the nursing community. While medical terminology is universally understood, it is insufficient to describe *nursing* aspects of client care. The need for school nurses to communicate in a common language has never been more vital than today as we begin to focus on student outcomes, build a body of research, and break down the walls of isolation between school nurse colleagues. To this end, standardized language amongst school nurses is essential.

In January 2004, Delaware School Nurse district representatives were invited to join the School Nurse Advisory Group (SNAG). Eighteen School Nurses provided input into a pilot computer documentation system and the development of standardized documentation. SNAG determined that identifying *reasons* for student visits to the nurse, *interventions* by the school nurse and *outcomes* from those interventions should be core components. Because the Nursing Intervention Classification System (NIC) had the most comprehensive list of nursing actions, it was selected for use in Delaware. The Department of Education (DOE) then obtained permission to use the copyrighted terminology of NIC and NOC (Nursing Outcome Classification) in the statewide computerized program.

NIC is a unique vocabulary that describes actions performed by a nurse. Interventions can be independent or collaborative, direct or indirect, and individual or group oriented. NIC was initially created for hospital use. Use in school settings, to date, has been rare. Thus, the challenge was to narrow the over 450 NIC terms to a reasonable list and then to customize definitions and activities to reflect potential Delaware use.

This document contains the Delaware selected NIC terms, along with their definitions, activities and related readings. Where these have been altered, is noted within the text.

***Terms*:** All NIC have been linked to Medicaid reimbursement, if appropriate. Some administrations activities, such as *seizure precautions,* are not billable, but are included because of their importance in providing comprehensive nursing services. Few terms are changed from the original NIC.

***Definitions*:** Due to Medicaid billing requirements, some changes were made to distinguish between a group or individual intervention or to establish a link to an injury or illness. In some cases new definitions and terms were created to articulate the type of care typical in Delaware schools (e.g. specific *health screenings).*

***Activities*:** These lists are neither exhaustive nor exclusive. It is likely other school nurse activities could be added and others could be removed, based upon a particular student population.
The lists herein have removed activities that are:

- clearly hospital in nature (e.g. *providing blood transfusions, monitoring electrolytes*); and/or
- inappropriate for the school setting (e.g. *limit visitors*).

Some activities, which remain in the list:

- may require special skills (e.g. *applying a cervical collar*);
- are unlikely to be used in the school setting, except in special instances (e.g. *obtaining a stool for culture*; *monitoring skin in the perianal area*);
- may require written orders from a healthcare provider (e.g. *insert rectal suppository*);
- should only be used AFTER an evaluation by a healthcare provider (e.g. *initiate suicide precautions* should not be the first intervention for a client who threatens suicide. The first response should be an immediate call to 911; later the school nurse may *initiate suicide precautions* as directed by the discharging entity.)

Finally, some additions were needed (e.g. *inform individual/family of available healthcare insurance*).
The reader is cautioned that this list should not replace doctor's orders or established protocols for an individual client; rather, this list compiles possible nursing activities for consideration.

The introduction of NIC into Delaware documentation is an important step towards assuring quality and standardized documentation. This document is a beginning.

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Nursing Intervention Classification Codes

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Nutrition Management	NUTMGT
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Substance Use Prevention (group)	SUBABG
Weight Management	WGTMGT

Health Promotion/Protection:	
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Health System Guidance	HGUIDE
Immunization Management	IZMGT
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Suicide Prevention	PRESUI
Surveillance: Safety	SAFE
Sustenance Support	SUST

Abuse Protection Support: Child (ABUSE)

***Definition*[1]: Identification of high-risk, dependent child relationships and actions to prevent possible or further infliction of physical, sexual or emotional harm or neglect of basic necessities of life.**

Activities:

Report suspected abuse or neglect to proper authorities
Identify mothers who have a history of late (4 months or later) or no prenatal care
Identify parents who have had another child removed from the home or have placed previous children with relatives for extended periods
Identify parents who have a history of substance abuse, depression, or major psychiatric illness
Identify parents who demonstrate an increased need for parent education (e.g., parents with learning problems, parents who verbalize feelings of inadequacy, parents of a first child, teen parents)
Identify parents with a history of domestic violence or a mother who has a history of numerous "accidental" injuries
Identify parents with a history of unhappy childhoods associated with abuse, rejection, excessive criticism, or feelings of being worthless and unloved
Identify crisis situations that may trigger abuse (e.g., poverty, unemployment, divorce, homelessness, and domestic violence)
Determine whether the family has an intact social support network to assist with family problems, respite child care, and crisis child care
Identify infants/children with high-care needs (e.g., prematurity, low birth weight, colic, feeding intolerances, major health problems in the first year of life, developmental disabilities, hyperactivity, and attention deficit disorders)
Identify caretaker explanations of child's injuries that are improbable or inconsistent, allege self-injury, blame other children, or demonstrate a delay in seeking treatment
Determine whether a child demonstrates signs of physical abuse, including numerous injuries in various stages of healing; unexplained bruises & welts; unexplained pattern, immersion, & friction burns; facial, spiral, shaft, or multiple fractures; unexplained facial lacerations & abrasions; human bite marks; intracranial, subdural, intraventricular, & intraoccular hemorrhaging; whiplash shaken infant syndrome; & diseases that are resistant to treatment and/or have changing signs & symptoms
Determine whether the child demonstrates signs of neglect, including poor or inconsistent growth patterns, failure to thrive, wasting of subcutaneous tissue, consistent hunger, poor hygiene, constant fatigue and listlessness, bald patches on scalp or other skin afflictions, apathy, unyielding body posture, and inappropriate dress for weather conditions
Determine whether the child demonstrates signs of sexual abuse, including difficulty walking or sitting; torn, stained, or bloody underclothing; reddened or traumatized genitals; vaginal or anal lacerations; recurrent urinary tract infections; poor sphincter tone; acquired sexually transmitted diseases; pregnancy; promiscuous behavior or prostitution; a history of running away, sudden massive weight loss or weight gain, aggression against self, or dramatic behavioral or health changes of undetermined etiology
Determine whether the child demonstrates signs of emotional abuse, including lags in physical development, habit disorders, conduct learning disorders, neurotic traits/psychoneurotic reactions, behavioral extremes, cognitive developmental lags, and attempted suicide
Monitor child for extreme compliance, such as passive submission to invasive procedures
Monitor child for role reversal, such as comforting the parent, or overactive or aggressive behavior
Listen to pregnant woman's feelings about pregnancy and expectations about the unborn child
Monitor new parents' reactions to their infant, observing for feelings of disgust, fear, or disappointment in gender
Monitor for a parent who holds newborn at arm's length, handles newborn awkwardly, asks for excessive assistance, & verbalizes or demonstrates discomfort in caring for the child
Monitor for repeated visits to clinics, emergency rooms, or physicians' offices for minor problems
Determine parent's knowledge of infant/child basic care needs and provide appropriate child care information as indicated
Instruct parents on problem solving, decision making, and childrearing & parenting skills, or refer parents to programs where these skills can be learned
Help families identify coping strategies for stressful situations
Provide parents with information on how to cope with protracted infant crying, emphasizing that they should not shake the baby
Provide the parents with noncorporal punishment methods for disciplining children
Provide pregnant women and their families with information on the effects of smoking, poor nutrition, & substance abuse on the baby's and their health
Engage parents and child in attachment-building exercises
Provide parents and their adolescents with information on decision making & communication skills & refer to youth services counseling, as appropriate
Provide older children with concrete information on how to provide for the basic care needs of their younger siblings
Provide children with positive affirmations of their worth, nurturing care, therapeutic communication, and developmental stimulation
Refer families to human services and counseling professionals, as needed
Provide parents with community resource information that includes addresses and phone numbers of agencies that provide respite care, emergency child care, housing assistance, substance abuse treatment, sliding-fee counseling services, food pantries, clothing distribution centers, health care, human services, hot lines, and domestic abuse shelters
Refer a parent who is being battered and at-risk children to a domestic violence shelter
Refer parents to Parents Anonymous for group support, as appropriate

Background Readings:

Campbell, J., & Humphreys, J. (1993). Nursing care of survivors of family violence (2nd ed.). St. Louis: Mosby.
Campbell, J., & Humphreys, J. (1984). Nursing care of victims of family violence. Reston, VA: Reston Publishing.
Cicchetti, D., & Carlson, V. (Eds.). (1990). Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect. New York: Cambridge University Press.
Cowen, P.S. (1994). Child abuse–What's nursing's role? In J.C. McCloskey & H.K. Grace (Eds.), Current issues in nursing (4th ed.) (pp. 731-741). St. Louis: Mosby.
Cowen, P.S., & Van Hoozer, H. (1993). Family violence computer assisted instruction programs. Chapel Hill: Health Sciences Consortium.
Dove, A., & Kobryn, M. (1991). Computer detection of child abuse. Nursing Standard, 6(10), 38-39.
Dykes, L.J. (1986). The whiplash shaken infant syndrome: What has been learned? Child Abuse & Neglect, 10, 211-221.
Rosenberg, D.A. (1987). Web of deceit: A literature review of Munchausen syndrome by proxy. Child Abuse & Neglect, 11(4), 547-563.

[1] Delaware definition; NIC definition reads identification of high-risk dependent relationships and actions to prevent further infliction of physical or emotional harm.

Admission Care (ADMINCARE)

Definition*[1]*: **Facilitating entry of a student into the school setting and identifying/addressing his/her healthcare needs.**

Activities:
Introduce yourself and your role in providing care
Orient patient/family/guardian to expectations of care
Provide appropriate privacy for the patient/family/guardian
Orient patient/family/guardian to immediate environment
Orient patient/family/guardian to agency facilities
Obtain admission history including information on past medical illnesses, medications, and allergies
Inform parent/family/guardian of school entry requirements; i.e., physical, immunizations, etc.
Perform admission risk assessment, as appropriate (e.g., TB screening, skin assessment)
Obtain healthcare provider information
Establish individualized healthcare plan, as appropriate
Document pertinent information
Maintain confidentiality of patient data
Implement safety precautions, as appropriate
Obtain physician's orders for patient care, as appropriate
Determine healthcare needs for school setting

Background Reading:
Perry, A., & Potter, P.A. (2002). Clinical nursing skill and techniques (5th ed.). St. Louis: Mosby.

[1] Delaware definition; NIC definition reads facilitating entry of a patient into a health care facility

Airway Management (AIRMGT)

Definition: **Facilitation of patency of air passages.**

Activities:

Open the airway, using the chin lift or jaw thrust technique, as appropriate
Position patient to maximize ventilation potential
Identify patient requiring actual/potential airway insertion
Insert oral or nasopharyngeal airway, as appropriate
Perform chest physical therapy, as appropriate
Remove secretions by encouraging coughing or by suctioning
Encourage slow, deep breathing; turning; and coughing
Use fun techniques to encourage deep breathing for children (e.g., blow bubbles with bubble blower; blow on pinwheel, whistle, harmonica, balloons, party blowers; have blowing contest using ping-pong balls, feathers)
Instruct how to cough effectively
Assist with incentive spirometer, as appropriate
Auscultate breath sounds, noting areas of decreased or absent ventilation and presence of adventitious sounds
Perform endotracheal or nasotracheal suctioning, as appropriate
Administer bronchodilators, as appropriate
Teach patient how to use prescribed inhalers, as appropriate
Administer aerosol treatments, as appropriate
Administer ultrasonic nebulizer treatments, as appropriate
Administer humidified air or oxygen, as appropriate
Regulate fluid intake to optimize fluid balance
Position to alleviate dyspnea
Monitor respiratory and oxygenation status, as appropriate

Background Readings:

American Association of Critical Care Nurses. (1998). Core curriculum for critical care nursing (5th ed.). Philadelphia: W.B. Saunders
Perry, A.G., & Potter, P.A. (2002). Clinical nursing skills and techniques (5th ed.). St. Louis: Mosby.
Racht, E.M. (2002). 10 pitfalls in airway management: how to avoid common airway management complications. JEMS: Journal of Emergency Medical Services, 27(3), 28-30, 32-4, 36-8.

Airway Suctioning (AIRSUC)

Definition: **Removal of airway secretions by inserting a suction catheter into the patient's oral airway and/or trachea.**

Activities:

Determine the need for oral and/or tracheal suctioning
Auscultate breath sounds before and after suctioning
Inform the patient and family about suctioning
Aspirate the nasopharynx with a bulb syringe or suction device, as appropriate
Provide sedation, as appropriate
Use universal precautions: gloves, goggles, and mask, as appropriate
Insert a nasal airway to facilitate nasotracheal suctioning, as appropriate
Instruct the patient to take several deep breaths before nasotracheal suctioning and use supplemental oxygen, as appropriate
Hyperoxygenate with 100% oxygen, using the ventilator or manual resuscitation bag
Hyperinflate at 1 to 1.5 times the preset tidal volume using the mechanical ventilator, as appropriate
Use sterile disposable equipment for each tracheal suction procedure
Select a suction catheter that is one half the internal diameter of the endotracheal tube, tracheostomy tube, or patient's airway
Instruct the patient to take slow, deep breaths during insertion of the suction catheter via the nasotracheal route
Leave the patient connected to the ventilator during suctioning, if a closed tracheal suction system or an oxygen insufflation device adaptor is being used
Use the lowest amount of wall suction necessary to remove secretions (e.g., 80 to 100 mm Hg for adults)
Monitor patient's oxygen status (SaO_2 and SvO_2 levels) and hemodynamic status (MAP level and cardiac rhythms) immediately before, during, and after suctioning
Base the duration of each tracheal suction pass on the necessity to remove secretions and the patient's response to suctioning
Hyperinflate and hyperoxygenate between each tracheal suction pass and after the final suction pass
Suction the oropharynx after completion of tracheal suctioning
Clean area around tracheal stoma after completion of tracheal suctioning, as appropriate
Stop tracheal suctioning and provide supplemental oxygen if patient experiences bradycardia, an increase in ventricular ectopy, and/or desaturation
Vary suctioning techniques, based on the clinical response of the patient
Note type and amount of secretions obtained
Send secretions for culture and sensitivity tests, as appropriate
Instruct the patient and/or family how to suction the airway, as appropriate

Background Readings:

Barnes, C., & Kirchhoff, K.T. (1986). Minimizing hypoxemia due to endotracheal suctioning: A review of the literature. Heart & Lung, 15, 164-176.

Craven, R. F., & Hirnle, C. J. (2000) Fundamentals of nursing: Human health and function (3rd ed.) (pp. 825-827). Philadelphia: Lippincott.

Nelson, D.M. (1992). Interventions related to respiratory care. In G.M. Bulechek & J.C. McCloskey (Eds.),
Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 301-324.

Stone, K., & Turner, B. (1988). Endotracheal suctioning. Annual Review of Nursing Research, 7, 27-49.

Stone, K.S., Preusser, B.A., Groch, K.F., Karl, J.I., & Gronyon, D.S. (1991). The effect of lung hyperinflation and endotracheal suctioning on cardiopulmonary hemodynamics. Nursing Research, 40(2), 76-79.

Titler, M.G., & Jones, G. (1992). Airway management. In G.M. Bulechek & J.C. McCloskey (Eds.), Nursing interventions: Essential nursing treatments (2nd ed.) (pp. 512-530). Philadelphia: W.B. Saunders.

Allergy Management (ALLERGY)

Definition: **Identification, treatment, and prevention of allergic responses to food, medications, insect bites, contrast material, blood, and other substances.**

Activities:

Identify known allergies (e.g., medication, food, insect, environmental) and usual reaction
Notify caregivers and health care providers of known allergies
Document all allergies in clinical record, according to protocol
Monitor patient for allergic reactions to new medications, formulas, foods, latex, and/or test dyes
Monitor the patient following exposures to agents known to cause allergic responses for signs of generalized flush, angioedema, urticaria, paroxysmal coughing, severe anxiety, dyspnea, wheezing, orthopnea, vomiting, cyanosis, or shock
Keep patient under observation for 30 minutes following administration of an agent known to be capable of inducing an allergic response
Instruct the patient with medication allergies to question all new prescriptions regarding potential for allergic reactions
Encourage patient to wear a medical alert tab, as appropriate
Identify immediately the level of threat an allergic reaction presents to patient's health status
Monitor for reoccurrence of anaphylaxis within 24 hours
Provide life-saving measures during anaphylactic shock or severe reactions
Provide medication to reduce or minimize an allergic response
Watch for allergic responses during immunizations
Instruct patient/parent to avoid substances that cause allergic reactions, as appropriate
Instruct patient/parent in how to treat rashes, vomiting, diarrhea, or respiratory problems associated with exposure to allergy-producing substance
Instruct patient to avoid further use of substances causing allergic responses
Discuss methods to control environmental allergens (e.g., dust, mold, and pollen)
Instruct patient and caregiver(s) on how to avoid situations that put the patient at risk and how to respond if an anaphylactic reaction should occur
Instruct patient and caregiver on use of epinephrine pen

Background Readings:

Hendry, C., & Farley, A.H. (2001). Understanding allergies and their treatment. Nursing Standard, 15(35), 47-53.
Hoole, A., Pickard, C., Ouimette, R., Lohr, J., & Greenberg, R. (1995). Patient care guidelines for nurse practitioners (4th ed.). Philadelphia: J.B. Lippincott.
Lemone, P., & Burke, K. (1996). Medical surgical nursing: Critical thinking in client care. Menlo Park, CA: Addison-Wesley.
Trzcinski, K.M. (1993). Update on common allergic diseases. Pediatric Nursing, 19(4), 410-415.

Anticipatory Guidance (AGUIDE and AGUIDEG)

***Definition*[1]*:* Preparation of patient or group of patients for an anticipated developmental and/or situational crisis.**

Anticipatory Guidance (individual) AGUIDE
Anticipatory Guidance (group) AGUIDEG

Activities:

Assist the patient to identify possible upcoming, developmental, and/or situational crisis and the effects the crisis may have on personal and family life
Instruct about normal development and behavior, as appropriate
Provide information on realistic expectations related to the patient's behavior
Determine the patient's usual methods of problem solving
Assist the patient to decide how the problem will be solved
Assist the patient to decide who will solve the problem
Use case examples to enhance the patient's problem-solving skills, as appropriate
Assist the patient to identify available resources and options for course of action, as appropriate
Rehearse techniques needed to cope with upcoming developmental milestone or situational crisis with the patient, as appropriate
Assist the patient to adapt to anticipated role changes
Provide a ready reference for the patient (e.g., educational materials/pamphlets), as appropriate
Suggest books/literature for the patient to read, as appropriate
Refer the patient to community agencies, as appropriate
Schedule visits at strategic developmental/situational points
Schedule extra visits for patient with concerns or difficulties
Schedule follow-up phone calls to evaluate success or reinforcement needs
Provide the patient with a phone number to call for assistance, if necessary
Include the family/significant others, as appropriate

Background Readings:

Craven, R. F., & Hirnle, C.J. (2000). Fundamentals of nursing: Human health and function (3rd ed.) (pp. 1269-1270). Philadelphia: Lippincott.

Denehy, J.A. (1990). Anticipatory guidance. In M.J. Craft & J.A. Denehy (Eds.), Nursing interventions for infants and children (pp. 53-68). Philadelphia: W.B. Saunders.

Rakel, B.A. (1992). Interventions related to patient teaching. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 397-424.

Schulman, J.L., & Hanley, K.K. (1987). Anticipatory guidance: An idea whose time has come. Baltimore: Williams & Wilkins.

Smith, C.E. (1987). Using the teaching process to determine what to teach and how to evaluate learning. In C.E. Smith (Ed.), Patient education: Nurses in partnership with other health professionals (pp. 61-95). Philadelphia: W.B. Saunders.

[1] Delaware definition differentiates between individual or group intervention.

Artificial Airway Management (ARTAIR)

Definition: **Maintenance of endotrachial and tracheostomy tubes and prevention of complications associated with their use.**

Activities:

Provide an oropharyngeal airway or bite block to prevent biting on the endotracheal tube, as appropriate
Provide 100% humidification of inspired gas/air
Provide adequate systemic hydration via oral or intravenous fluid administration
Inflate endotracheal/tracheostoma cuff using minimal occlusive volume technique or minimal leak technique
Maintain inflation of the endotracheal/tracheostoma cuff at 15 to 20mm Hg during mechanical ventilation and during and after feeding
Suction the oropharynx and secretions from the top of the tube cuff before deflating cuff
Monitor cuff pressures every 4 to 8 hours during expiration using a three-way stopcock, calibrated syringe, and mercury manometer
Check cuff pressure immediately after delivery of any general anesthesia
Change endotracheal tapes/ties every 24 hours, inspect the skin and oral mucosa, and move ET tube to the other side of the mouth
Loosen commercial endotracheal tube holders at least once a day, and provide skin care
Auscultate for presence of lung sounds bilaterally after insertion and after changing endotracheal/tracheostomy ties
Note the centimeter reference marking on endotracheal tube to monitor for possible displacement
Assist with chest x-ray examination, as needed, to monitor position of tube
Minimize leverage and traction on the artificial airway by suspending ventilator tubing from overhead supports, using flexible catheter mounts and swivels, and supporting tubes during turning, suctioning, and ventilator disconnection and reconnection
Monitor for presence of crackles and rhonchi over large airways
Monitor for decrease in exhaled volume and increase in inspiratory pressure in patients receiving mechanical ventilation
Institute endotracheal suctioning, as appropriate
Institute measures to prevent spontaneous decannulation: secure artificial airway with tape/ties; administer sedation and muscle-paralyzing agent, as appropriate; and use arm restraints, as appropriate
Provide additional intubation equipment and ambu bag in a readily available location
Provide trachea care every 4 to 8 hours as appropriate: clean the inner cannula, clean and dry the area around the stoma, and change tracheostomy ties
Inspect skin around tracheal stoma for drainage, redness, and irritation
Maintain sterile technique when suctioning and providing tracheostomy care
Shield the tracheostomy from water
Provide mouth care and suction oropharynx, as appropriate
Tape the tracheostomyobturator to head of bed
Tape a second tracheostomy tube (same type and size) and forceps to head of bed
Institute chest physiotherapy, as appropriate
Ensure that endotracheal/tracheostomy cuff is inflated during feedings, as appropriate
Elevate head of the bed or assist patient to a sitting position in a chair during feedings, as appropriate
Add food coloring to enteral feedings, as appropriate

Background Readings:

Boggs, R.L., & Woolridge-Kim, M. (1993). AACN procedural manual for critical care (3rd ed). Philadelphia: W.B. Saunders.

Craven, R.F., & Hirnle, C. J. (2000) Fundamentals of Nursing: Human Health and Function (3rd ed.) (pp. 819-824). Philadelphia: Lippincott

Goodnough, S.K.C. (1988). Reducing tracheal injury and aspiration. Dimensions of Critical Care Nursing, 7, 324-331.

McHugh, J.M. (1985). Airway management. In S. Millar, L.K., Sampson, & M. Soukup (Eds.), AACN Procedural Manual for Critical Care (pp. 203-239). Philadelphia: W.B. Saunders.

Nelson, D.M. (1992). Interventions related to respiratory care. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 301-324.

Titler, M.G., & Jones, G. (1992). Airway management. In G.M. Bulechek & J.C. McCloskey (Eds.), Nursing Interventions: Essential Nursing Treatments (2nd ed.) (pp. 512-530). Philadelphia: W.B. Saunders.

Aspiration Precautions (ASPIR)

Definition: **Prevention or minimization of risk factors in the patient at risk for aspiration.**

Activities:

Monitor level of consciousness, cough reflex, gag reflex, and swallowing ability
Monitor pulmonary status
Maintain an airway
Position upright 90 degrees or as far as possible
Keep tracheal cuff inflated
Keep suction setup available
Feed in small amounts
Check NG or gastrostomy tube placement before feeding
Check NG or gastrostomy tube residual before feeding
Avoid feeding, if residuals are high
Place "dye" in NG feeding tube
Avoid liquids or use thickening agent
Offer foods or liquids that can be formed into a bolus before swallowing
Cut food into small pieces
Request medication in elixir form
Break or crush pills before administration
Keep head of bed elevated 30 to 45 minutes after feeding
Suggest speech pathology consult, as appropriate
Suggest barium cookie swallow or video fluoroscopy, as appropriate

Background Readings:

Ackerman, L.L. (1992). Interventions related to neurological care. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 325-346.

American Nurses' Association Council in Medical-Surgical Nursing Practice & American Association of Neuroscience Nurses. (1985). Neuroscience nursing practice: Process and outcome for selected diagnoses. Kansas City, MO: American Nurses Association.

Maas, M.L., Buckwalter, K.C., Hardy, M.D., Reimer, T.T., Titler, M.G., & Specht, J.P. (2001) Nursing Care of Older Adults: Diagnoses, Outcomes, and Interventions (pp. 167-168). St. Louis: Mosby.

Sands, J.A. (1991). Incidence of pulmonary aspiration in intubated patients receiving enteral nutrition through wide- and narrow-bore nasogastric feeding tubes. Heart & Lung, 20(1), 75-80.

Schwartz-Cowley, R., & Gruen, A.K. (1988). Swallowing dysfunction in patients with altered mobility. In P.H. Mitchell, L.C. Hodges, M. Muwaswes, et al. (Eds.), AANN's Neuroscience Nursing (pp. 345-357). Norwalk, CT: Appleton & Lange.

Taylor, T. (1982). A comparison of two methods of nasogastric tube feedings. Journal of Neurosurgical Nursing, 14(1), 49-55.

Asthma Management (ASTHMA)

Definition: **Identification, treatment and prevention of reactions to inflammation/constriction in the airway passages.**

Activities:

Determine baseline respiratory status to use as a comparison point
Document baseline measurements in clinical record
Compare current status with previous status to detect changes in respiratory status
Monitor peak expiratory flow rate (PERF), as appropriate
Educate patient about the use of the PERF meter at home
Monitor for asthmatic reactions
Determine client/family understanding of disease and management
Instruct client/family on anti-inflammatory and bronchodilator medications and their appropriate use
Teach proper techniques for using medication and equipment (e.g., inhaler, nebulizer, peak flow meter)
Determine compliance with prescribed treatments
Encourage verbalization of feelings about diagnosis, treatment, and impact on lifestyle
Identify known triggers and usual reaction
Teach client to identify and avoid triggers as possible
Establish a written plan with the client for managing exacerbations
Assist in the recognition of signs/symptoms of impending asthmatic reaction and implementation of appropriate response measures
Monitor rate, rhythm, depth, and effort of respiration
Note onset, characteristics, and duration of cough
Observe chest movement, including symmetry, use of accessory muscles, and supraclavicular and intercostal muscle retractions
Auscultate breath sounds, noting areas of decreased/absent ventilation and adventitious sounds
Administer medication as appropriate and/or per policy and procedural guidelines
Auscultate lung sounds after treatment to determine results
Offer warm fluids to drink, as appropriate
Coach in breathing/relaxation techniques
Use a calm, reassuring approach during asthma attack
Inform client/family about the policy & procedures for carrying & administration of asthma medications at school
Inform parent/guardian when child has needed/used PRN medication in school, as appropriate
Refer for medical assessment, as appropriate
Establish a regular schedule of follow-up care
Instruct and monitor pertinent school staff in emergency procedures
Prescribe and/or renew asthma medications, as appropriate

Background Readings:

American Academy of Allergy, Asthma and Immunology. (1999). Pediatric Asthma: Promoting Best Practice. Guide for Managing Asthma in Children. Milwaukee, WI: Author.

National Asthma Education and Prevention Program. Second Expert Panel. (1997). Guidelines for Diagnosis and Management of Asthma. NIH Publication No. 97-4051.

Silkworth, C.K. (1993). IHP: Asthma. In M.B. Haas, M.J.V. Gerber, W.R. Miller, K.M. Kalb, C.K. Silkworth, R.E. Leuhr, & S.I.S. Will. (Eds.), The School Nurse's Source Book of Individualized Healthcare Plans—Volume 1. (pp. 133-150). North Branch, MN: Sunrise River Press.

Szilagyi, P. & Kemper, K. (1999). Management of chronic childhood asthma in the primary care office. Pediatric Annuals, 28(1), 43-52.

University of Michigan Health System. (2000). Asthma: Guidelines for clinical care. Available online: http://www.cme.med.umich.edu/ pdf/guideline/asthma.pdf

Yoos, H.L., & McMullen, A. (1999). Symptom monitoring in childhood asthma: How to use a peak flow meter. Pediatric Annals, 28(1), 31-39.

Bleeding Reduction: Nasal (NOSEBL)

Definition: **Limitation of the amount of blood loss from the nasal cavity.**

Activities:

Apply manual pressure over the bleeding or the potential bleeding area
Identify the cause of the bleeding
Monitor the amount and nature of blood loss
Monitor the amount of bleeding into the oropharynx
Apply ice pack to affected area
Place packing in nasal cavity, if appropriate
Instruct the patient on activity restrictions, if appropriate
Promote stress reduction
Provide pain relief/comfort measures
Maintain a patent airway
Instruct patient to avoid traumatizing nares (e.g., avoid scratching or touching nose)
Assist patient with oral care, as appropriate
Instruct the patient and/or family on signs of bleeding and appropriate actions (e.g., notify the nurse), should further bleeding occur

Background Readings:

Cullen, L.M. (1992). Interventions related to circulatory care. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 445-476.

Jennings, B. (1991). The hematologic system. In J. Alspach (Ed.), AACN's core curriculum for critical care nursing (4th ed.) (pp. 675-747). Philadelphia: W.B. Saunders.

Johanson, B.C., Wells, S.J., Hoffmeister, D., & Dungca, C.U. (1988). Standards for critical care (3rd ed.). St. Louis: Mosby.

Kitt, S., & Karser, J. (1990). Emergency nursing: A physiological and clinical perspective. Philadelphia: W.B. Saunders.

Thompson, J.M., McFarland, G.K., Hirsch, J.E., & Tucker, S.M. (1998). Mosby's clinical nursing (4th ed.). St. Louis: Mosby.

Bleeding Reduction: Wound (BLEED)

Definition: **Limitation of the blood loss from a wound that may be a result of trauma, incisions, or placement of a tube or catheter.**

Activities:

Identify the cause of the bleeding
Monitor the patient closely for hemorrhage
Monitor the amount and nature of blood loss
Monitor trends in blood pressure and hemodynamic parameters, if available (e.g., central venous pressure and pulmonary capillary/artery wedge pressure)
Monitor fluid status, including intake and output, as appropriate
Instruct the patient and/or family on signs of bleeding and appropriate actions (e.g., notify the nurse), should further bleeding occur
Instruct the patient on activity restrictions, if appropriate
Instruct patient and family on severity of blood loss and appropriate actions being performed
Perform proper precautions in handling blood products or bloody secretions
Apply direct pressure or pressure dressing, if appropriate

Background Readings:

Cullen, L.M. (1992). Interventions related to circulatory care. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 445-476.
Jennings, B. (1991). The hematologic system. In J. Alspach (Ed.), AACN's core curriculum for critical care nursing (4th ed.) (pp. 675-747). Philadelphia: W.B. Saunders.
Johanson, B.C., Wells, S.J., Hoffmeister, D., & Dungca, C.U. (1988). Standards for critical care (3rd ed.). St. Louis: Mosby.
Thompson, J.M., McFarland, G.K., Hirsch, J.E., & Tucker, S.M. (1998). Mosby's clinical nursing (4th ed.). St. Louis: Mosby.

Body Mechanics Promotion (BODY and BODYG)

Definition*[1]*: **Facilitating a patient or a group of patients in the use of posture and movement in daily activities to prevent fatigue and musculoskeletal strain or injury.**

Body Mechanics Promotion (individual) BODY
Body Mechanics Promotion (group) BODYG

Activities:

Determine patient's commitment to learning and using correct posture
Collaborate with physical/occupational therapy in developing a body mechanics promotion plan, as indicated
Determine patient's understanding of body mechanics and exercises (e.g., return demonstration of correct techniques while performing activities/exercises)
Instruct patient on structure and function of spine and optimal posture for moving and using the body
Instruct patient about need for correct posture to prevent fatigue, strain, or injury
Instruct patient how to use posture and body mechanics to prevent injury while performing any physical activities
Determine patient awareness of own musculoskeletal abnormalities and the potential effects of posture and muscle tissue
Instruct to use a firm mattress/chair or pillow, if appropriate
Instruct to avoid sleeping prone
Assist to demonstrate appropriate sleeping positions
Assist to avoid sitting in the same position for prolonged periods
Demonstrate how to shift weight from one foot to another while standing
Instruct patient to move feet first and then body when turning to walk from a standing position
Assist patient/family to identify appropriate posture exercises
Assist patient to select warm-up activities before beginning exercise or work not done routinely
Assist patient to perform flexion exercises to facilitate back mobility, as indicated
Instruct patient/family regarding frequency and number of repetitions for each exercise
Monitor improvement in patient's posture/body mechanics
Provide information about possible positional causes of muscle or joint pain

Background Readings:

Craven, R.F., & Hirnle, C.J. (2000) Fundamentals of nursing: Human health and function (3rd ed.). (pp. 738-739). Philadelphia: Lippincott.
Glick, O.J. (1992). Interventions related to activity and movement. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 541-568.
Lewis, C.B. (1989). Improving mobility in older persons. Rockville, MD: Aspen.
Sheahan, S. (1982). Assessment of low back pain. Nurse Practitioner, 7, 15-23.
Sweezey, S. (1988). Low back pain. Geriatrics, 43(2), 39-44.

[1] Delaware definition differentiates between individual or group intervention.

Bowel Management (BWL)

Definition: **Establishment and maintenance of a regular pattern of bowel elimination.**

Activities:

Note date of last bowel movement
Monitor bowel movements including frequency, consistency, shape, volume, and color, as appropriate
Monitor bowel sounds
Report an increase in frequency of and/or high-pitched bowel sounds
Report diminished bowel sounds
Monitor for signs and symptoms of diarrhea, constipation, and impaction
Evaluate for fecal incontinence as necessary
Note preexistent bowel problems, bowel routine, and use of laxatives
Teach patient about specific foods that assist in promoting bowel regularity
Instruct patient/family members to record color, volume, frequency, and consistency of stools
Initiate a bowel training program, as appropriate
Encourage decreased gas-forming food intake, as appropriate
Instruct patient on foods high in fiber, as appropriate
Give warm liquids after meals, as appropriate
Evaluate medication profile for gastrointestinal side effects
Refrain from doing rectal/vaginal examination if medical condition warrants

Background Readings:

Craft, M.J., & Denehy, J.A. (Eds.). (1990). Nursing interventions for infants and children. Philadelphia: W.B. Saunders.

Craven, R.F., & Hirnle, C.J. (2000) Fundamentals of nursing: Human health and function (3rd ed.) (pp. 1077-1114). Philadelphia: Lippincott.

Goetz, L.L., Hurvitz, E.A., Nelson, V.S., & Waring, W. (1998). Bowel management in children and adolescents with spinal cord injury. The Journal of Spinal Cord Medicine, 21(4), 335-341.

Hardy, M.A. (1991). Normal changes with aging. In M. Maas, K.C. Buckwalter, & M. Hardy (Eds.), Nursing diagnoses and interventions for the elderly (pp. 145-146). Redwood City, CA: Addison-Wesley.

McLane, A.M., & McShane, R.E. (1991). Constipation. In M. Maas, K. Buckwalter, & M. Hardy (Eds.), Nursing diagnoses and interventions for the elderly (pp. 147-158). Redwood City, CA: Addison-Wesley.

Mangan, P., & Thomas, L. (1988). Preserving dignity. Geriatric Nursing and Home Care, 8(9), 14.

Cast Care: Maintenance (CAST)

Definition: **Care of a cast after the drying period.**

Activities:
Apply sodium bicarbonate (baking soda) to an odiferous cast
Inspect cast for signs of drainage from wounds under the cast
Mark the circumference of any drainage as a gauge for future assessments
Apply plastic to cast if close to groin
Instruct patient not to scratch skin under the cast with any objects
Avoid getting a plaster cast wet
Position cast on pillows to lessen strain on other body parts
Check for cracking or breaks in the cast
Apply an arm sling for support, if appropriate
Pad rough cast edges and traction connections, as appropriate

Background Readings:
Beck, C.K., Rawlins, R.P., & Williams, S.R. (1988). Mental health-psychiatric nursing. St. Louis: Mosby.
Farrell, J. (1986). Illustrated guide to orthopedic nursing (3rd ed.). Philadelphia: J.B. Lippincott.
Feller, N.G., Stroup, K., & Christian, L. (1989). Helping staff nurses become mini-specialists: Cast care. American Journal of Nursing, 89(7), 991-992.
Kozier, B., & Erb, G. (1989). Techniques in clinical nursing (3rd ed.). Menlo Park, CA: Addison-Wesley.
Perry, A.G., & Potter, P.A. (1998). Clinical nursing skills and techniques. (4th ed.) St. Louis: Mosby.
Smith, S., & Duell, D. (1992). Clinical nursing skills (3rd ed.). Los Altos, CA: National Nursing Review.

Chest Physiotherapy (CHEST)

Definition: **Assisting the patient to move airway secretions from peripheral airways to more central airways for expectoration and/or suctioning.**

Activities:

Determine presence of contraindications for use of chest physical therapy
Determine which lung segment(s) needs to be drained
Position patient with the lung segment to be drained in uppermost position
Use pillows to support patient in designated position
Use percussion with postural drainage by cupping hands and clapping the chest wall in rapid succession to produce a series of hollow sounds
Use chest vibration in combination with postural drainage, as appropriate
Use an ultrasonic nebulizer, as appropriate
Use aerosol therapy, as appropriate
Administer bronchodilators, as appropriate
Administer mucokinetic agents, as appropriate
Monitor amount and type of sputum expectoration
Encourage coughing during and after postural drainage
Monitor patient tolerance by means of SaO_2, respiratory rhythm and rate, cardiac rhythm and rate, and comfort levels

Background Reading:

Brooks-Brunn, J. (1986). Respiration. In L. Abels (Ed.), Critical care nursing: A physiologic approach (pp. 168-253). St. Louis: Mosby.

Craven, R.F., & Hirnle, C.J. (2000) Fundamentals of nursing: Human health and function. (3rd ed.) (pp. 810-813). Philadelphia: Lippincott.

Kiriloff, L.H., Owens, G.R., Rogers, R.M., & Mazzocco, M.C. (1985). Does chest physical therapy work? Chest, 88, 436-444.

Nelson, D.M. (1992). Interventions related to respiratory care. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 301-324.

Sutton, P., Parker, R., Webber, B., Newman, S., Garland, N., Lapez-Vidriera, M., Pavia, D., & Clark, S.W. (1983). Assessment of forced expiration technique, postural drainage, and directed coughing in chest physiotherapy. European Journal of Respiratory Disease, 64, 62-68.

Contact Lens Care (EYECL)

Definition: **Prevention of eye injury and lens damage by proper use of contact lenses.**

Activities:

Wash hands thoroughly before touching the lenses
Clean lenses with the recommended sterile solution
Use recommended solutions to wet lenses
Store in a clean storage kit
Remove lenses at bedtime or at appropriate intervals for patient who cannot do this for self
Instruct patient how to examine lenses for damage
Instruct the patient to avoid irritating eye makeup
Avoid use of chemicals (e.g.; soaps, lotions, creams and sprays) near lenses because they may damage the lenses
Make referral to eye specialist, as appropriate

Background Readings:

Perry, A.G. & Potter, P.A. (2002). Clinical nursing skills and techniques (5th ed.). St. Louis: Mosby.

Counseling (COUNSEL and COUNSELG)

***Definition*[1]*:* Use of an interactive helping process focusing on the needs, problems, or feelings of the patient (or group) and significant others to enhance or support coping, problem solving, and interpersonal relationships.**

Counseling (individual) COUNSEL
Counseling (group) COUNSELG

Activities:

Establish a therapeutic relationship based on trust and respect
Demonstrate empathy, warmth, and genuineness
Establish the length of the counseling relationship
Establish goals
Provide privacy and ensure confidentiality
Provide factual information as necessary and appropriate
Encourage expression of feelings
Assist patient to identify the problem or situation that is causing the distress
Use techniques of reflection and clarification to facilitate expression of concerns
Ask patient/significant others to identify what they can/cannot do about what is happening
Assist patient to list and prioritize all possible alternatives to a problem
Identify any differences between patient's view of the situation and the view of the health care team
Determine how family behavior affects patient
Verbalize the discrepancy between the patient's feelings and behaviors
Use assessment tools (e.g., paper and pencil measures, audiotape, videotape, interactional exercises with other people) to help increase patient's self-awareness and counselor's knowledge of situation, as appropriate
Reveal selected aspects of your own experiences or personality to foster genuineness and trust as appropriate
Assist patient to identify strengths, and reinforce these
Encourage new skill development as appropriate
Encourage substitution of undesirable habits with desirable habits
Reinforce new skills
Discourage decision making when the patient is under severe stress, when possible

Background Readings:

Banks, L.J. (1992). Counseling. In G.M. Bulechek & J.C. McCloskey (Eds.), Nursing interventions: Essential nursing treatments (pp. 279-291). Philadelphia: W.B. Saunders.
Corey, G. (1991). Theory and practice of counseling and psychotherapy. (4th ed.). Pacific Grove, CA: Brooks/Cole Publishing Company.

[1] Delaware definition differentiates between individual's or group intervention.

Diarrhea Management (DIARR)

Definition: **prevention and alleviation of diarrhea**

Activities:
Determine history of diarrhea
Obtain stool for culture and sensitivity if diarrhea continues
Evaluate medication profile for gastrointestinal side effects
Teach patient appropriate use of antidiarrheal medications
Instruct patient/family members to record color, volume, frequency, and consistency of stools
Evaluate recorded intake for nutritional content
Encourage frequent, small feedings, adding bulk gradually
Teach patient to eliminate gas-forming and spicy foods from diet
Suggest trial elimination of foods containing lactose
Identify factors (e.g., medications, bacteria, tube feedings) that may cause or contribute to diarrhea
Monitor for signs and symptoms of diarrhea
Instruct patient to notify staff of each episode of diarrhea
Observe skin turgor regularly
Monitor skin in perianal area for irritation and ulceration
Measure diarrhea/bowel output
Weigh patient regularly
Notify physician of an increase in frequency or pitch of bowel sounds
Consult physician if signs and symptoms of diarrhea persist
Instruct in low-fiber, high-protein, high-calorie diet, as appropriate
Instruct in avoidance of laxatives
Teach patient/family how to keep a food diary
Teach patient stress-reduction techniques, as appropriate
Assist patient in performing stress-reduction techniques
Monitor safe food preparation
Perform actions to rest the bowel (e.g., NPO, liquid diet)

Background Readings:
Hogan, C.M. (1998) The nurse's role in diarrhea management, Oncology Nurse Forum, 25(5), 879-886.
Taylor, C.M. (1987). Nursing diagnosis cards. Springhouse, PA: Springhouse Corporation.
Wadle, K. (2001) Diarrhea. In Maas, M.L., Buckwalter, K.C., Hardy, M.D., Reimer, T.T., Titler, M.G., & Specht, J.P. (Eds.). (2001) Nursing care of older adults: Diagnoses, outcomes, & interventions (pp. 227-237). St. Louis: Mosby.
Williams, M.S., Harper, R., Magnuson, B., Loan, T., Kearney, P. (1998). Diarrhea management in enterally fed patients. Nutrition in Clinical Problems, 13, 225-229.

Emergency Care (ERILL and ERINJ)

***Definition*[1]*:* Providing life-saving measures in life-threatening situations caused by illness or injury.**

Emergency Care (illness) ERILL
Emergency Care (injury) ERINJ

Activities:

Act quickly and methodically, giving care to the most urgent conditions
Activate the emergency medical system
Instruct others to call for help, if needed
Maintain an open airway
Perform cardiopulmonary resuscitation, as appropriate
Perform the Heimlich maneuver, as appropriate
Move patient to a safe location, as appropriate
Check for medical alert tags
Apply manual pressure over bleeding site, as appropriate
Apply a pressure dressing, as needed
Monitor the amount and nature of blood loss
Check for signs and symptoms of pneumothorax or flailing chest
Elevate injured part, as appropriate
Apply mast trousers, as appropriate
Monitor vital signs
Determine the history of the accident from the patient or others in the area
Determine whether an overdose of a drug or other substance is involved
Determine whether toxic or poisonous substances are involved
Send drugs believed to be affecting patient to treatment facility, as appropriate
Monitor level of consciousness
Immobilize fractures, large wounds, and any injured part
Monitor neurological status for possible head or spinal injuries
Apply a cervical collar, as appropriate
Maintain body alignment in suspected spinal injuries
Provide reassurance and emotional support to patient
Initiate medical transport, as appropriate
Transport using a back board, as appropriate

Background Readings:

Beaver, B.M. (1990). Care of the multiple trauma victim: The first hour. Nursing Clinics of North America, 25(1), 11-22.

Laskowski-Jones, L. (2000) Responding to summer emergencies-education STATPack, Dimensions of Critical Care Nursing, 19(4), 11-12, July-August.

Smith, S., & Duell, D. (1992). Clinical nursing skills (3rd ed.). Los Altos, CA: National Nursing Review.

Sorensen, K., & Luckmann, J. (1986). Basic nursing: A psychophysiologic approach (2nd ed.). Philadelphia: W.B. Saunders.

[1] Delaware definition differentiates between intervention related to illness or injury.

Enteral Tube Feeding (TUBEFEED)

Definition: **Delivering nutrients and water through a gastrointestinal tube.**

Activities:

Explain the procedure to the patient
Insert a nasogastric, nasoduodenal, or nasojejunal tube according to agency protocol
Apply anchoring substance to skin and secure feeding tube with tape
Monitor for proper placement of the tube by inspecting oral cavity, checking for gastric residual, or listening while air is injected and withdrawn according to agency protocol
Mark the tubing at the point of exit to maintain proper placement
Confirm tube placement by x-ray examination prior to administering feedings or medications via the tube per agency protocol
Monitor for presence of bowel sounds every 4 to 8 hours, as appropriate
Monitor fluid and electrolyte status
Consult with other health care team members in selecting the type and strength of enteral feeding
Elevate head of the bed 30 to 45 degrees during feedings
Offer pacifier to infant during feeding, as appropriate
Hold and talk to infant during feeding to simulate usual feeding activities
Discontinue feedings 30 to 60 minutes before putting patient in a head-down position
Turn off the tube feeding 1 hour prior to a procedure or if the patient needs to be in a position with the head less than 30 degrees
Irrigate the tube every 4 to 6 hours as appropriate during continuous feedings and after every intermittent feeding
Use clean technique in administering tube feedings
Check gravity drip rate or pump rate every hour
Slow tube feeding rate and/or decrease strength to control diarrhea
Monitor for sensation of fullness, nausea, and vomiting
Check residual every 4 to 6 hours for the first 24 hours, then every 8 hours during continuous feedings
Check residual before each intermittent feeding
Hold tube feedings if residual is greater than 150 cc or more than 110% to 120% of the hourly rate in adults
Keep cuff of endotracheal or tracheostomy tube inflated during feeding, as appropriate
Keep open containers of enteral feeding refrigerated
Change insertion site and infusion tubing according to agency protocol
Wash skin around skin level device daily with mild soap and dry thoroughly
Check water level in skin level device balloon according to equipment protocol
Discard enteral feeding containers and administration sets every 24 hours
Refill feeding bag every 4 hours, as appropriate
Monitor for presence of bowel sounds every 4 to 8 hours, as appropriate
Monitor fluid and electrolyte status
Monitor for growth (height/weight) changes monthly, as appropriate
Monitor weight 3 times weekly initially, decreasing to once a month
Monitor for signs of edema or dehydration
Monitor fluid intake and output
Monitor calorie, fat, carbohydrate, vitamin, and mineral intake for adequacy (or refer to dietitian) 2 times weekly initially, decreasing to once a month
Monitor for mood changes
Prepare individual and family for home tube feedings, as appropriate
Monitor weight at least three times a week, as appropriate for age

Background Readings:

Fellows, L.S., Miller, E.H., Frederickson, M, Bly, B., & Felt, P. (2000). Evidence-based practice for enteral feedings and aspiration prevention: Strategies, bedside detection and practice change. MEDSUR6 Nursing, 9(1), 27-31.
Mahan, K.L., & Escott-Stump, S. (2000) In Krause's food, nutrition & diet therapy (9th ed.). Philadelphia: W.B. Saunders.
Methany, N.A. & Titler, M.G. (2001). Assessing placement of feeding tubes. American Journal of Nursing, 101(5), 6-45.
Perry, A.G., & Potter, P.A. (2002). Clinical nursing skills and techniques (5th ed.) (pp. 559-616). St. Louis: Mosby.

Environmental Management (ENVMGT)

Definition: **Manipulation of the patient's surroundings for therapeutic benefit, sensory appeal and psychological well-being.**

Activities:

Create a safe environment for the patient
Identify the safety needs of patient, based on level of physical and cognitive function and history of behavior
Remove environmental hazards (e.g., loose rugs and small, movable furniture)
Remove harmful objects from the environment
Safeguard with side rails/side-rail padding, as appropriate
Provide low-height bed, as appropriate
Provide adaptive devices (e.g., step stools or handrails), as appropriate
Place furniture in room in an appropriate arrangement that best accommodates patient or family disabilities
Provide sufficiently long tubing to allow freedom of movement, as appropriate
Place frequently used objects within reach
Consider the aesthetics of the environment when selecting furnishings
Provide a clean, comfortable bed and environment
Provide a firm mattress
Place bed-positioning switch within easy reach
Reduce environmental stimuli, as appropriate
Avoid unnecessary exposure, drafts, overheating, or chilling
Adjust environmental temperature to meet patient's needs, if body temperature is altered
Control or prevent undesirable or excessive noise, when possible
Provide music of choice
Provide headphones for private listening when music may disturb others
Manipulate lighting for therapeutic benefit
Provide attractively arranged meals and snacks
Clean areas used for eating and drinking utensils prior to patient use
Individualize daily routine to meet patient's needs
Bring familiar objects from home
Facilitate use of personal items such as pajamas, robes, and toiletries
Maintain consistency of staff assignment over time
Provide immediate and continuous means to summon nurse, and let the patient and family know they will be answered immediately
Educate patient and visitors about the changes/precautions, so they will not inadvertently disrupt the planned environment
Provide family/guardian with information about making home environment safe for patient
Promote fire safety, as appropriate
Control environmental pests, as appropriate
Provide room deodorizers, as needed

Background Readings:

Ackerman, L.L. (1992). Interventions related to neurological care. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 325-346.

Drury, J., & Akins, J. (1991). Sensory/perceptual alterations. In M. Maas, K. Buckwalter, & M. Hardy (Eds.), Nursing diagnoses and interventions for the elderly (pp. 369-389). Redwood City, CA: Addison-Wesley.

Gerdner, L., & Buckwalter, K. (1999). Music therapy. In G. Bulechek & J. McCloskey (Eds.), Nursing interventions: Effective nursing treatments (3rd ed.) (pp. 451-468). Philadelphia: W.B. Saunders.

Phylar, P.A. (1989). Management of the agitated and aggressive head injury patient in an acute hospital setting. Journal of Neuroscience Nursing, 21(6), 353-356.

Schuster, E., & Keegan, L. (2000). Environment. In B. Dossey, L. Keegan, & C. Guzzetta. Holistic nursing: A handbook for practice (3rd ed.) (pp. 249-282). Gaithersburg, MD: Aspen Publishers.

Stoner, N. (1999). Feeding. In G. Bulechek & J. McCloskey (Eds.) Nursing interventions: Effective nursing treatments (3rd ed.) (pp. 31-46). Philadelphia: W.B. Saunders.

Exercise Promotion (EXER and EXERG)

***Definition*[1]*:* Facilitating a patient of a group of patients in regular physical exercise to maintain or advance to a higher level of fitness and health.**

Exercise Promotion (individual) EXER
Exercise Promotion (group) EXERG

Activities:

Appraise individual's health beliefs about physical exercise
Explore prior exercise experiences
Determine individual's motivation to begin/continue exercise program
Explore barriers to exercise
Encourage verbalization of feelings about exercise or need for exercise
Encourage individual to begin or continue exercise
Assist in identifying a positive role model for maintaining the exercise program
Assist individual to develop an appropriate exercise program to meet needs
Assist individual to set short-term and long-term goals for the exercise program
Assist individual to schedule regular periods for the exercise program into weekly routine
Perform exercise activities with individual, as appropriate
Include family/caregivers in planning and maintaining the exercise program
Inform individual about health benefits and physiological effects of exercise
Instruct individual about appropriate type of exercise for level of health, in collaboration with physician and/or exercise physiologist
Instruct individual about desired frequency, duration, and intensity of the exercise program
Monitor individual's adherence to exercise program/activity
Assist individual to prepare and maintain a progress graph/chart to motivate adherence to the exercise program
Instruct individual about conditions warranting cessation of or alteration in the exercise program
Instruct individual on proper warm-up and cool-down exercises
Instruct individual in techniques to avoid injury while exercising
Instruct individual in proper breathing techniques to maximize oxygen uptake during physical exercise
Provide reinforcement schedule to enhance individual's motivation (e.g., increased endurance estimation; weekly weigh-in)
Monitor individual's response to exercise program
Provide positive feedback for individual's efforts

Background Readings:

Allan, J.D., & Tyler, D.O. (1999). Exercise promotion. In G.M. Bulechek & J.C. McCloskey (Eds.), Nursing interventions: Effective nursing treatments (3rd ed.) (pp. 130-148). Philadelphia: W.B. Saunders.

Glick, O.J. (1992). Interventions related to activity and movement. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 541-568.

NIH Consensus Development Panel on Physical Activity and Cardiovascular Health. (1996). Physical activity and cardiovascular health. Journal of the American Medical Association, 276 (3), 241-246.

Rippe, J., Ward, A., Porcari, J. et al. (1989). The cardiovascular benefits of walking. Practical Cardiology, 15(1).

Sorenson, S., & Poh, A. (1989). Physical fitness. In P. Swinford & J. Webster (Eds.), Promoting wellness: A nurse's handbook (pp. 101-140). Rockville, MD: Aspen.

Timmermans, H., & Martin, M. (1987). Top ten potentially dangerous exercises. Journal of Physical Education, Recreation and Dance, 58, 29.

Topp, R. (1991). Development of an exercise program for older adults: Pre-exercise testing, exercise prescription and program maintenance. Nurse Practitioner, 16(10), 16-28.

[1] Delaware definition differentiates between individual or group intervention.

Feeding (FEED)

***Definition*[1]*:* Feeding of patient with oral motor deficits.**

Activities:
Identify prescribed diet
Set food tray and table attractively
Create a pleasant environment during mealtime (e.g., put bedpans, urinals, and suctioning equipment out of sight)
Provide for adequate pain relief before meals, as appropriate
Provide for oral hygiene before meals
Identify presence of swallowing reflex, if necessary
Sit down while feeding to convey pleasure and relaxation
Offer opportunity to smell foods to stimulate appetite
Ask patient preference for order of eating
Fix foods as patient prefers
Maintain patient in an upright position, with head and neck flexed slightly forward during feeding
Place food in the unaffected side of the mouth, as appropriate
Follow feedings with water, if needed
Protect patient's clothing with a bib, as appropriate
Ask the patient to indicate when finished, as appropriate
Record intake, if appropriate
Avoid disguising drugs in food
Provide a drinking straw, as needed or desired
Provide finger foods, as appropriate
Provide foods at most appetizing temperature
Avoid distracting patient during swallowing
Feed unhurriedly/slowly
Postpone feeding, if patient is fatigued
Encourage parents/family to feed patient

Background Readings:
Evans-Stoner, N.J. (1999). Feeding. In G.M. Bulechek & J.C. McCloskey (Eds.), Nursing interventions: Effective nursing treatments (3rd ed.) (pp. 31-46). Philadelphia: W.B. Saunders.
Styker, R. (1977). Rehabilitative aspects of acute and chronic nursing care. Philadelphia: W.B. Saunders.

[1] Delaware definition; NIC definition reads *providing nutritional intake for patient who is unable to feed self.*

Fever Treatment (FVR)

Definition: **Management of a patient with hyperpyrexia caused by nonenvironmental factors.**

Activities:
Monitor temperature as frequently as is appropriate
Monitor for insensible fluid loss
Institute a continuous core temperature–monitoring device, as appropriate
Monitor skin color and temperature
Monitor blood pressure, pulse, and respiration, as appropriate
Monitor for decreasing levels of consciousness
Monitor for seizure activity
Monitor intake and output
Monitor for presence of cardiac arrhythmias
Administer antipyretic medication, as appropriate
Administer medications to treat the cause of fever, as appropriate
Cover the patient with a sheet, only as appropriate
Encourage increased intake of oral fluids, as appropriate
Increase air circulation by using a fan
Encourage or administer oral hygiene, as appropriate
Give appropriate medication to prevent or control shivering
Administer oxygen, as appropriate
Monitor temperature closely to prevent treatment-induced hypothermia

Background Readings:
Beutler, B., & Beutler, S. (1992). Pathogenesis of fever. In J.B. Wyngaarden, L.H. Smith, Jr., & J.C. Bennett, Jr. (Eds.), Cecil textbook of medicine (19th ed.) (pp. 1568-1571). Philadelphia: W.B. Saunders.
Thompson, J.M., McFarland, G.K., Hirsch, J.E., & Tucker, S.M. (1993). Mosby's clinical nursing (3rd ed.). St. Louis: Mosby.

First Aid (WOUNDFA)

Definition: **Providing initial care for a minor injury.**

Activities:

Control bleeding
Immobilize the affected body part, as appropriate
Elevate the affected body part
Apply a sling, if appropriate
Cover any open or exposed bony parts
Apply ice to the affected body part, as appropriate
Monitor vital signs, as appropriate
Cool the skin with water in cases of minor burns
Flood with water any tissue exposed to a chemical irritant
Remove the stinger from an insect bite, as appropriate
Remove the tick from the skin, as appropriate
Cleanse and remove secretions from the area around a nonpoisonous snake bite
Cover patient with a blanket, as appropriate
Instruct to seek further medical care, as appropriate
Coordinate emergency transport, as needed

Background Readings:

Arnold, R.E. (1973). What to do about bites and stings from venomous animals. New York: Macmillan.
Bizjak, G., Elling, B., Gaull, E.S., & Linn, D. (1994). Emergency care (6th ed.). Englewood Cliffs, NJ: Prentice Hall.
Judd, R.L. (1982). The first responder: The critical first minutes. St. Louis: Mosby.
Phillips, C. (1986). Basic life support skills manual: For EMT-As and first responders. Bowie, MD: Brady.
Sorensen, K., & Luckmann, J. (1986). Basic nursing: A psychophysiologic approach (2nd ed.). Philadelphia: W.B. Saunders.

Health Care Information Exchange (INFOILL and INFOINJ)

***Definition*[1]*:* Providing patient care information to other health professionals related to illness or injury.**

Health Care Information Exchange (illness) INFOILL
Health Care Information Exchange (injury) INFOINJ

Activities:

Identify referring nurse and location
Identify essential demographic data
Describe pertinent health history
Identify current nursing and medical diagnoses
Identify resolved nursing and medical diagnoses, as appropriate
Describe plan of care, including diet, medications, and exercise
Describe nursing interventions being implemented
Identify equipment and supplies necessary for care
Summarize progress of patient toward goals
Identify anticipated date of discharge or transfer
Identify planned return appointment for follow-up care
Describe role of family in continuing care
Identify capabilities of patient and family in implementing care after discharge
Identify other agencies providing care
Request information from health professionals in other agencies
Coordinate care with other health professionals
Discuss patient's strengths and resources
Share concerns of patient or family with other health care providers
Share information from other health professionals with patient and family, as appropriate

Background Readings:

Jenkins, C.A., Schullz, M., Hanson, J., Bruera. E. (2000). Demographic, symptom and medication profiles of cancer patients seen by a palliative care consult team in a tertiary referral hospital. Journal of Pain & Symptom Management 19(3), 174-184.

Job, T. (1999). A system for determining the priority of referrals within a multidisciplinary community mental health team. British Journal of Occupation Therapy 62(11), 486-490.

Kron, T., & Gray, A. (1987). The management of patient care. Putting leadership skills to work (6th ed.). Philadelphia: W.B. Saunders.

Smith, F.A. (2000). The function of consumer health information centers in hospitals. Medical Library Association News 327(Jun-Jul), 23.

Summerton, H. (1998). Clinical management. Discharge planning: Establishing an effective coordination team. British Journal of Nursing 7(20), 1263-7.

[1] Delaware definition differentiates between intervention related to illness or injury.

Health Education (HLTHED and HLTHEDG)

***Definition*[1]*:* Developing and providing individual or group instruction and learning experiences to facilitate voluntary adaptation of behavior conducive to health in individuals, families, groups, or communities.**

Health Education (individual) HLTHED
Health Education (group) HLTHEDG

Activities:

Target high-risk groups and age ranges that would benefit most from health education
Target needs identified in Healthy People 2000: National Health Promotion and Disease Prevention Objectives or other local, state, and national needs
Identify internal or external factors that may enhance or reduce motivation for healthy behavior
Determine personal context and social-cultural history of individual, family, or community health behavior
Determine current health knowledge and lifestyle behaviors of individual, family, or target group
Assist individuals, families, and communities in clarifying health beliefs and values
Identify characteristics of target population that affect selection of learning strategies
Prioritize identified learner needs based on client preference, skills of nurse, resources available, and likelihood of successful goal attainment
Formulate objectives for health education program
Identify resources (e.g., personnel, space, equipment, money) needed to conduct program
Consider accessibility, consumer preference, and cost in program planning
Strategically place attractive advertising to capture attention of target audience
Avoid use of fear or scare techniques as strategy to motivate people to change health or lifestyle behaviors
Emphasize immediate or short-term positive health benefits to be received by positive lifestyle behaviors rather than long-term benefits or negative effects of noncompliance
Incorporate strategies to enhance the self-esteem of target audience
Develop educational materials written at a reading level appropriate to target audience
Teach strategies that can be used to resist unhealthy behavior or risk taking rather than give advice to avoid or change behavior
Keep presentation focused, short, and beginning and ending on main point
Use group presentations to provide support and lessen threat to learners experiencing similar problems or concerns, as appropriate
Use peer leaders, teachers, and support groups in implementing programs to groups less likely to listen to health professionals or adults (e.g., adolescents), as appropriate
Use lectures to convey the maximum amount of information when appropriate
Use group discussions and role-playing to influence health beliefs, attitudes, and values
Use demonstrations/return demonstrations, learner participation, and manipulation of materials when teaching psychomotor skills
Use computer-assisted instruction, television, interactive video, and other technologies to convey information
Use teleconferencing, telecommunications, and computer technologies for distance learning
Involve individuals, families, and groups in planning and implementing plans for lifestyle or health behavior modification
Determine family, peer, and community support for behavior conducive to health
Utilize social and family support systems to enhance effectiveness of lifestyle or heath behavior modification
Emphasize importance of healthy patterns of eating, sleeping, exercising, etc. to individuals, families, and groups who model these values and behaviors to others, particularly children
Use variety of strategies and intervention points in educational program
Plan long-term follow-up to reinforce health behavior or lifestyle adaptations
Design and implement strategies to measure client outcomes at regular intervals during and after completion of program
Design and implement strategies to measure program and cost-effectiveness of education, using these data to improve the effectiveness of subsequent programs
Influence development of policy that guarantees health education as an employee benefit
Encourage policy whereby insurance companies give consideration for premium reductions or benefits for healthful lifestyle practices

Background Readings:

APHA Technical Report. (1987). Criteria for the development of health promotion and education programs. American Journal of Public Health, 77 (1), 89-92.
Bastable, S.B. (2003). Nurse as educator: Principles of teaching and learning for nursing practice. Boston: Jones and Bartlett Publishers.
Clark, M.J. (1992). Nursing in the community. The health education process (pp. 126-141). Norfolk, CT: Appleton & Lange.
Damrosch, S. (1991). General strategies for motivating people to change their behavior. Nursing Clinics of North America, 26(4), 833-843.
Department of Health and Human Services. (1991). Healthy People 2000: National health promotion and disease prevention objectives (DHHS Publication No. PHS 91-50213). Washington, DC. U.S. Government Printing Office.
Green, L.W., & Johnson, K.W. (1983). Health education and health promotion. In D. Mechanic (Ed.), Handbook of health, health care, and the health professional (pp. 744-765). New York: The Free Press, Macmillan Publishing Co.
Somas Job, R.F. (1988). Effective and ineffective use of fear in health promotion campaigns. American Journal of Public Health, 78(2), 163-167.
Pahnos, M.L. (1992). The continuing challenge of multicultural health education. Journal of School Health 62(1), 24-26.

[1] Delaware definition differentiates between individual or group intervention.

Health System Guidance (HGUIDE)

Definition: **Facilitating a patient's location and use of appropriate health services.**

Activities:

Explain the immediate health care system, how it works, and what the patient/family can expect
Assist patient or family to coordinate health care and communication
Assist patient or family to choose appropriate health care professionals
Instruct patient on what type of services to expect from each type of health care provider (e.g., nurse specialists, registered dietitians, registered nurses, licensed practical nurses, physical therapists, cardiologists, internists, optometrists, and psychologists)
Inform the patient about different types of health care facilities (e.g., general hospital, specialty hospital, teaching hospital, walk-in clinic, and outpatient surgical clinic), as appropriate
Inform the patient of accreditation and state health department requirements for judging the quality of a facility
Inform patient of appropriate community resources and contact persons
Advise use of second opinion
Inform patient of right to change health care provider
Inform the patient as to the meaning of signing a consent form
Provide patient with copy of Patient's Bill of Rights
Inform patient how to access emergency services by telephone and vehicle, as appropriate
Encourage patient to go to the emergency department, if appropriate
Identify and facilitate communication among health care providers and patient/family, as appropriate
Inform patient/family how to challenge decision made by a health care provider, as needed
Encourage consultation with other health care professionals, as appropriate
Request services from other health professionals for patient, as appropriate
Coordinate referrals to relevant health care providers, as appropriate
Review and reinforce information given by other health care professionals
Provide information on how to obtain equipment
Coordinate/schedule time needed by each service to deliver care, as appropriate
Inform patient of the cost, time, alternatives, and risks involved in a specific test or procedure
Give written instructions for purpose and location of post-hospitalization/outpatient activities, as appropriate
Give written instructions for purpose and location of health care activities, as appropriate
Discuss outcome of visit with other health care providers, as appropriate
Identify and facilitate transportation needs for obtaining health care services
Provide follow-up contact with patient, as appropriate
Monitor adequacy of current health care follow-up
Provide report to post-hospital caregivers, as appropriate
Encourage the patient/family to ask questions about services and charges
Comply with regulations for third-party reimbursement
Assist individual to complete forms for assistance, such as housing and financial aid, as needed
Notify patient of scheduled appointments, as appropriate
Inform individual/family of available healthcare insurance

Background Readings:

Arnold, E., & Boggs, K. (1989). Interpersonal relationships: Professional communication skills for nurses. Philadelphia: W.B. Saunders.

Dunne, P.J. (1998). The emerging health care delivery system. American Association of Respiratory Care (AARC) Times 22(1), 24-8.

Matthews, P. (2000). Planning for successful outcomes in the new millennium. Topics in Health Information Management 20(3), 55-64.

Viscardis, L. (1998). The family-centered approach to providing services: A parent perspective. Physical & Occupation Therapy in Pediatrics 18(1), 41-53.

Zarbock, S.G. (1999). Sharing in all dimensions: Providing nourishment at home. Home Care Provider 4(3), 106-107.

Heat/Cold Application (Injury[1]) (HTCLD)

Definition: **Stimulation of the skin and underlying tissues with heat or cold for the purpose of decreasing pain, muscle spasms, or inflammation.**

Activities:

Explain the use of heat or cold, the reason for the treatment, and how it will affect the patient's symptoms
Screen for contraindications to cold or heat, such as decreased or absent sensation, decreased circulation, and decreased ability to communicate
Select a method of stimulation that is convenient and readily available, such as waterproof plastic bags with melting ice; frozen gel packs; chemical ice envelope; ice immersion; cloth or towel in freezer for cold; hot water bottle; electric heating pad; hot, moist compresses; immersion in tub or whirlpool; paraffin wax; sitz bath; radiant bulb; or plastic wrap for heat
Determine availability and safe working condition of all equipment used for heat or cold application
Determine condition of skin and identify any alterations requiring a change in procedure or contraindications to stimulation
Select stimulation site, considering alternate sites when direct application is not possible (e.g., adjacent to, distal to, between affected areas and the brain, and contralateral)
Wrap the heat/cold application device with a protective cloth, if appropriate
Use a moist cloth next to the skin to increase the sensation of cold/heat, when appropriate
Instruct how to avoid tissue damage associated with heat/cold
Check the temperature of the application, especially when using heat
Determine duration of application based on individual verbal, behavioral, and biological responses
Time all applications carefully
Apply cold/heat directly on or near the affected site, if possible
Inspect the site carefully for signs of skin irritation or tissue damage throughout the first 5 minutes and then frequently during the treatment
Evaluate general condition, safety, and comfort throughout the treatment
Position to allow movement from the temperature source, if needed
Instruct not to adjust temperature settings independently without prior instruction
Change sites of cold/heat application or switch form of stimulation, if relief is not achieved
Instruct that cold application may be painful briefly, with numbness about 5 minutes after the initial stimulation
Instruct on indications for, frequency of, and procedure for application
Instruct to avoid injury to the skin after stimulation
Evaluate and document response to heat/cold application

Background Readings:

Herr, K.A., & Mobily, P.R. (1992). Interventions related to pain. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 347-370.
McCaffery, M., & Beebe, A. (1989). Pain. Clinical manual for nursing practice (pp. 145-154). St. Louis: Mosby.
Perry, A.G., & Potter, P.A. (1998). Clinical nursing skills and techniques (pp. 1113-1132). St. Louis: Mosby.
Ridgeway, S., Brauer, D., Cross, J., Daniels, J.S., & Steffes, M. (1998). Application of heat and cold. In M. Snyder & R. Lindquist. (Eds.), Complementary/alternative therapies in nursing (3rd ed.) (pp. 89-102). New York: Springer Publishing Company.
Sorensen, K., & Luckmann, J. (1986). Basic nursing: A psychophysiologic approach (2nd ed.) (pp. 966-981). Philadelphia: W.B. Saunders.

[1] Delaware definition limits to injury.

Heat Exposure Treatment (HEATX)

Definition: **Management of patient overcome by heat due to excessive environmental heat exposure.**

Activities:

Remove patient from direct sunlight and/or heat source
Loosen or remove clothing, as appropriate
Wet the body surface and fan the patient
Give cool oral fluids if patient is able to swallow
Provide fluids rich in electrolytes, such as Gatorade
Transport to a cool environment, as appropriate
Determine the cause as exertional or nonexertional
Monitor level of consciousness
Monitor for hypoglycemia
Monitor for hypotension, cardiac arrhythmias, and signs of respiratory distress
Teach measures to prevent heat exhaustion and heat stroke
Teach early indications of heat exhaustion and appropriate actions to take

Background Readings:

Davis, L. (1997). Environmental heat-related illnesses. MedSurg Nursing, 6 (3), 153-161.

Knochel, J.P. (1992). Disorders due to heat and cold. In J.B. Wyngaarden, L.H. Smith, Jr., & J.C. Bennett, Jr. (Eds.), Cecil textbook of medicine (19th ed.) (pp. 2358-2361). Philadelphia: W.B. Saunders.

Thompson, J.M., McFarland, G.K., Hirsch, J.E., & Tucker, S.M. (1998). Mosby's clinical nursing (4th ed.). St. Louis: Mosby– Year Book.

Hemorrhage Control (HMRR)

Definition: **Reduction or elimination of rapid and excessive blood loss.**

Activities:

Apply a pressure dressing, as indicated
Identify the cause of the bleeding
Monitor the amount and nature of blood loss
Apply manual pressure over the bleeding or the potential bleeding area
Apply ice pack to affected area
Evaluate patient's psychological response to hemorrhage and perception of events
Inspect for bleeding from mucous membranes, bruising after minimal trauma, oozing from puncture sites, and presence of petechiae
Monitor for signs and symptoms of persistent bleeding (e.g., check all secretions for frank or occult blood)
Monitor neurological functioning

Background Readings:

Cullen, L.M. (1992). Interventions related to circulatory care. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 445-478.
Kitt, S., & Karser, J. (1990). Emergency nursing: A physiological and clinical perspective. Philadelphia: W.B. Saunders.
Thompson, J.M., McFarland, G.K., Hirsch, J.E., & Tucker, S.M. (1998). Mosby's clinical nursing (4th ed.). St. Louis: Mosby.

High-Risk Pregnancy Care (PREG)

Definition: **Identification and management of a high-risk pregnancy to promote healthy outcomes for mother and baby.**

Activities:

Determine the presence of medical factors that are related to poor pregnancy outcome (e.g., diabetes, hypertension, lupus erythmatosus, herpes, hepatitis, HIV, and epilepsy)
Review obstetrical history for pregnancy-related risk factors (e.g., prematurity, postmaturity, preeclampsia, multifetal pregnancy, intrauterine growth retardation, abruption, previa, Rh sensitization, premature rupture of membranes, and family history of genetic disorder)
Recognize demographic and social factors related to poor pregnancy outcome (e.g., maternal age, race, poverty, late or no prenatal care, physical abuse, and substance abuse)
Determine client's knowledge of identified risk factors
Encourage expression of feelings and fears about lifestyle changes, fetal well-being, financial changes, family functioning, and personal safety
Provide educational materials that address the risk factors and usual surveillance tests and procedures
Instruct client in self-care techniques to increase the chance of a healthy outcome (e.g., hydration, diet, activity modifications, importance of regular prenatal check-ups, normalization of blood sugars, and sexual precautions, including abstinence)
Instruct about alternate methods of sexual gratification and intimacy
Refer as appropriate for specific programs (e.g., smoking cessation, substance abuse treatment, diabetes education, preterm birth prevention education, abuse shelter, and sexually transmitted disease clinic)
Instruct client on use of prescribed medication (e.g., insulin, tocolytics, antihypertensives, antibiotics, anticoagulants, and anticonvulsants)
Instruct client on self-monitoring skills, as appropriate (e.g., vital signs, blood glucose testing, uterine activity monitoring, and continuous subcutaneous medication delivery)
Write guidelines for signs and symptoms that require immediate medical attention (e.g., bright red vaginal bleeding, change in amniotic fluid, decreased fetal movement, four or more contractions/hour before 37 weeks of gestation, headache, visual disturbances, epigastic pain, and rapid weight gain with facial edema)
Discuss fetal risks associated with preterm birth at various gestational ages
Tour the neonatal intensive care unit if preterm birth is anticipated (e.g., multifetal pregnancy)
Teach fetal movement counts
Establish plan for clinic follow-up
Provide anticipatory guidance for likely interventions during birth process (e.g., Electronic Fetal Monitoring: Intrapartum, Labor Suppression, Labor Induction, Medication Administration, Cesarean Section Care)
Encourage early enrollment in prenatal classes or provide childbirth education materials for patients on bed rest
Provide anticipatory guidance for common experiences that high-risk mothers have during the postpartum period (e.g., exhaustion, depression, chronic stress, disenchantment with childbearing, loss of income, partner discord, and sexual dysfunction)
Refer to high-risk mother support group, as needed
Refer to home care agencies (e.g., specialized perinatal nursing services, perinatal case management, and public health nursing)
Monitor physical and psychosocial status closely throughout pregnancy
Report deviations from normal in maternal and/or fetal status immediately to physician or nurse midwife
Document client education, lab results, fetal testing results, and client responses

Background Readings:

Association of Women's Health, Obstetric, and Neonatal Nurses. (1993). Didactic content and clinical skills verification for professional nurse providers of basic, high-risk and critical-care intrapartum nursing. Washington, DC: AWHONN.
Field, P.A., & Marck, P. (1994). Uncertain motherhood: Negotiating the risks of the childbearing years. Newbury Park, CA: Sage Publishing.
Gilbert, E.S., & Harmon, J.S. (1998). Manual of high risk pregnancy and delivery. (2nd ed.). St. Louis: Mosby.
Mandeville, L.K., & Troiano, N.H. (Eds.). (1992). High-risk intrapartum nursing. Philadelphia: J.B. Lippincott.
Mattson, S. & J.E. Smith (Eds.). (1993). Core curriculum for maternal-newborn nursing. Philadelphia: W.B. Saunders.

Hyperglycemia Management (HYPERG)

Definition: **Preventing and treating above-normal blood glucose levels.**

Activities:

Monitor blood glucose levels, as indicated
Monitor for signs and symptoms of hyperglycemia: polyuria, polydipsia, polyphagia, weakness, lethargy, malaise, blurring of vision, or headache
Monitor urine ketones, as indicated
Monitor ABG, electrolyte, and betahydroxybutyrate levels, as available
Monitor orthostatic blood pressure and pulse, as indicated
Administer insulin, as prescribed
Encourage oral fluid intake
Consult physician if signs and symptoms of hyperglycemia persist or worsen
Assist with ambulation if orthostatic hypotension is present
Provide oral hygiene, if necessary
Identify possible cause of hyperglycemia
Anticipate situations in which insulin requirements will increase (e.g., intercurrent illness)
Restrict exercise when blood glucose levels are >250 mg/dl, especially if urine ketones are present
Instruct patient/family and significant others on prevention, recognition, and management of hyperglycemia
Encourage self-monitoring of blood glucose levels
Assist patient to interpret blood glucose levels
Review blood glucose records with patient and/or family
Instruct on urine ketone testing, as appropriate
Instruct on indications for, and significance of, urine ketone testing, if appropriate
Instruct patient to report moderate or high urine ketone levels to the health professional
Instruct patient/family and significant others on diabetes management during illness, including use of insulin and/or oral agents; monitoring fluid intake; carbohydrate replacement; and when to seek health professional assistance, as appropriate
Provide assistance in adjusting regimen to prevent and treat hyperglycemia (e.g., increasing insulin or oral agent), as indicated
Facilitate adherence to diet and exercise regimen
Test blood glucose levels of family members

Background Readings:

Guthrie, D.W. (Ed.). (1988). Diabetes education: Core curriculum for health professionals. Chicago: American Association of Diabetes Educators.
Thompson, J.M., McFarland, G.K., Hirsch, J.E., & Tucker, S.M. (1998). Mosby's clinical nursing (4th ed.). St. Louis: Mosby.

Hypoglycemia Management (HYPOG)

Definition: **Preventing and treating low blood glucose levels.**

Activities:

Identify patient at risk for hypoglycemia
Determine recognition of hypoglycemia signs and symptoms
Monitor blood glucose levels, as indicated
Monitor for signs and symptoms of hypoglycemia (e.g., shakiness, tremor, sweating, nervousness, anxiety, irritability, impatience, tachycardia, palpitations, chills, clamminess, light-headedness, pallor, hunger, nausea, headache, tiredness, drowsiness, weakness, warmth, dizziness, faintness, blurred vision, nightmares, crying out in sleep, paresthesias, difficulty concentrating, difficulty speaking, incoordination, behavior change, confusion, coma, seizure)
Provide simple carbohydrate, as indicated
Provide complex carbohydrate and protein, as indicated
Administer glucagon, as indicated
Contact emergency medical services, as necessary
Maintain patent airway, as necessary
Protect from injury, as necessary
Review events prior to hypoglycemia to determine probable cause
Provide feedback regarding appropriateness of self-management of hypoglycemia
Instruct patient/family and significant others on signs and symptoms, risk factors, and treatment of hypoglycemia
Instruct patient to have simple carbohydrate available at all times
Instruct patient to obtain and carry/wear appropriate emergency identification
Instruct significant others on the use and administration of glucagon, as appropriate
Instruct on interaction of diet, insulin/oral agents, and exercise
Provide assistance in making self-care decisions to prevent hypoglycemia, (e.g., reducing insulin/oral agents and/or increasing food intake for exercise)
Encourage self-monitoring of blood glucose levels
Encourage ongoing telephone contact with diabetes care team for consultation regarding adjustments in treatment regimen
Collaborate with patient and diabetes care team to make changes in insulin regimen (e.g., multiple daily injections), as indicated
Modify blood glucose goals to prevent hypoglycemia in the absence of hypoglycemia symptoms
Inform patient of increased risk of hypoglycemia with intensive therapy and normalization of blood glucose levels
Instruct patient regarding probable changes in hypoglycemia symptoms with intensive therapy and normalization of blood glucose levels

Background Readings:

American Diabetes Association. (1995). Intensive diabetes management. Alexandria, VA: Author.
American Diabetes Association. (1994). Medical management of insulin-dependent (type I) diabetes. (2nd ed.). Alexandria, VA: Author.
Ahern, J., & Tamborlane, W.V. (1997). Steps to reduce the risks of severe hypoglycemia. Diabetes Spectrum, 10(1), 39-41.
Cryer, P.E., Fisher J.N., & Shamoon, H (1994). Hypoglycemia. Diabetes Care, 17(7), 734-755.
Havlin, C.E., & Cryer, P.E. (1988). Hypoglycemia: The limiting factor in the management of insulin-dependent diabetes mellitus. Diabetes Educator, 14(5), 407-411.
Levandoski, L.A. (1993). Hypoglycemia. In V. Peragallo-Dittko (Ed.), A core curriculum for diabetes education (pp. 351-372). Chicago: American Association of Diabetes Educators and AADE Education and Research Foundation.

Immunization Management (IZMGT)

Definition: **Monitoring immunization status and facilitating access to immunizations to prevent communicable disease.**

Activities:

Teach parent(s) recommended immunization necessary for children, their route of medication administration, reasons and benefits of use, adverse reactions, and side effects schedule (e.g.; hepatitis B, diphtheria, tetanus, pertussis, Haemophilus influenza, polio, measles, mumps, rubella, and varicella)
Inform individuals of immunization protective against illness but not presently required by law (e.g.; influenza, pneumonia, and hepatitis B vaccinations)
Teach individual/families about vaccinations available in the event of special incidence and/or exposure (e.g.; cholera, influenza, plague, rabies, Rocky Mountain spotted fever, smallpox, typhoid fever, typhus, yellow fever, and tuberculosis)
Provide vaccine information statements prepared by CDC
Provide and update diary for recording date and type of immunizations
Identify proper administration techniques, including simultaneous administration
Note patient's medical history and history of allergies
Administer injections to infant in the anterolateral thigh, as appropriate
Document vaccination information per agency protocol (e.g.; manufacturer, lot number, expiration date)
Inform families which immunizations are required by law for entering preschool, kindergarten, junior high, high school, and college
Audit school immunization records for completeness on a yearly basis
Notify individual/family when immunizations are not up-to-date
Follow the American Academy of Pediatrics, American Academy of Family Physicians, and U.S. Public Health Service guidelines for immunization administration
Inform travelers of vaccinations appropriate for travel to foreign countries
Identify true contraindications for administering immunizations (anaphylactic reaction to previous vaccine and moderate or severe illness with or without fever)
Recognize that a delay in series administration does not indicate restarting the schedule
Secure informed consent to administer vaccine
Help family with financial planning to pay for immunizations (e.g.; insurance coverage and health department clinics)
Identify providers who participate in Federal "Vaccine for Children" program to provide free vaccines
Inform parent(s) of comfort measures helpful after medication administration to child
Observe patient for a specified period after medication administration
Schedule immunizations at appropriate time intervals
Determine immunization status at every health care visit (including emergency department and hospital admission), and provide immunizations as needed
Advocate for programs and policies that provide free or affordable immunizations to all populations
Support national registry to track immunization status

Background Readings:

Centers for Disease Control. (1997). Recommended childhood immunization schedule: United States 1997. Mortality and Morbidity Weekly Report, 46(2), 35-40.
Centers for Disease Control. (2002). Recommended adult immunization schedule: United States, 2002-2003. Mortality and Morbidity Weekly Report, 51(40), 904-908.
Lambert, J. (1995). Every child by two. A program of the American Nurses Foundation. American Nurse, 27(8), 12.
Lerner-Durjava, L. (1998). Nurse's guide to immunizations. Nursing 28(7), 32hn10-12.
Scudder, L. (1995). Child immunization initiative: Politics and health policy in action. Nursing Policy Forum, 1 (3), 20-29.
Scarbrough, M.L., & Landis, S.E. (1997). A pilot study for the development of a hospital-based immunization program. Clinical Nurse Specialist, 11(2), 70-75.
West, A.R., & Kopp, M. (1999). Making a difference: Immunizing infants and children. American Nurse Foundation, A1-A6.

Infection Protection (INFPRO)

Definition: **Prevention and early detection of infection in a patient at risk.**

Activities:

Monitor for systemic and localized signs and symptoms of infection
Monitor vulnerability to infection
Monitor absolute granulocyte count, WBC count, and differential results
Follow neutropenic precautions, as appropriate
Monitor others for communicable disease
Maintain asepsis for patient at risk
Maintain isolation techniques, as appropriate
Provide appropriate skin care to edematous areas
Inspect skin and mucous membranes for redness, extreme warmth, or drainage
Inspect condition of any surgical incision/wound
Obtain cultures, as needed
Promote sufficient nutritional intake
Encourage fluid intake, as appropriate
Encourage rest
Monitor for change in energy level/malaise
Encourage increased mobility and exercise, as appropriate
Encourage deep breathing and coughing, as appropriate
Administer an immunizing agent, as appropriate
Instruct patient to take antibiotics as prescribed
Teach the patient and family about signs and symptoms of infection and when to report them to the health care provider
Teach patient and family members how to avoid infections
Eliminate fresh fruits, vegetables, and pepper from the diet of patients with neutropenia
Remove fresh flowers and plants from patient areas, as appropriate
Report suspected infections

Background Readings:

Degroot-Kosolcharoen, J., & Jones, J.M. (1989). Permeability of latex and vinyl gloves to water and blood. American Journal of Infection Control, 17, 196-201.

Ehrenkranz, J.J., Eckert, D.G., & Phillips, P.M. (1989). Sporadic bacteremia complicating central venous catheter use in a community hospital. American Journal of Infection Control, 17(2), 69-76.

Larsen, E., Mayur, K., & Laughon, B.A. (1989). Influence of two handwashing frequencies on reduction in colonizing flora with three handwashing products used by health care personnel. American Journal of Infection Control, 17(2), 83-88.

Pottinger, J., Burns, S., & Manske, C. (1989). Bacterial carriage by artificial versus natural nails. American Journal of Infection Control, 17, 340-344.

Pugliese, G., & Lampinen, T. (1989). Prevention of human immunodeficiency virus infection: Our responsibilities as health care professionals. American Journal of Infection Control, 17(1), 1-22.

Thompson, J.M., McFarland, G.K., Hirsch, J.E., & Tucker, S.M. (1998). Mosby's clinical nursing (4th ed.). St. Louis: Mosby.

Medication Administration (MEDADM)

Definition: **Preparing, giving, and evaluating the effectiveness of prescription and nonprescription drugs.**

Activities:

Develop agency policies and procedures for accurate and safe administration of medications
Develop and use an environment that maximizes safe and efficient administration of medications
Follow the five rights of medication administration
Verify the prescription or medication order before administering the drug
Monitor for possible medication allergies, interactions, and contraindications
Note patient's allergies before delivery of each medication and hold medications, as appropriate
Ensure that hypnotics, narcotics, and antibiotics are either discontinued or reordered on their renewal date
Note expiration date on medication container
Prepare medications using appropriate equipment and techniques for the drug administration modality
Restrict administration of medications not properly labeled
Dispose of unused or expired drugs, according to agency guidelines
Monitor vital signs and laboratory values before medication administration, as appropriate
Assist patient in taking medication
Give medication using appropriate technique and route
Use orders, agency policies, and procedures to guide appropriate method of medication administration
Instruct patient and family about expected actions and adverse effects of the medication
Monitor patient to determine need for PRN medications, as appropriate
Monitor patient for the therapeutic effect of the medication
Monitor patient for adverse effects, toxicity, and interactions of the administered medications
Sign out and store narcotics and other restricted drugs, according to agency protocol
Verify all questioned medication orders with the appropriate health care personnel
Document medication administration and patient responsiveness, according to agency protocol

Background Readings:

Deglin, J.H., & Vallerand, A.H. (2001). Davis's drug guide for nurses (7th ed.). Philadelphia: F.A. Davis Co.
Lehne, R.A. (2001). Pharmacology for nursing care (4th ed.). Philadelphia: Saunders.
Naegle, M.A. (1999). Medication management. In G.M. Bulechek & J.C. McCloskey (Eds.), Nursing interventions: Effective nursing treatments (3rd ed.) (pp. 234-242). Philadelphia: W.B. Saunders.
Perry, A.G., & Potter, P.A. (2002). Clinical nursing skills & techniques (5th ed.) (pp. 435-557). St. Louis: Mosby.
Strome, T., & Howell, T. (1991). How antipsychotics affect the elderly. American Journal of Nursing, 91(5), 46-49.

Medication Management (MEDMGT)

Definition: **Facilitation of safe and effective use of prescription and over-the-counter drugs.**

Activities:

Determine what drugs are needed, and administer according to prescriptive authority and/or protocol
Discuss financial concerns related to medication regimen
Determine patient's ability to self-medicate, as appropriate
Monitor effectiveness of the medication administration modality
Monitor patient for the therapeutic effect of the medication
Monitor for signs and symptoms of drug toxicity
Monitor for adverse effects of the drug
Monitor for nontherapeutic drug interactions
Review periodically with the patient and/or family types and amounts of medications taken
Discard old, discontinued, or contraindicated medications, as appropriate
Facilitate changes in medication with physician, as appropriate
Monitor for response to changes in medication regimen, as appropriate
Determine the patient's knowledge about medication
Monitor adherence with medication regimen
Determine factors that may preclude the patient from taking drugs as prescribed
Develop strategies with the patient to enhance compliance with prescribed medication regimen
Consult with other health care professionals to minimize the number of drugs and frequency of doses needed for a therapeutic effect
Teach patient and/or family members the method of drug administration, as appropriate
Teach patient and/or family members the expected action and side effects of the medication
Provide patient and family members with written and illustrated information to enhance self-administration of medications, as appropriate
Develop strategies to manage side effects of drugs
Obtain physician order for patient self-medication, as appropriate
Establish a protocol for the storage, restocking, and monitoring of medications left at the bedside for self-medication purposes
Investigate possible financial resources for acquisition of prescribed drugs, as appropriate
Determine impact of medication use on patient's lifestyle
Provide alternatives for timing and modality of self-administered medications to minimize lifestyle effects
Assist the patient and family members in making necessary lifestyle adjustments associated with certain medications, as appropriate
Instruct patient when to seek medical attention
Identify types and amounts of over-the-counter drugs used
Provide information about the use of over-the-counter drugs and how they may influence the existing condition
Determine whether the patient is using culturally based home health remedies and the possible effects on use of over-the-counter and prescribed medications
Review with the patient strategies for managing medication regimen
Provide patient with a list of resources to contact for further information about the medication regimen
Contact patient and family after discharge, as appropriate, to answer questions and discuss concerns associated with the medication regimen
Encourage the patient to have screening tests to determine medication effects

Background Readings:

Le Sage, J. (1991). Polypharmacy in geriatric patients. Nursing Clinics of North America, 26(2), 273-290.
Malseed, R.T. (1990). Pharmacology drug therapy and nursing considerations (3rd ed.). Philadelphia: J.B. Lippincott.
Mathewson, M.J. (1986). Pharmacotherapeutics: A nursing approach. Philadelphia: F.A. Davis.
Weitzel, E.A. (1992). Medication management. In G.M. Bulechek & J.C. McCloskey (Eds.), Nursing interventions: Essential nursing treatments (2nd ed.) (pp. 213-220). Philadelphia: W.B. Saunders.

Multidisciplinary Care Conference (CONFILL and CONFINJ)

***Definition*[1]*:* Planning and evaluating patient care with health professionals from other disciplines as related to illness or injury.**

Multidisciplinary Care Conference (illness) CONFILL
Multidisciplinary Care Conference (injury) CONFINJ

Activities:

Summarize health status data pertinent to patient care planning
Identify current nursing diagnoses
Describe nursing interventions being implemented
Describe patient and family responses to nursing interventions
Seek input about effectiveness of nursing interventions
Discuss progress toward goals
Revise patient care plan, as necessary
Solicit input for patient care planning
Establish mutually agreeable goals
Review discharge plans
Discuss referrals, as appropriate
Recommend changes in treatment plan, as necessary
Provide data to facilitate evaluation of patient care plan
Clarify responsibilities related to implementation of patient care plan

Background Readings:

Mariano, C. (1989). The case for interdisciplinary collaboration. Nursing Outlook, 37(6), 285-288.
Richardson, A.T. (1986). Nurses interfacing with other members of the team. In D.A. England (Ed.), Collaboration in nursing (pp. 163-185). Rockville, MD: Aspen.

[1] Delaware definition differentiates between intervention related to illness or injury.

Nausea Management (NAUSEA)

Definition: **Prevention and alleviation of nausea.**

Activities:

Encourage patient to monitor own nausea experience
Encourage patient to learn strategies for managing own nausea
Perform complete assessment of nausea including frequency, duration, severity, and precipitating factors, using such tools as Self-Care Journal, Visual Analog Scales, Duke Descriptive Scales, and Rhodes Index of Nausea and Vomiting (INV) Form 2
Observe for nonverbal cues of discomfort, especially for infants, children, and those unable to communicate effectively, such as individuals with Alzheimer's disease
Evaluate past experiences with nausea (e.g., pregnancy and car sickness)
Obtain a complete pretreatment history
Obtain dietary history including the person's likes dislikes and cultural food preferences
Evaluate the impact of nausea experience on quality of life (e.g., appetite, activity, job performance, role responsibility, and sleep)
Identify factors (e.g., medication and procedures) that may cause or contribute to nausea
Ensure that effective antiemetic drugs are given to prevent nausea when possible (except for nausea related to pregnancy)
Control environmental factors that may evoke nausea (e.g., aversive smells, sound and unpleasant visual stimulation)
Reduce or eliminate personal factors that precipitate or increase the nausea (anxiety, fear, fatigue and lack of knowledge)
Identify strategies that have been successful in relieving nausea
Demonstrate acceptance of nausea and collaborate with the patient when selecting a nausea control strategy
Consider the cultural influence on nausea response while implementing intervention
Encourage not to tolerate nausea but to be assertive with health care providers in obtaining pharmacological and nonpharmacological relief
Teach the use of nonpharmacological techniques (e.g., biofeedback, hypnosis, relaxation, guided imagery, music therapy, distraction, acupressure) to manage nausea
Encourage the use of nonpharmacological techniques before, during and after chemotherapy; before nausea occurs or increases; and along with other nausea control measures
Inform other health care professionals and family members of any nonpharmacological strategies being used by the nauseated person
Promote adequate rest and sleep to facilitate nausea relief
Use frequent oral hygiene to promote comfort, unless it stimulates nausea
Encourage eating small amounts of food that are appealing to the nauseated person
Instruct on high-carbohydrate and low-fat food, as appropriate
Give cold, clear liquid and odorless and colorless food, as appropriate
Monitor recorded intake for nutritional content and calories
Weigh patient regularly
Provide information about the nausea, such as causes of the nausea and how long it will last
Assist to seek and provide emotional support
Monitor effects of nausea management throughout

Background Readings:

Fessele, K.S. (1996). Managing the multiple causes of nausea and vomiting in the patient with cancer. Oncology Nursing Forum, 23(9), 1409-1417.
Grant, M. (1987). Nausea, vomiting, and anorexia. Seminars in Oncology Nursing, 3(4), 227-286.
Hogan, C., M. (1990). Advances in the management of nausea and vomiting. Nursing Clinics of North America, 25(2), 475-497.
Hablonski, R.S. (1993). Nausea: The forgotten symptom. Holistic Nursing Practice, 7(2), 64-72.
Larson, P., Halliburton, P., & Di Julio, J. (1993). Nausea, vomiting, and retching. In V. Carrier-Kohlman, A.M. Lindsey, & C.M. West (Eds.), Pathophysiological phenomena in nursing human responses to illness. Philadelphia: W.B. Saunders Company.
Rhodes, V.A. (1990). Nausea, vomiting, and retching. Nursing Clinics of North America, 25(4), 885-900.

Neurologic Monitoring (NEURO)

Definition: **Collection and analysis of patient data to prevent or minimize neurologic complications.**

Activities:

Monitor pupillary size, shape, symmetry, and reactivity
Monitor level of consciousness
Monitor level of orientation
Monitor trend of Glascow Coma Scale
Monitor recent memory, attention span, past memory, mood, affect, and behaviors
Monitor vital signs: temperature, blood pressure, pulse, and respirations
Monitor respiratory status: ABG levels, pulse oximetry, depth, pattern, rate, and effort
Monitor ICP and CPP
Monitor corneal reflex
Monitor cough and gag reflex
Monitor muscle tone, motor movement, gait, and proprioception
Monitor for pronator drift
Monitor grip strength
Monitor for tremor
Monitor facial symmetry
Monitor tongue protrusion
Monitor for tracking response
Monitor EOMs and gaze characteristics
Monitor for visual disturbance: diplopia, nystagmus, visual field cuts, blurred vision, and visual acuity
Note complaint of headache
Monitor speech characteristics: fluency, presence of aphasias, or word-finding difficulty
Monitor response to stimuli: verbal, tactile, and noxious
Monitor sharp/dull and hot/cold discrimination
Monitor for paresthesia: numbness and tingling
Monitor sense of smell
Monitor sweating patterns
Monitor Babinski response
Monitor for Cushing response
Monitor dressings for drainage
Monitor response to medications
Consult with co-workers to confirm data, as appropriate
Identify emerging patterns in data
Increase frequency of neurologic monitoring, as appropriate
Avoid activities that increase intracranial pressure
Space required nursing activities that increase intracranial pressure
Notify physician of change in patient's condition
Institute emergency protocols, as needed

Background Readings:

Ackerman, L.L. (1992). Interventions related to neurological care. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 325-346.

Allan, D. (1986). Management of the head injured patient. Nursing Times, 82(25), 36-39.

Alspach, J.G. (Ed.). (1991). Core curriculum for critical care nursing (4th ed.). Philadelphia: W.B. Saunders.

Ammons, A.M. (1990). Cerebral injuries and intracranial hemorrhages as a result of trauma. Nursing Clinics of North America, 25(1), 23-34.

Cammermeyer, M., & Appeldorn, C. (Eds.). (1990). Core curriculum for neuroscience nursing (3rd ed.) (pp. Val-Val8 & Vbl-Vb5). Chicago: American Association of Neuroscience Nurses.

Crosby, L., & Parsons, L.C. (1989). Clinical neurologic assessment tool: Development and testing of an instrument to index neurologic status. Heart & Lung, 18(2), 121-125.

Hickey, J.V. (1992). The clinical practice of neurological and neurosurgical nursing (3rd ed.). Philadelphia: J.B. Lippincott.

Mitchell, P.H., & Ackerman, L.L. (1992). Secondary brain injury reduction. In G.M. Bulechek & J.C. McCloskey (Eds.), Nursing interventions: Essential nursing treatments (2nd ed.) (pp. 558-573). Philadelphia: W.B. Saunders.

Price, M.B., & Vroom, H.L. (1985). A quick and easy guide to neurological assessment. Journal of Neurosurgical Nursing, 17(5), 313-320.

Titler, M.G. (1992). Interventions related to surveillance. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 495-516.

Non-Nursing Intervention (NONNURSE)

Definition: **Providing service not required nursing skills/expertise.**

Nursing Assessment, No Intervention (NASS)

Definition: **Providing assessment requiring professional nursing knowledge and skills without related intervention.**

Nursing Intervention (NURSE)

Definition*[1]*: **Intervention requiring professional nursing knowledge and skills (not available on current Delaware NIC list).**

[1] Delaware definition.

Nutrition Management (NUTMGT)

Definition: **Assisting with or providing a balanced dietary intake of foods and fluids.**

Activities:

Inquire if patient has any food allergies
Ascertain patient's food preferences
Determine, in collaboration with dietician as appropriate, number of calories and type of nutrients needed to meet nutrition requirements
Encourage calorie intake appropriate for body type and lifestyle
Encourage increased intake of protein, iron, and vitamin C, as appropriate
Offer snacks (e.g.; frequent drinks, fresh fruits/fruit juice), as appropriate
Give light, pureed, and bland foods, as appropriate
Provide a sugar substitute, as appropriate
Ensure that diet includes foods high in fiber content to prevent constipation
Offer herbs and spices as an alternative to salt
Provide patient with high-protein, high-calorie, nutritious finger foods and drinks that can be readily consumed, as appropriate
Provide food selection
Adjust diet to patient's lifestyle, as appropriate
Teach patient how to keep a food diary, as needed
Monitor recorded intake for nutritional content and calories
Weigh patient at appropriate intervals
Encourage patient to wear properly fitted dentures and/or obtain dental care
Provide appropriate information about nutritional needs and how to meet them
Encourage safe food preparation and preservation techniques
Determine patient's ability to meet nutritional needs
Assist patient in receiving help from appropriate community nutritional programs, as needed.

Background Readings:

Mahan, L.K. (1996). Krause's food nutrition and diet therapy (pp. 403-423). Philadelphia: Saunders.
Thelan, L.A. and Urden, L.D. (1998). Critical care nursing: Diagnosis and management (3rd ed.). St. Louis: Mosby – Year Book.
Whitney, E.N. & Cataldo, C.B. (1991). Understanding normal and clinical nutrition (3rd ed.). St. Paul, MN: West Publishing.

Nutrition, Special Diet (SPDIET)

Definition*[1]*: **Modification and monitoring of special diet.**

Activities:

Inquire if patient has any food allergies
Ascertain patient's food preferences
Determine, in collaboration with dietician as appropriate, number of calories and type of nutrients needed to meet nutrition requirements
Encourage calorie intake appropriate for body type and lifestyle
Encourage increased intake of protein, iron and vitamin C, as appropriate
Offer snacks (e.g., frequent drinks, fresh fruits/fruit juice), as appropriate
Give light, pureed and bland foods, as appropriate
Provide a sugar substitute, as appropriate
Ensure that diet includes foods high in fiber content to prevent constipation
Provide patient with high-protein, high-calorie, nutritious finger foods and drinks that can be readily consumed, as appropriate
Provide food selection, as appropriate
Teach patient how to keep a food diary, as needed
Monitor recorded intake for nutritional content and calories
Weigh patient at appropriate or specified intervals
Provide appropriate information about nutritional needs and how to meet them
Encourage safe food preparation and preservation techniques
Determine patient's ability to meet nutritional needs
Assist patient in receiving help from appropriate community nutritional programs, as needed
Monitor trends in weight loss and gain
Monitor type and amount of usual exercise
Monitor environment where eating occurs
Schedule treatment and procedures at times other than feeding times
Monitor for symptoms of inadequate nutritional intake
Monitor growth and development
Determine whether the patient needs a special diet

Background Readings:

Mahan, L.K. (1996). Krause's food nutrition and diet therapy (pp. 403-423). Philadelphia: Saunders.
Thelan, L.A. and Urden, L.D. (1998). Critical care nursing: Diagnosis and management (3rd ed.). St. Louis: Mosby – Year Book.
Whitney, E.N. & Cataldo, C.B. (1991). Understanding normal and clinical nutrition (3rd ed.). St. Paul, MN: West Publishing.

[1] Delaware definition incorporates aspects of NIC's "Nutrition Management" and "Nutrition Limiting."

Ostomy Care (OSTO)

Definition: **Maintenance of elimination through a stoma and care of surrounding tissue.**

Activities:

Instruct patient/family in the use of ostomy equipment/care
Have patient/significant other demonstrate use of equipment
Assist patient in obtaining needed equipment
Apply appropriately fitting ostomy appliance, as needed
Monitor for incision/stoma healing
Monitor for postop complications, such as intestinal obstruction, paralytic ileus, anastomotic leaks, mucocutaneous separation, as appropriate
Monitor stoma/surrounding tissue healing and adaptation to ostomy equipment
Change/empty ostomy bag, as appropriate
Irrigate ostomy, as appropriate
Assist patient in providing self-care
Encourage patient/significant other to express feelings and concerns about changes in body image
Explore patient's care of ostomy
Explain to the patient what the ostomy care will mean to his/her day-to-day routine
Assist patient to plan time for care routine
Instruct patient how to monitor for complications (e.g., mechanical breakdown, chemical breakdown, rash, leaks, dehydration, infection)
Instruct patient on mechanisms to reduce odor
Monitor elimination patterns
Assist patient to identify factors that affect elimination pattern
Instruct patient/significant other in appropriate diet and expected changes in elimination function
Provide support and assistance while patient develops skill in caring for stoma/surrounding tissue
Teach patient to chew thoroughly, avoid foods that caused digestive upset in the past, add new foods one at a time, and drink plenty of fluids
Discuss concerns about sexual functioning, as appropriate
Encourage visitation by persons from support group who have same condition
Express confidence that patient can resume normal life with ostomy
Encourage participation in ostomy support groups after discharge

Background Readings:

Bradley, M., & Pupiales, M. (1997). Essential elements of ostomy care. American Journal of Nursing, 97(7), 38-46.
Craven, R.F., & Hirnle, C.J. (2000) Fundamentals of nursing: Human health and function (3rd ed.) (pp. 1109-1112). Philadelphia: Lippincott.
Innes, B.S. (1986). Meeting bowel elimination needs. In K.C. Sorenson & J. Luckmann (Eds.), Basic nursing (pp. 827-851). Philadelphia: W.B. Saunders.
O'Shea, H.S. (2001). Teaching the adult ostomy patient. Journal of Wound Ostomy and Continence Nurses Society, 28(1), 47-54.

Pain Management (PAIN)

Definition: **Alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient.**

Activities:

Perform a comprehensive assessment of pain to include location, characteristics, onset/duration, frequency, quality, intensity or severity of pain, and precipitating factors
Observe for nonverbal cues of discomfort, especially in those unable to communicate effectively
Ensure that patient receives attentive analgesic care
Use therapeutic communication strategies to acknowledge the pain experience & convey acceptance of the patient's response to pain
Explore patient's knowledge and beliefs about pain
Consider cultural influences on pain response
Determine the impact of the pain experience on quality of life (e.g., sleep, appetite, activity, cognition, mood, relationships, performance of job, and role responsibilities)
Explore with patient factors that relieve/worsen pain
Evaluate past experiences with pain to include individual or family history of chronic pain or resulting disability, as appropriate
Evaluate, with the patient and the health care team, the effectiveness of past pain control measures that have been used
Assist patient and family to seek and obtain support
Utilize a developmentally appropriate assessment method that allows for monitoring of change in pain and that will assist in identifying actual and potential precipitating factors (e.g., flow sheet, daily diary)
Determine the needed frequency of making an assessment of patient comfort and implement monitoring plan
Provide information about the pain, such as causes of the pain, how long it will last, and anticipated discomforts from procedures
Control environmental factors that may influence the patient's response to discomfort (e.g., room temperature, lighting, noise)
Reduce or eliminate factors that precipitate or increase the pain experience (e.g., fear, fatigue, monotony, and lack of knowledge)
Consider the patient's willingness to participate, ability to participate, preference, support of significant others for method, and contraindications when selecting a pain relief strategy
Select & implement a variety of measures (e.g., pharmacological, nonpharmacological, interpersonal) to facilitate pain relief, as appropriate
Teach principles of pain management
Consider type and source of pain when selecting pain relief strategy
Encourage patient to monitor own pain and to intervene appropriately
Teach the use of nonpharmacological techniques (e.g., biofeedback, TENS, hypnosis, relaxation, guided imagery, music therapy, distraction, play therapy, activity therapy, acupressure, hot/cold application, and massage) before, after, and, if possible, during painful activities; before pain occurs or increases; and along with other pain relief measures
Explore patient's current use of pharmacological methods of pain relief
Teach about pharmacological methods of pain relief
Encourage patient to use adequate pain medication
Collaborate with the patient, significant other, and other health professionals to select and implement nonpharmacological pain relief measures, as appropriate
Provide the person optimal pain relief with prescribed analgesics
Implement the use of patient-controlled analgesia (PCA), if appropriate
Use pain control measures before pain becomes severe
Verify level of discomfort with patient, note changes in the medical record, inform other health professionals working with the patient
Evaluate the effectiveness of the pain control measures used through ongoing assessment of the pain experience
Institute and modify pain control measures on the basis of the patient's response
Promote adequate rest/sleep to facilitate pain relief
Encourage patient to discuss his/her pain experience, as appropriate
Notify physician if measures are unsuccessful or if current complaint is a significant change from patient's past experience of pain
Inform other health care professionals/family members of nonpharmacological strategies being used by the patient to encourage preventive approaches to pain management
Utilize a multidisciplinary approach to pain management, when appropriate
Consider referrals for patient, family, and significant others to support groups, and other resources, as appropriate
Provide accurate information to promote family's knowledge of and response to the pain experience
Incorporate the family in the pain relief modality, if possible
Monitor patient satisfaction with pain management at specified intervals

Background Readings:

Acute Pain Management Guideline Panel. (1992). Acute pain management: Operative or medical procedures and trauma. Clinical practice guideline. AHCPR Pub. No. 92-0032. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services.
Herr, K.A., & Mobily, P.R. (1992). Interventions related to pain. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 347-370.
McCaffery, M., & Pasero, C. (1999). Pain. Clinical manual for nursing practice (2nd ed.). St. Louis: Mosby–Year Book.
McGuire, L. (1994). The nurse's role in pain relief. Medsurg Nursing, 3(2), 94-107.
Mobily, P.R., & Herr, K.A. (2000). Pain. In M. Maas, K. Buckwalter, M. Hardy, T. Tripp-Reimer, M. Titler, & J. Specht (Eds.), Nursing diagnosis, interventions, and outcomes for elders (2nd ed.). Thousand Oaks, CA: Sage Publications.
Perry, A.G., & Potter, P.A. (2000). Clinical nursing skills and techniques (pp. 84-101). St. Louis: Mosby–Year Book.
Rhiner, M. (1999), Managing breakthrough pain: A new approach. American Journal of Nursing, March Suppl., 3-12.
Titler, M.G., & Rakel, B.A. (2001). Nonpharmacologic treatment of pain. Critical Care Nursing Clinics of North America, 13(2), 221-232.
Victor, K. (2001). Properly assessing pain in the elderly. RN, 64(5), 45-49.

Positioning (POSI)

Definition: **Deliberative placement of the patient or a body part to promote physiological and/or psychological well-being.**

Activities:

Place on an appropriate therapeutic mattress/bed
Provide a firm mattress
Explain to the patient that he/she is going to be turned, as appropriate
Encourage the patient to get involved in positioning changes, as appropriate
Monitor oxygenation status before and after position change
Premedicate patient before turning, as appropriate
Place in the designated therapeutic position
Incorporate preferred sleeping position into the plan of care, if not contraindicated
Position in proper body alignment
Immobilize or support the affected body part, as appropriate
Elevate the affected body part, as appropriate
Position to alleviate dyspnea (e.g., semi-Fowler position), as appropriate
Provide support to edematous areas (e.g., pillow under arms and scrotal support), as appropriate
Position to facilitate ventilation/perfusion matching ("good lung down"), as appropriate
Encourage active or passive range-of-motion exercises, as appropriate
Provide appropriate support for the neck
Avoid placing a patient in a position that increases pain
Avoid placing an amputation stump in the flexion position
Minimize friction and shearing forces when positioning and turning the patient
Apply a footboard to the bed
Turn using the log roll technique
Position to promote urinary drainage, as appropriate
Position to avoid placing tension on the wound, as appropriate
Prop with a backrest, as appropriate
Elevate affected limb 20 degrees or greater, above the level of the heart, to improve venous return, as appropriate
Instruct the patient how to use good posture and good body mechanics while performing any activity
Monitor traction devices for proper setup
Maintain position and integrity of traction
Elevate head of the bed, as appropriate
Turn as indicated by skin condition
Develop a written schedule for repositioning, as appropriate
Turn the immobilized patient at least every 2 hours, according to a specific schedule, as appropriate
Use appropriate devices to support limbs (e.g., hand roll and trochanter roll)
Place frequently used objects within reach
Place bed-positioning switch within easy reach
Place the call light within reach

Background Readings:

Metzler, D., & Finesilver, C. (1999). Positioning. In G.M. Bulechek & J.C. McCloskey, (Eds.), Nursing interventions: Effective nursing treatments (3rd ed.). Philadelphia: W.B. Saunders.

Sundberg, M.C. (1989). Alterations in mobility. In M.C. Sundberg, (Ed.), Fundamentals of nursing: With clinical procedures (2nd ed.) (pp. 767-807). Boston: Jones & Bartlett.

Titler, M.G., Pettit, D., Bulechek, G.M., McCloskey, J.C., Craft, M.J., Cohen, M.Z., Crossley, J.D., Denehy, J.A., Glick, O.J., Kruckeberg, T.W., Maas, M.L., Prophet, C.M., & Tripp-Reimer T. (1991). Classification of nursing interventions for care of the integument. Nursing Diagnosis, 2(2), 45-56.

Preventative Care (PREVCAR)

***Definition*[1]*:* Prevention of medical condition for an individual at high risk for developing them.**

Activities:
Use an established risk assessment tool to monitor individual's risk factors
Utilize appropriated methods to reduce risk

Background Readings:
McCaffery, M., & Beebe, A. (1989). Pain: Clinical manual for nursing practice. St. Louis: Mosby.
Scandrett, S., & Uecker, S. (1992). Relaxation training. In G.M. Bulechek & J.C. McCloskey (Eds.), Nursing interventions: Essential nursing treatments (2nd ed.) (pp. 434-461). Philadelphia: W.B. Saunders.
Snyder, M. (1998). Progressive muscle relaxation. In M. Snyder & R. Lindquist. (Eds.), Complementary/alternative therapies in nursing (3rd ed.) (pp. 1-13). New York: Springer Publishing Company.

[1] Delaware definition.

Progressive Muscle Relaxation (MURELX)

Definition: **Facilitating the tensing and releasing of successive muscle groups while attending to the resulting differences in sensation.**

Activities:

Choose a quiet, comfortable setting
Subdue the lighting
Take precautions to prevent interruptions
Seat patient in a reclining chair, or otherwise make comfortable
Instruct patient to wear comfortable, nonrestrictive clothing
Screen for neck or back orthopedic injuries in which hyperextension of the upper spine would add discomfort and complications
Screen for increased intracranial pressure, capillary fragility, bleeding tendencies, severe acute cardiac difficulties with hypertension, or other conditions in which tensing muscles might produce greater physiological injury, and modify the technique, as appropriate
Instruct patient in jaw relaxation exercise
Have the patient tense, for 5 to 10 seconds, each of 8 to 16 major muscle groups
Tense the foot muscles for no longer than 5 seconds to avoid cramping
Instruct patient to focus on the sensations in the muscles while they are tensed
Instruct patient to focus on the sensations in the muscles while they are relaxed
Check periodically with the patient to ensure that the muscle group is relaxed
Have the patient tense the muscle group again, if relaxation is not experienced
Monitor for indicators of nonrelaxation, such as movement, uneasy breathing, talking, and coughing
Instruct the patient to breathe deeply and to slowly let the breath and tension out
Develop a personal relaxation "patter" that helps the patient to focus and feel comfortable
Terminate the relaxation session gradually
Allow time for the patient to express feelings concerning the intervention
Encourage the patient to practice between regular sessions with the nurse

Background Readings:

McCaffery, M., & Beebe, A. (1989). Pain: Clinical manual for nursing practice. St. Louis: Mosby.
Scandrett, S., & Uecker, S. (1992). Relaxation training. In G.M. Bulechek & J.C. McCloskey (Eds.), Nursing interventions: Essential nursing treatments (2nd ed.) (pp. 434-461). Philadelphia: W.B. Saunders.
Snyder, M. (1998). Progressive muscle relaxation. In M. Snyder & R. Lindquist. (Eds.), Complementary/alternative therapies in nursing (3rd ed.) (pp. 1-13). New York: Springer Publishing Company.

Referral Management[1] (REFMGT)

Definition: **Arrangement for services by another care provider or agency.**

Activities:

Perform ongoing monitoring to determine the need for referral
Identify preference of patient/family/significant others for referral agency
Identify health care providers' recommendation for referral, as needed
Identify nursing/health care required
Evaluate strengths and weaknesses of family/significant others for responsibility of care
Evaluate accessibility of environmental needs for the patient in the home/community
Arrange for appropriate healthcare provider services, as needed
Encourage an assessment visit by receiving agency or other care provider, as appropriate
Contact appropriate agency/health care provider
Complete appropriate referral
Discuss patient's plan of care with next health care provider

Background Readings:

Bowles, K.H., Naylor, M.D., & Foust, J.B. (2002). Patient characteristics at hospital discharge and a comparison of home care referral decisions. Journal of the American Geriatrics Society, 50 (2), 336-342.

McClelland, E., Kelly, K., & Buckwalter, K.C. (1985). Continuity of care: Advancing the concept of discharge planning. New York: Harcourt Brace Jovanovich.

McKeehan, K.M. (1981). Continuing care. St. Louis: Mosby.

[1] Delaware uses term "Referral Arrangement" for NIC's "Referral."

Respiratory Monitoring (RESP)

Definition: **Collection and analysis of patient data to ensure airway patency and adequate gas exchange.**

Activities:

Monitor rate, rhythm, depth, and effort of respirations
Note chest movement, watching for symmetry, use of accessory muscles, and supraclavicular and intercostal muscle retractions
Monitor for noisy respirations, such as crowing or snoring
Monitor breathing patterns: bradypnea, tachypnea, hyperventilation, Kussmaul respirations, Cheyne-Stokes respirations, apneustic breathing, Biot's respiration, and ataxic patterns
Palpate for equal lung expansion
Percuss anterior and posterior thorax from apices to bases bilaterally
Note location of trachea
Monitor for diaphragmatic muscle fatigue (paradoxical motion)
Auscultate breath sounds, noting areas of decreased/absent ventilation and presence of adventitious sounds
Determine the need for suctioning by auscultating for crackles and rhonchi over major airways
Auscultate lung sounds after treatments to note results
Monitor mechanical ventilator readings, noting increases in inspiratory pressures and decreases in tidal volume, as appropriate
Monitor for increased restlessness, anxiety, and air hunger
Monitor patient's ability to cough effectively
Note onset, characteristics, and duration of cough
Monitor patient's respiratory secretions
Monitor for dyspnea and events that decrease and worsen it
Monitor for hoarseness and voice changes every hour in patients with facial burns
Monitor for crepitus, as appropriate
Open the airway, using the chin lift or jaw thrust technique, as appropriate
Place the patient on side, as indicated, to prevent aspiration; log roll if cervical aspiration is suspected
Institute resuscitation efforts, as needed
Institute respiratory therapy treatments (e.g., nebulizer), as needed

Background Readings:

Capps, J.S., & Schade, K. (1988). Work of breathing: Clinical monitoring and considerations in the critical care setting. Critical Care Nursing Quarterly, 11(3), 1-11.
Carrol, P. (1999). Evolutions/revolutions: Respiratory monitoring: Revolutions: continuous spirometry. RN, 62(5), 72-74, 77-78.
Carroll, P. (1999). Evolutions/revolutions respiratory monitoring: Evolutions: capnography. RN, 62(5), 68-71, 78.
Lane, G.H. (1990). Pulmonary therapeutic management. In L.A. Thelan, J.K. Davie, & L.D. Urden (Eds.), Textbook of critical care nursing (pp. 444-471). St. Louis: Mosby.
Nelson, D.M. (1992). Interventions related to respiratory care. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 301-324.

Rest (REST)

***Definition*[1]*:* Providing environment and supervision to facilitate rest/sleep <u>after</u> nursing evaluation.**

Activities:
Perform nursing assessment
Provide space and supervision for patient to rest or sleep during school hours
Monitor/evaluate response to rest

[1] Delaware classification and definition.

Seizure Management (SZR)

Definition: **Care of a patient during a seizure and the postictal state.**

Activities:
Guide movements to prevent injury
Monitor direction of head and eyes during seizure
Loosen clothing
Remain with patient during seizure
Maintain airway
Apply oxygen, as appropriate
Monitor neurological status
Monitor vital signs
Reorient after seizure
Record length of seizure
Record seizure characteristics: body parts involved, motor activity, and seizure progression
Document information about seizure
Administer medication, as appropriate
Administer anticonvulsants, as appropriate
Monitor postictal period duration and characteristics

Background Readings:

Ackerman, L.L. (1992). Interventions related to neurological care. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 325-346.

Brewer, K., & Sperling, M.R. (1988). Neurosurgical treatment of intractible epilepsy. Journal of Neuroscience Nursing, 20(6), 366-372.

Cammermeyer, M., & Appledorn, C. (Eds.). (1990). Core curriculum for neuroscience nursing (3rd ed.) (pp. Ig1-Ig3). Chicago: American Association of Neuroscience Nurses.

Graham, O., Naveau, I., & Cummings, C. (1989). A model for ambulatory care of patients with epilepsy and other neurological disorders. Journal of Neuroscience Nursing, 21(2), 108-112.

Johanson, B.C., Wells, S.J., Hoffmeister, D., & Dungca, C.U. (1988). Standards for critical care (3rd ed.). St. Louis: Mosby.

LeMone, P., & Burke, K.M. (2000). Medical-surgical nursing: Critical thinking in client care, (2nd ed.) (pp. 1719-1727). Upper Saddle River, NJ: Prentice Hall Health

Santilli, N., & Sierzant, T.L. (1987). Advances in the treatment of epilepsy. Journal of Neuroscience Nursing, 19(3), 141-155.

Seizure Precautions (SZRPRE)

Definition: **Prevention or minimization of potential injuries sustained by a patient with a known seizure disorder.**

Activities:

Provide low-height bed, as appropriate
Escort patient during off-ward activities, as appropriate
Monitor drug regimen
Monitor compliance in taking antiepileptic medications
Have patient/significant other keep record of medications taken and occurrence of seizure activity
Instruct patient not to drive
Instruct patient about medications and side effects
Instruct family/significant other about seizure first aid
Monitor antiepileptic drug levels, as appropriate
Instruct patient to carry medication alert card
Remove potentially harmful objects from the environment
Keep suction at bedside
Keep ambu bag at bedside
Keep oral or nasopharyngeal airway at bedside
Use padded side rails
Keep side rails up
Instruct patient on potential precipitating factors
Instruct patient to call if aura occurs

Background Readings:

Ackerman, L.L. (1992). Interventions related to neurological care. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 325-346.

Brewer, K., & Sperling, M.R. (1988). Neurosurgical treatment of intractible epilepsy. Journal of Neuroscience Nursing, 20(6), 366-372.

Cammermeyer, M., & Appledorn, C. (Eds.). (1990). Core curriculum for neuroscience nursing (3rd ed.) (pp. Ig1-Ig3). Chicago: American Association of Neuroscience Nurses.

Graham, O., Naveau, I., & Cummings, C. (1989). A model for ambulatory care of patients with epilepsy and other neurological disorders. Journal of Neuroscience Nursing, 21(2), 108-112.

Johanson, B.C., Wells, S.J., Hoffmeister, D., & Dungca, C.U. (1988). Standards for critical care (3rd ed.). St. Louis: Mosby.

LeMone, P., & Burke, K.M. (2000). Medical-surgical nursing: Critical thinking in client care, (2nd ed.) (pp. 1719-1727). Upper Saddle River, NJ: Prentice Hall Health.

Santilli, N., & Sierzant, T.L. (1987). Advances in the treatment of epilepsy. Journal of Neuroscience Nursing, 19(3), 141-155.

Self-Care Assistance (SELFNUR and SELFNON)

Definition*[1]*: **Assisting another to perform activities of daily living.**

Self-Care Assistance, Nursing SELFNUR
Self-Care Assistance, Non-Nursing SELFNON

Activities:

Monitor patient's ability for independent self-care
Monitor patient's need for adaptive devices for personal hygiene, dressing, grooming, toileting, and eating
Provide desired personal articles (e.g., deodorant, toothbrush, and bath soap)
Provide assistance until patient is fully able to assume self-care
Assist patient in accepting dependency needs
Use consistent repetition of health routines as a means of establishing them
Encourage patient to perform normal activities of daily living to level of ability
Encourage independence, but intervene when patient is unable to perform
Teach parents/family to encourage independence, to intervene only when the patient is unable to perform
Establish a routine for self-care activities
Consider age of patient when promoting self-care activities

Background Readings:

Lantz, J., Penn, C., Stamper, J., & Natividad, P. (1991). Self-care deficit. In M. Maas, K. Buckwalter, & M. Hardy (Eds.), Nursing diagnoses and interventions for the elderly (pp. 285-312). Redwood City, CA: Addison-Wesley.

Potter, P.A., & Perry, A.G. (1998). Fundamentals of nursing: Concepts, process, and practice (4th ed.). St. Louis: Mosby.

Sorensen, K., & Luckmann, J. (1986). Basic nursing: A psychophysiologic approach (2nd ed.). Philadelphia: W.B. Saunders.

Styker, R. (1977). Rehabilitative aspects of acute and chronic nursing care. Philadelphia: W.B. Saunders.

Taylor, C.M. (1987). Nursing diagnosis cards. Springhouse, PA: Springhouse.

[1] Delaware definition differentiates between medically necessary and non-medically necessary interventions.

Skin Care[1] (SKIN)

Definition: **Application of topical substances or manipulation of devices to promote skin integrity and minimize skin breakdown.**

Activities:

Avoid using rough-textured bed linens
Clean with antibacterial soap, as appropriate
Dress patient in nonrestrictive clothing
Dust the skin with medicated powder, as appropriate
Remove adhesive tape and debris
Provide support to edematous areas (e.g., pillow under arms and scrotal support), as appropriate
Apply lubricant to moisten lips and oral mucosa, as needed
Administer back rub/neck rub, as appropriate
Change condom catheter, as appropriate
Apply diapers loosely, as appropriate
Place on incontinence pads, as appropriate
Massage around the affected area
Apply appropriately fitting ostomy appliance, as needed
Cover the hands with mittens, as appropriate
Provide toilet hygiene, as needed
Refrain from giving local heat applications
Refrain from using an alkaline soap on the skin
Soak in a colloidal bath, as appropriate
Keep bed linen clean, dry, and wrinkle free
Turn the immobilized patient at least every 2 hours, according to a specific schedule
Use devices on the bed (e.g., sheepskin) that protect the patient
Apply heel protectors, as appropriate
Apply drying powders to deep skin folds
Initiate consultation services of the enterostomal therapy nurse, as needed
Apply clear occlusive dressing (e.g., Tegaderm or Duoderm), as needed
Apply topical antibiotic to the affected area, as appropriate
Apply topical antiinflammatory agent to the affected area, as appropriate
Apply emollients to the affected area
Apply topical antifungal agent to the affected area, as appropriate
Apply topical debriding agent to the affected area, as appropriate
Inspect skin of patients at risk of breakdown daily
Document degree of skin breakdown
Add moisture to environment with a humidifier, as needed

Background Readings:

Frantz, R.A., & Gardner, S. (1994). Management of dry skin. Journal of Gerontological Nursing, 20(9), 15-18.

Hardy, M.A. (1992). Dry skin care. In G.M. Bulechek & J.C. McCloskey (Eds.), Nursing interventions: Essential nursing treatments (2nd ed.) (pp. 34-47). Philadelphia: W.B. Saunders.

Kemp, M.G. (1994). Protecting the skin from moisture and associated irritants. Journal of Gerontological Nursing, 20(9), 8-14.

Titler, M.G., Pettit, D., Bulechek, G.M., McCloskey, J.C., Craft, M.J., Cohen, M.Z., Crossley, J.D., Denehy, J.A., Glick, O.J., Kruckeberg, T.W., Maas, M.L., Prophet, C.M., & Tripp-Reimer, T. (1991). Classification of nursing interventions for care of the integument. Nursing Diagnosis, 2(2), 45-56.

[1] NIC terminology is "Skin Care: topical treatments"

Smoking Cessation Assistance (SMOKE and SMOKEG)

Definition*[1]*: **Helping patient to stop smoking through individual or group process.**

Smoking Cessation Assistance (individual) SMOKE
Smoking Cessation Assistance (group) SMOKEG

Activities:

Record current smoking status and smoking history
Determine patient's readiness to learn about smoking cessation
Monitor patient's readiness to attempt to quit smoking
Give smoker clear, consistent advice to quit smoking
Help patient identify reasons to quit and barriers to quitting
Instruct patient on the physical symptoms of nicotine withdrawal (e.g., headache, dizziness, nausea, irritability, and insomnia)
Reassure patient that physical withdrawal symptoms from nicotine are temporary
Inform patient about nicotine replacement products (e.g., patch, gum, nasal spray, inhaler) to help reduce physical withdrawal symptoms
Assist patient to identify psychosocial aspects (e.g., positive and negative feelings associated with smoking) that influence smoking behavior
Assist patient in developing a smoking cessation plan that addresses psychosocial aspects that influence smoking behavior
Assist patient to recognize cues that prompt him/her to smoke (e.g., being around others who smoke, frequenting places where smoking is allowed)
Assist patient to develop practical methods to resist cravings (e.g., spend time with nonsmoking friends, frequent places where smoking is not allowed, relaxation exercises)
Help choose best method for giving up cigarettes, when patient is ready to quit
Help motivated smokers to set a quit date
Provide encouragement to maintain a smoke-free lifestyle (e.g., make the quit day a celebration day; encourage self-rewards at specific intervals of smoke-free living, such as at 1 week, 1 month, 6 months; encourage saving money used previously on smoking materials to buy a special reward)
Encourage patient to join a smoking cessation support group that meets weekly
Refer to group programs or individual therapists, as appropriate
Assist patient with any self-help methods
Help patient plan specific coping strategies and resolve problems that result from quitting
Advise to avoid dieting while trying to give up smoking because it can undermine chances of quitting
Advise to work out a plan to cope with others who smoke and to avoid being around them
Inform patient that dry mouth, cough, scratchy throat, and feeling on edge are symptoms that may occur after quitting; the patch or gum may help with cravings
Advise patient to keep a list of "slips" or near slips, what causes them, and what he/she learned from them
Advise patient to avoid smokeless tobacco, dipping, and chewing as these can lead to addiction and/or health problems including oral cancer, gum problems, loss of teeth, and heart disease
Manage nicotine replacement therapy
Contact national and local resource organizations for resource materials
Follow patient for 2 years after quitting if possible, to provide encouragement
Arrange to maintain frequent telephone contact with patient (e.g., to acknowledge that withdrawal is difficult, to reinforce the importance of remaining abstinent, to offer congratulations on progress)
Help patient deal with any lapses (e.g., reassure patient that he/she is not a "failure," reassure that much can be learned from this temporary regression, assist patient in identifying reasons for the relapse)
Support patient who begins smoking again by helping to identify what has been learned
Encourage the relapsed patient to try again
Promote policies that establish and enforce smoke-free environment
Serve as a nonsmoking role model

Background Readings:

Lenaghan, N.A. (2000). The nurse's role in smoking cessation. MEDSURG Nursing, 9(6), 298-312.
O'Connell, K.A. (1990). Smoking cessation: Research on relapse crises. In J.J. Fitzpatrick, R.L. Taunton, & J.Z. Benoliel (Eds.), Annual Review of Nursing Research, 8, 83-100. New York: Springer Publishing.
O'Connell, K.A., & Koerin, C.A. (1999). Smoking cessation assistance. In G.M. Bulechek & J.C. McCloskey (Eds.), Nursing interventions: Effective nursing treatments (3rd ed.) (pp. 438-450). Philadelphia: W.B. Saunders.
U.S. Department of Health and Human Services. (1997). Smoking cessation: Clinical practice guideline No. 18. Rockville, MD: Agency for Health Care Policy & Research.
Wewers, M.E., & Ahijeoych, K.L. (1996). Smoking cessation interventions in chronic illness. In J.J. Fitzpatrick & J. Norbeck. (Eds.), Annual Review of Nursing Research, 14, 75-93.

[1] Delaware definition differentiates between individual and group intervention.

Substance Use Prevention (SUBAB and SUBABG)

***Definition*[1]*:* Prevention of an alcoholic or drug use lifestyle through an individual or group process.**

Substance Use Prevention (individual) SUBAB
Substance Use Prevention (group) SUBABG

Activities:

Assist individual to tolerate increased levels of stress, as appropriate
Prepare individual for difficult or painful events
Reduce irritating or frustrating environmental stress
Reduce social isolation, as appropriate
Support measures to regulate the sale and distribution of alcohol to minors
Recommend responsible changes in the alcohol and drug curricula for primary grades
Conduct programs in schools on the avoidance of drugs and alcohol as recreational activities
Encourage responsible decision making about lifestyle choices
Recommend media campaigns on substance use issues in the community
Instruct parents in the importance of example regarding substance use
Instruct parents and teachers in the identification of signs and symptoms of addiction
Assist individual to identify substitute tension-reducing strategies
Support or organize community groups to reduce injuries associated with alcohol, such as SADD and MADD
Survey students in grades 1 to 12 on the use of alcohol and drugs and alcohol-related behaviors
Instruct parents to support school policy that prohibits drug and alcohol consumption at extracurricular activities
Assist in the organization of substance-free activities for teenagers for such functions as prom and homecoming
Facilitate coordination of efforts between various community groups concerned with substance use
Encourage parents to participate in children's activities beginning in preschool through adolescence

Background Readings:

Finley, B. (1989). The role of the psychiatric nurse in the community substance abuse prevention program. Nursing Clinics of North America, 24(1), 121-136.
Hagemaster, J. (1999). Substance use prevention. In G.M. Bulechek & J.C. McCloskey (Eds.), Nursing interventions: Effective nursing treatments (3rd ed.) (pp. 482-490). Philadelphia: W.B. Saunders Company.
Hahn, E.J (1995). Predicting Head Start parent involvement in an alcohol and other drug prevention program. Nursing Research, 44(1), 45-51.
Solari-Twadell, P.A. (1990). Recreational drugs: Societal and professional issues. Nursing Clinics of North America, 26(2), 499-509

[1] Delaware definition differentiates between individual or group intervention.

Suicide Prevention (PRESUI)

Definition: **Reducing risk of self-inflicted harm with intent to end life.**

Activities:

Determine presence and degree of suicidal risk
Determine if patient has available means to follow through with suicide plan
Consider hospitalization of patient who is at serious risk for suicidal behavior
Treat and manage any psychiatric illness or symptoms that may be placing patient at risk for suicide (e.g., mood disorder, hallucinations, delusions, panic, substance abuse, grief, personality disorder, organic impairment, crisis)
Administer medications to decrease anxiety, agitation, or psychosis and to stabilize mood, as appropriate
Advocate for quality-of-life and pain control issues
Conduct mouth checks following medication administration to ensure that patient is not "cheeking" the medications for later overdose attempt
Provide small amounts of prescribed medications that may be lethal to those at risk to decrease the opportunity for suicide, as appropriate
Monitor for medication side effects and desired outcomes
Involve patient in planning his/her own treatment, as appropriate
Instruct patient in coping strategies (e.g., assertiveness training, impulse control, and progressive muscle relaxation), as appropriate
Contract (verbally or in writing) with patient for "no self-harm" for a specified period of time, recontracting at specified time intervals, as appropriate
Implement necessary actions to reduce an individual's immediate distress when negotiating a no-self-harm or safety contract
Identify immediate safety needs when negotiating a no–self-harm or safety contract
Assist the individual in discussing his/her feelings about the contract
Observe individual for signs of incongruence that may indicate lack of commitment to fulfilling the contract
Take action to prevent individual from harming or killing self, when contract is a no–self-harm or safety contract (e.g., increased observation, removal of objects that may be used to harm self)
Interact with the patient at regular intervals to convey caring and openness and to provide an opportunity for patient to talk about feelings
Use direct, nonjudgmental approach in discussing suicide
Encourage patient to seek out care providers to talk as urge to harm self occurs
Avoid repeated discussion of suicide history by keeping discussions present- and future-oriented
Discuss plans for dealing with suicidal ideation in the future (e.g., precipitating factors, whom to contact, where to go for help, ways to alleviate impulses to harm self)
Assist patient to identify network of supportive persons and resources (e.g., clergy, family care providers)
Initiate suicide precautions (e.g., ongoing observation and monitoring of the patient, provision of a protective environment) for the patient who is at serious risk of suicide
Place patient in least restrictive environment that allows for necessary level of observation
Continue regular assessment of suicidal risk (at least daily) in order to adjust suicide precautions appropriately
Consult with treatment team before modifying suicide precautions
Communicate risk and relevant safety issues to other care providers
Consider strategies to decrease isolation and opportunity to act on harmful thoughts (e.g., use of a sitter)
Observe, record, and report any change in mood or behavior that may signify increasing suicidal risk and document results of regular surveillance checks
Explain suicide precautions and relevant safety, issues to the patient/family/significant others (e.g., purpose, duration, behavioral expectations, and behavioral consequences)
Facilitate support of patient by family and friends
Refer patient to mental health care provider (e.g., psychiatrist or psychiatric/mental health advanced practice nurse) for evaluation and treatment of suicidal ideation and behavior, as needed
Provide information about what community resources and outreach programs are available
Improve access to mental health services
Increase the public's awareness that suicide is a preventable health problem

Background Readings:

Conwell, Y. (1997). Management of suicidal behavior in the elderly. Psychiatric Clinics of North America, 20(3), 667-683.
Drew, B.L. (2001). Self-harm behavior and no-suicide contracting in psychiatric inpatient settings. Archives of Psychiatric Nursing, 15(3), 99-106.
Hirschfeld, R.M.A., & Russel, J.M. (1997). Assessment and treatment of suicidal patients. New England Journal of Medicine, 337(13), 910-915.
Potter, M.L., & Dawson, A.M. (2001). From safety contract to safety agreement. Journal of Psychosocial Nursing, 39(8), 38-45.
Schultz, J.M., & Videbeck, S.D. (1998). Lippincott's manual of psychiatric nursing care plans. Philadelphia: Lippincott.
Suicide Prevention and Advocacy Network (1998). Working draft 2—National strategy for suicide prevention. Available on-line: http://www.spanusa.org/draft.htm
Valente, S.M., & Trainor, D. (1998). Rational suicide among patients who are terminally ill. Official Journal of the Association of Operating Room Nurses, 68(2), 252-255, 257-258, 260-264.

Surveillance (SURV)

Definition: **Purposeful and ongoing acquisition, interpretation, and synthesis of patient data for clinical decision making.**

Activities:

Determine patient's health risk(s), as appropriate
Obtain information about normal behavior and routines
Ask patient for her/his perception of health status
Select appropriate patient indices for ongoing monitoring, based on patient's condition
Ask patient about recent signs, symptoms, or problems
Establish the frequency of data collection and interpretation, as indicated by status of the patient
Facilitate acquisition of diagnostic tests, as appropriate
Interpret results of diagnostic tests, as appropriate
Monitor patient's ability to do self-care activities
Monitor neurological status
Monitor behavior patterns
Monitor emotional state
Monitor vital signs, as appropriate
Monitor comfort level, and take appropriate action
Monitor coping strategies used by patient and family
Monitor changes in sleep patterns
Monitor oxygenation and initiate measures to promote adequate oxygenation of vital organs
Initiate routine skin surveillance in high-risk patient
Monitor for signs and symptoms of fluid and electrolyte imbalance
Monitor tissue perfusion, as appropriate
Monitor for infection, as appropriate
Monitor nutritional status, as appropriate
Monitor gastrointestinal function, as appropriate
Monitor elimination patterns, as appropriate
Monitor for bleeding tendencies in high-risk patient
Note type and amount of drainage from tubes and orifices and notify the physician of significant changes
Troubleshoot equipment and systems to enhance acquisition of reliable patient data
Compare current status with previous status to detect improvements and deterioration in patient's condition
Initiate and/or change medical treatment to maintain patient parameters within the limits specified by the physician, using established protocols
Facilitate acquisition of interdisciplinary services (e.g., pastoral services or audiology), as appropriate
Obtain a physician consult when patient data indicate a needed change in medical therapy
Institute appropriate treatment, using standing orders
Prioritize actions, based on patient status
Analyze physician orders in conjunction with patient status to ensure safety of the patient
Obtain consultation from the appropriate health care worker to initiate new treatment or change existing treatments

Background Readings:

Dougherty, C.M. (1992). Surveillance. In G.M. Bulechek & J.C. McCloskey (Eds.), Nursing interventions: Essential nursing treatments (2nd ed.) (pp. 500-511). Philadelphia: W.B. Saunders.
Titler, M.G. (1992). Interventions related to surveillance. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 495-517.

Surveillance: Safety (SAFE)

Definition: **Purposeful and ongoing collection and analysis of information about the patient and the environment for use in promoting and maintaining patient safety.**

Activities:

Monitor patient for alterations in physical or cognitive function that might lead to unsafe behavior
Monitor environment for potential safety hazards
Determine degree of surveillance required by patient, based on level of functioning and the hazards present in environment
Provide appropriate level of supervision/surveillance to monitor patient and to allow for therapeutic actions, as needed
Place patient in least restrictive environment that allows for necessary level of observation
Initiate and maintain precaution status for patient at high risk for dangers specific to the care setting
Communicate information about patient's risk to other nursing staff

Background Readings:

Dougherty, C.M. (1992). Surveillance. In G.M. Bulechek & J.C. McCloskey (Eds.), Nursing interventions: Essential nursing treatments (2nd ed.) (pp. 500-511). Philadelphia: W.B. Saunders.
Kanak, M.F. (1992). Interventions related to safety. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 371-396.
Kozier, B., & Erb, G. (1987). Fundamentals of nursing: Concepts and procedures (3rd ed.). Menlo Park, CA: Addison-Wesley.
Nightingale, F. (1969). Notes on nursing: What it is and what it is not. New York: Dover Publications.

Surveillance: Skin (SKINSRV)

Definition: **Collection and analysis of patient data to maintain skin and mucous membrane integrity.**

Activities:

Inspect condition of surgical incision, as appropriate
Observe extremities for color, warmth, swelling, pulses, texture, edema, and ulcerations
Inspect skin and mucous membranes for redness, extreme warmth, or drainage
Monitor skin for areas of redness and breakdown
Monitor for sources of pressure and friction
Monitor for infection, especially of edematous areas
Monitor skin and mucous membranes for areas of discoloration and bruising
Monitor skin for rashes and abrasions
Monitor skin for excessive dryness and moistness
Inspect clothing for tightness
Monitor skin color
Monitor skin temperature
Note skin or mucous membrane changes
Institute measures to prevent further deterioration, as needed
Instruct family member/caregiver about signs of skin breakdown, as appropriate

Background Readings:

Deters, G.R. (1991). Management of patients with dermatologic problems. In S.C. Smeltzer, & B.G. Bare (Eds.), Brunner and Suddarth's textbook of medical-surgical nursing (5th ed.) (pp. 809-837). Philadelphia: J.B. Lippincott.

Sundberg, M.C. (1989). Promoting personal hygiene and skin integrity. In M.C. Sundberg, Fundamentals of nursing with clinical procedures (2nd ed.) (pp. 570-600). Boston: Jones & Bartlett.

Titler, M.G., Pettit, D., Bulechek, G.M., McCloskey, J.C., Craft, M.J., Cohen, M.Z., Crossley, J.D., Denehy, J.A., Glick, O.J., Kruckeberg, T.W., Maas, M.L., Prophet, C.M., & Tripp-Reimer, T. (1991). Classification of nursing interventions for care of the integument. Nursing Diagnosis, 2(2), 45-56.

Sustenance Support (SUST)

Definition: **Helping a needy individual/family to locate food, clothing, or shelter.**

Activities:

Determine adequacy of patient's financial situation
Determine adequacy of food supplies in home
Inform individual/families about how to access local food pantries and free lunch programs, as appropriate
Inform individual/families about how to access low-rent housing and subsidy programs, as appropriate
Inform individual/families about rental laws and protections
Inform individual/families of available emergency housing shelter programs, as appropriate
Arrange transportation to emergency housing shelter, as appropriate
Discuss with the individual/families available job service agencies, as appropriate
Arrange for transportation to job services, if necessary
Inform individual/families of agency providing clothing assistance, as appropriate
Arrange transportation to agency providing clothing assistance, as necessary
Inform individual/families of agency programs for support, such as Red Cross and Salvation Army, as appropriate
Discuss with the individual/families financial aid support available
Assist individual/families to complete forms for assistance, such as housing and financial aid
Inform individual/families of available free health clinics
Assist individual/families to reach free health clinics
Inform individual/families of eligibility requirements for food stamps
Inform individual/families of available schools and/or day care centers, as appropriate
Inform individual/families of available health insurance

Background Readings:

Boyer, D.E., & Heppner, I. (1992). Community mental health: Problem identification and treatment. In M. Stanhope & J. Lancaster (Eds.), Community health nursing (3rd ed.) (pp. 351-363). St. Louis: Mosby.
Hymovich, D.P., & Barnard, M.U. (1979). Family health care (2nd ed.) (pp. 165-182). New York: McGraw-Hill.

Telephone Consultation (TC)

***Definition*[1]*:* Eliciting patient's concerns, listening or providing support or teaching in response to patient's concerns over the telephone for the purpose of updating medical information.**

Activities:

Identify self with name and credentials, organization; let caller know if call is being recorded (e.g., for quality monitoring), using voice to create therapeutic relationship
Inform patient about call process and obtain consent
Consider cultural, socioeconomic barriers to patient's response
Obtain information about purpose of the call (e.g., medical diagnoses if any, health history, and current treatment regimen)
Identify concerns about health status
Establish level of caller's knowledge and source of that knowledge
Determine patient's ability to understand telephone teaching/instructions (e.g., hearing deficits, confusion, language barriers)
Provide means of overcoming any identified barrier to learning or use of support system(s)
Identify degree of family support and involvement in care
Inquire about related complaints/symptoms/ (according to standard protocol, if available)
Obtain data related to effectiveness of current treatment(s) if any, by consulting and citing approved references as sources (e.g., "American Red Cross suggests...")
Determine psychological response to situation and availability of support system(s)
Determine safety risk to caller and/others
Determine whether concerns require further evaluation (use standard protocol)
Provide information about community resources, educational programs, support groups, and self-help groups, as indicated
Involve family/significant others in the care and planning
Answer questions
Determine caller's understanding of information provided
Maintain confidentiality, as indicated
Document any assessments, advice, instructions, or other information given to patient according to specified guidelines
Follow guidelines for investigating or reporting suspected child, elder, or spousal abuse situations
Follow up to determine disposition; document disposition and patient's intended action(s)
Determine need, and establish time intervals for, further intermittent assessment, as appropriate
Determine how patient or family member can be reached for a return telephone call, as appropriate
Document permission for return call and identify persons able to receive call information
Discuss and resolve problem calls with supervisory/collegial help

Background Readings:

American Academy of Ambulatory Nursing. (1997). Telephone nursing practice administration and practice standards. Pitman, NJ: Anthony J. Jannetti, Inc.
Anderson, K., Qiu, Y., Whittaker, A.R., & Lucas, M. (2001). Breath sounds, asthma, and the mobile phone. Lancet, 358(9290), 1343-1344.
Haas, S.A., & Androwich, I.A. (1999). Telephone consultation. In G.M. Bulechek & J.C. McCloskey (Eds.), Nursing interventions: Effective nursing treatments (3rd ed.) (pp. 670-685). Philadelphia: W.B. Saunders.
Hagan, L., Morin, D., & Lepine, R. (2000). Evaluation of telenursing outcomes: Satisfaction, self-care practices, and cost savings. Public Health Nursing, 17(4), 305-313.
Larson-Dahn, M. L. (2001). Tel-eNurse practice: Quality of care and patient outcomes. Journal of Nursing Administration, 31(3), 145-152.
Poole, S. G., Schmitt, B.D., Carruth, T., Peterson-Smith, A.A., & Slusarski, M. (1993). After-hours telephone coverage: The application of an area-wide telephone triage and advice system for pediatric practices. Pediatrics, 92(5), 670-679.
Wheeler, S., & Siebelt, B. (1997). Calling all nurses: How to perform telephone triage. Nursing, 97(7), 37-41.

[1] Delaware definition is more narrow in scope by limiting activity to general purpose of updating medical information, which can be an exchange of ideas. Activities such as health education and counseling via telephone are documented as health education and counseling.

Treatment Administration (TXADM)

***Definition*[1]*:* Preparing, giving, and evaluating the effectiveness of prescribed treatments.**

Activities:

Develop agency policies and procedures for accurate and safe administration of treatment
Develop and use an environment that maximizes safe and efficient administration of treatment
Verify the treatment order before administering the treatment
Prescribe and/or recommend medications or treatment, as appropriate, according to prescriptive authority
Monitor for possible allergies, interactions and contraindications
Note patient's allergies or previous responses before delivery of each treatment and hold treatment, as appropriate
Prepare treatment using appropriate equipment and techniques
Monitor vital signs and laboratory values before and after treatment administration, as appropriate
Assist patient with treatment
Give treatment using appropriate technique and route
Use orders, agency policies and procedures to guide appropriate method of treatment administration
Instruct patient and family about expected actions and adverse effects of the treatment
Monitor patient to determine need for PRN medications, as appropriate
Monitor patient for the therapeutic effect of the treatment
Monitor patient for adverse effects of the administered treatment
Count restricted drugs, according to agency protocol
Verify all questioned treatment orders with the appropriate health care personnel
Document treatment administration and patient responsiveness, according to agency protocol

[1] Delaware definition parallels NIC's Medication Administration.

Treatment Management (TXMGT)

Definition*[1]*: **Facilitation of safe and effective prescribed treatments.**

Activities:

Determine what treatments are needed, and administer according to prescriptive authority and/or protocol
Discuss financial concerns related to treatment regimen
Determine patient's ability to do the treatment independently, as appropriate
Monitor effectiveness of the treatment administration modality
Monitor patient for the therapeutic effect of the treatment
Monitor for adverse effects of the treatment
Review periodically with the patient and/or family types and amounts of medications and treatments taken
Facilitate changes in treatments with physician, as appropriate
Monitor for response to changes in treatment regimen, as appropriate
Determine the patient's knowledge about treatment
Monitor adherence with treatment regimen
Determine factors that may preclude the patient from taking the treatments as prescribed
Develop strategies with the patient to enhance compliance with the treatment regimen
Teach patient and/or family members the method of treatment, as appropriate
Teach patient and/or family members the expected action and side effects of the treatment
Provide patient and family members with written and illustrated information to enhance treatment administration, as appropriate
Develop strategies to manage any side effects
Obtain physician order for patient to do the treatment independently, as appropriate
Establish a protocol for the storage, restocking and monitoring of any equipment left at the bedside for self-medication purposes
Investigate possible financial resources for acquisition of prescribed treatments, as appropriate
Determine impact of treatment on patient's lifestyle
Instruct patient when to seek medical attention
Determine whether the patient is using culturally based home health remedies and the possible effects on prescribed treatments
Review with the patient strategies for managing treatment regimen
Provide patient with a list of resources to contact for further information about the treatment regimen
Contact patient and family, as appropriate, to answer questions and discuss concerns associated with the treatment regimen

[1] Delaware definition and activities parallel NIC's Medication Management.

Tube Care (TUBECARE)

Definition: **Management of a patient with an external drainage device exiting the body.**

Activities:

Maintain patency of tube, as appropriate
Keep the drainage container at the proper level
Provide sufficiently long tubing to allow freedom of movement, as appropriate
Secure tubing, as appropriate, to prevent pressure and accidental removal
Monitor patency of catheter, noting any difficulty in drainage
Monitor amount, color, and consistency of drainage from tube
Empty the collection appliance, as appropriate
Ensure proper placement of the tube
Ensure functioning of tube and associated equipment
Connect tube to suction, as appropriate
Irrigate tube, as appropriate
Change tube routinely, as indicated by agency protocol
Inspect the area around the tube insertion site for redness and skin breakdown, as appropriate
Administer skin care at the tube insertion site, as appropriate
Assist the patient in securing tube(s) and/or drainage devices while walking, sitting, and standing, as appropriate
Encourage periods of increased activity, as appropriate
Monitor patient's and family members' responses to presence of external drainage devices
Clamp tubing, if appropriate, to facilitate ambulation
Teach patient and family the purpose of the tube and how to care for it, as appropriate
Provide emotional support to deal with long-term use of tubes and/or external drainage devices, as appropriate

Background Readings:

Ahrens, T.S. (1993). Pulmonary data acquisition. In M.R. Kinney, D.R. Packa, & S.B. Dunbar (Eds.), AACN's clinical reference for critical-care nursing (pp. 689-700). St. Louis: Mosby.

Johanson, B.C., Wells, S.J., Hoffmeister, D., & Dungca, C.U. (1988). Standards for critical care (pp. 67-73). St. Louis: Mosby.

Nelson, D.M. (1992). Interventions related to respiratory care. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 301-324.

Suddarth, D. (1991). The Lippincott manual of nursing practice (5th ed.) (pp. 196-198). Philadelphia: J.B. Lippincott.

Tube Care, Gastrointestinal (TUBECAREGI)

Definition: **Management of a patient with a gastrointestinal tube.**

Activities:
Monitor for correct placement of the tube, per agency protocol
Verify placement with x-ray exam, per agency protocol
Connect tube to suction, if indicated
Secure tube to appropriate body part, with consideration for patient comfort and skin integrity
Irrigate tube, per agency protocol
Monitor for sensations of fullness, nausea, and vomiting
Monitor bowel sounds
Monitor for diarrhea
Monitor fluid and electrolyte status
Monitor amount, color, and consistency of nasogastric output
Replace the amount of gastrointestinal output with the appropriate IV solution, as ordered
Provide nose and mouth care 3 to 4 times daily or as needed
Provide hard candy or chewing gum to moisten mouth, as appropriate
Initiate and monitor delivery of enteral tube feedings, per agency protocol, as appropriate
Teach patient and family how to care for tube, when indicated
Provide skin care around tube insertion site
Remove tube when indicated

Background Readings:
Bowers, S. (1996). Tubes: A nurses' guide to enteral feeding devices. MedSurg Nursing, 5(5) 313-326.
Perry, A.G., & Potter, P.A. (1998). Clinical nursing skills and techniques. St. Louis: Mosby.
Thompson, J.M., McFarland, G.K., Hirsch, J.E., & Tucker, S.M. (1998). Mosby's clinical nursing (4th ed.). St. Louis: Mosby–Year Book.

Urinary Catheterization (CATH)

Definition: **Insertion of a catheter into the bladder for temporary or permanent drainage of urine.**

Activities:

Explain procedure and rationale for the intervention
Assemble appropriate catheterization equipment
Maintain strict aseptic technique
Insert straight or retention catheter into the bladder, as appropriate
Use smallest size catheter, as appropriate
Connect retention catheter to a bedside drainage bag or leg bag
Secure catheter to skin, as appropriate
Maintain a closed urinary drainage system
Monitor intake and output
Perform or teach patient to perform clean intermittent catheterization, when appropriate
Perform post-void residual catheterization, as needed

Background Readings:

Norton, B.A., & Miller, A.M. (1986). Skills for professional nursing practice (pp. 641-648). Norwalk, CT: Appleton-Century-Crofts.

Potter, P.A., & Perry, A.G. (1993). Fundamentals of nursing (3rd ed.) (pp. 1097-1114). St. Louis: Mosby.

Vital Signs Monitoring (VS)

Definition: **Collection and analysis of cardiovascular, respiratory, and body temperature data to determine and prevent complications.**

Activities:

Monitor blood pressure, pulse, temperature, and respiratory status, as appropriate
Note trends and wide fluctuations in blood pressure
Monitor blood pressure while patient is lying, sitting, and standing before and after position change, as appropriate
Monitor blood pressure after patient has taken medications, if possible
Auscultate blood pressures in both arms and compare, as appropriate
Monitor blood pressure, pulse, and respirations before, during, and after activity, as appropriate
Initiate and maintain a continuous temperature monitoring device, as appropriate
Monitor for and report signs and symptoms of hypothermia and hyperthermia
Monitor presence and quality of pulses
Take apical and radial pulses simultaneously and note the difference, as appropriate
Monitor for pulsus paradoxus
Monitor for pulsus alternans
Monitor for a widening or narrowing pulse pressure
Monitor cardiac rhythm and rate
Monitor heart tones
Monitor respiratory rate and rhythm (e.g., depth and symmetry)
Monitor lung sounds
Monitor pulse oximetry
Monitor for abnormal respiratory patterns (e.g., Cheyne-Stokes, Kussmaul, Biot, apneustic, ataxic, respiration and excessive sighing)
Monitor skin color, temperature, and moistness
Monitor for central and peripheral cyanosis
Monitor for clubbing of nailbeds
Monitor for presence of Cushing triad (e.g., wide pulse pressure, bradycardia, and increase in systolic BP)
Identify possible causes of changes in vital signs
Check periodically the accuracy of instruments used for acquisition of patient data

Background Readings:

Erickson, R.S., & Yount, S.J. (1991). Comparison of tympanic and oral temperatures in surgical patients. Nursing Research, 40(2), 90-93.
Thelan, L.A., & Urden, L.D. (1998). Critical care nursing: Diagnosis and management (3rd ed.). St. Louis: Mosby.
Titler, M.G. (1992). Interventions related to surveillance. In G.M. Bulechek & J.C. McCloskey (Eds.), Symposium on Nursing Interventions. Nursing Clinics of North America, 27(2), 495-516.

Weight Management (WGTMGT)

Definition: **Facilitating maintenance of optimal body weight and percent body fat.**

Activities:

Discuss with individual the relationships among food intake, exercise, weight gain, and weight loss
Discuss with individual the medical conditions that may affect weight
Discuss with individual the habits and customs and cultural and heredity factors that influence weight
Discuss risks associated with being over- and underweight
Determine individual motivation for changing eating habits
Determine individual's ideal body weight
Determine individual's ideal percent body fat
Develop with the individual a method to keep a daily record of intake, exercise sessions, and/or changes in body weight
Encourage individual to write down realistic weekly goals for food intake and exercise and to display them in a location where they can be reviewed daily
Encourage individual to chart weekly weights, as appropriate
Encourage individual to consume adequate amounts of water daily
Plan rewards with the individual to celebrate reaching short-term and long-term goals
Inform individual about whether support groups are available for assistance
Assist in developing well-balanced meal plans consistent with level of energy expenditure

Background Readings:

National Institutes of Health. (2000). The practical guide: Identification, evaluation, and treatment of overweight and obesity in adults. NIH Publication Number 00-4084. Washington, DC: US Department of Health and Human Services.

Thelan, L.A., & Urden, L.D. (1998). Critical care nursing: Diagnosis and management (3rd ed.). St. Louis: Mosby.

Whitney, E.N., & Cataldo, C.B. (1991). Understanding normal and clinical nutrition (3rd ed.). St. Paul, MN: West Publishing.

Wound Care (Ongoing) (WOUNDON)

Definition: **Prevention of wound complications and promotion of wound healing.**

Activities:

Remove dressing and adhesive tape
Shave the hair surrounding the affected area, as needed
Monitor characteristics of the wound, including drainage, color, size, and odor
Measure the wound bed, as appropriate
Remove embedded material (e.g., splinter, tick, glass, gravel, metal), as needed
Cleanse with normal saline or a nontoxic cleanser, as appropriate
Place affected area in a whirlpool bath, as appropriate
Provide incision site care, as needed
Administer skin ulcer care, as needed
Apply an appropriate ointment to the skin/lesion, as appropriate
Apply a dressing, appropriate for wound type
Reinforce the dressing, as needed
Maintain sterile dressing technique when doing wound care, as appropriate
Change dressing according to amount of exudate and drainage
Inspect the wound with each dressing change
Compare and record regularly any changes in the wound
Position to avoid placing tension on the wound, as appropriate
Reposition patient at least every 2 hours, as appropriate
Encourage intake of fluids, as appropriate
Refer to wound ostomy clinician, as appropriate
Refer to dietitian, as appropriate
Place pressure-relieving devices (e.g., low-air-loss, foam, or gel mattresses; heel or elbow pads; chair cushion), as appropriate
Assist patient and family to obtain supplies
Instruct patient and family on storage and disposal of dressings and supplies
Instruct patient or family member(s) in wound care procedures
Instruct patient and family on signs and symptoms of infection
Document wound location, size, and appearance

Background Readings:

Bryant, R.A. (2000). Acute and chronic wounds: Nursing management. St. Louis: Mosby.
Dwyer, F.M., & Keeler, D. (1997). Protocols for wound management. Nursing Management, 28(7), 45-49.
Hall, P., & Schumann, L. (2001). Wound care: Meeting the challenge. Journal of the American Academy of Nurse Practitioners, 13(6), 258-266.
Thompson, J. (2000). A practical guide to wound care. RN, 63(1), 48-52.

NURSING INTERVENTION CLASSIFICATION©

NURSING CARE

Admission Care ADMINCARE – *facilitating entry of student into school (health needs)*
Airway Management AIRMGT–*facilitation of patency of air passages*
Airway Suctioning AIRSUC–*removal of airway secretions by inserting a suction catheter into the patient's oral airway &/or trachea*
Allergy Management ALLERGY–*identification, treatment, & prevention of allergic responses to food, medications, insect bites, contrast material, blood, & other substances*
Artificial Airway Management ARTAIR–*maintenance of endotrachial/tracheostomy tubes & prevention of complications associated with their use*
Aspiration Precautions ASPIR–*prevention/minimization of risk factors in the patient at risk for aspiration*
Asthma Management ASTHMA–*identification, treatment and prevention of reactions to inflammation/constriction of the airway passages*
Bleeding Reduction: Nasal NOSEBL– *Limitation of blood loss from the nasal cavity*
Bleeding Reduction: Wound BLEED–*limitation of the blood loss from a wound that may be a result of trauma, incisions, or placement of a tube or catheter*
Bowel Management BWL–*establishment & maintenance of a regular pattern of bowel elimination*
Cast Care: Maintenance CAST–*care of a cast after the drying period*
Chest Physiotherapy CHEST–*assisting the patient to move airway secretions from peripheral airways to more central airways for expectoration &/or suctioning*
Contact Lens Care EYECL – *prevention of eye injury & lens damage*
Diarrhea Management DIARR–*prevention & alleviation of diarrhea*
Emergency Care (illness) ERILL–*providing life-saving measures in life-threatening situations caused by illness*
Emergency Care (injury) ERINJ–*providing life-saving measures in life-threatening situations caused by injury*
Enteral Tube Feeding TUBEFEED–*delivering nutrients & water through a gastrointestinal tube*
Feeding FEED – *feeding of patient with oral motor deficits*
Fever Treatment FVR–*management of a patient with hyperpyrexia caused by nonenvironmental factors*
First Aid WOUNDFA–*providing initial care for a minor injury*
Health Care Information Exchange (illness) INFOILL–*providing patient care information to other health professionals related to illness*
Health Care Information Exchange (injury) INFOINJ–*providing patient care information to other health professionals related to injury*
Heat/Cold Application (injury) HTCLD–*stimulation of the skin & underlying tissues with heat or cold for the purpose of decreasing pain, muscle spasms, or inflammation*
Heat Exposure Treatment HEATX–*management of patient overcome by heat due to excessive environmental heat exposure*
Hemorrhage Control HMRR–*reduction or elimination of rapid & excessive blood loss*
High-Risk Pregnancy Care PREG–*identification & management of a high-risk pregnancy to promote healthy outcomes for mother & baby*
Hyperglycemia Management HYPERG–*preventing & treating above-normal blood glucose levels*
Hypoglycemia Management HYPOG–*preventing & treating low blood glucose levels*
Medication Administration MEDADM–*preparing, giving, & evaluating the effectiveness of prescription & nonprescription drugs*
Medication Management MEDMGT–*facilitation of safe/effective use of prescription & over-the-counter drugs*
Multidisciplinary Care Conference (illness) CONFILL–*planning & evaluating patient care with health professionals from other disciplines*
Multidisciplinary Care Conference (injury) CONFINJ–*planning & evaluating patient care with health professionals from other disciplines*
Nausea Management NAUSEA – *prevention & alleviation of nausea*
Neurologic Monitoring NEURO–*collection & analysis of patient data to prevent or minimize neurological complications*
Non-Nursing Intervention NONNURSE – *providing service not requiring nursing skills/expertise*
Nursing Assessment, No Intervention NASS – *providing assessment requiring professional nursing knowledge & skills without related intervention*
Nursing Intervention NURSE – *intervention requiring professional nursing knowledge and skills (not available on current list)*
Nutrition, Special Diet SPDIET–*modification & monitoring of special diet*
Ostomy Care OSTO– *maintenance of elimination through a stoma & care of surrounding tissue*
Pain Management PAIN–*alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient*
Positioning POSI–*deliberative placement of the patient or a body part to promote physiological &/or psychological well-being*
Referral Management REFMGT – *arrangement for services by another healthcare provider or agency*
Respiratory Monitoring RESP–*collection & analysis of patient data to ensure airway patency & adequate gas exchange*
Rest REST – *providing environment & supervision to facilitate rest/sleep (NON-nursing)*
Seizure Management SZR–*care of a patient during a seizure & the postictal state*
Self-Care Assistance, Nursing SELFNUR–*assisting another to perform activities of daily living*
Self-Care Assistance, Non-Nursing SELFNON–*assisting another to perform activities of daily living*
Skin Care SKIN–*application of topical substances or manipulation of devices to promote skin integrity & minimize skin breakdown*
Surveillance SURV - *purposeful/ongoing acquisition, interpretation, & synthesis of patient data for clinical decision making*
Surveillance: Skin SKINSRV–*collection/analysis of patient data to maintain skin & mucous membrane integrity*
Telephone Consultation TC–*for purpose of updating medical information*
Treatment Administration TXADM–*preparing, giving, & evaluating the effectiveness of prescribed treatments*
Treatment Management TXMGT–*facilitation of safe & effective prescribed treatments*
Tube Care TUBECARE–*management of a patient with an external drainage device exiting the body*
Tube Care, Gastrointestinal TUBECAREGI–*management of a patient with a gastrointestinal tube*
Urinary Catheterization CATH–*insertion of a catheter into the bladder for temporary or permanent drainage of urine*
Vital Signs Monitoring VS–*collection/analysis of cardiovascular, respiratory, & body temperature data to determine/prevent complications*
Wound Care (Ongoing) WOUNDON–*prevention of wound complications & promotion of wound healing*

NURSING INTERVENTION CLASSIFICATION©

COUNSELING

Abuse Protection Support: Child ABUSE – *identification of high-risk, dependent child relationships & actions to prevent possible or further infliction of physical, sexual, or emotional harm or neglect of basic necessities of life*

Counseling (individual) COUNSEL – *use of an interactive helping process focusing on the needs, problems, or feelings of the patient & significant others to enhance or support coping, problem-solving, & interpersonal relationships*

Counseling (group) COUNSELG – *use of an interactive helping process focusing on the needs, problems, or feelings of the group & significant others to enhance or support coping, problem-solving, & interpersonal relationships*

HEALTH EDUCATION

Anticipatory Guidance (individual) AGUIDE – *preparation of patient for an anticipated developmental &/or situational crisis*

Anticipatory Guidance (group) AGUIDEG – *preparation of a group of patients for an anticipated developmental &/or situational crisis*

Body Mechanics Promotion (individual) BODY – *facilitating a patient in the use of posture & movement in daily activities to prevent fatigue & musculoskeletal strain or injury*

Body Mechanics Promotion (group) BODYG – *facilitating a group of patients in the use of posture & movement in daily activities to prevent fatigue & musculoskeletal strain or injury*

Exercise Promotion (individual) EXER – *facilitation of a patient in regular physical exercise to maintain or advance to a higher level of fitness & health*

Exercise Promotion (group) EXERG – *facilitation of a group of patients in regular physical exercise to maintain or advance to a higher level of fitness & health*

Health Education (individual) HLTHED – *developing & providing individual instruction & learning experiences to facilitate voluntary adaptation of behavior conducive to health in individuals, families, groups, or communities*

Health Education (group) HLTHEDG – *developing & providing group instruction & learning experiences to facilitate voluntary adaptation of behavior conducive to health in individuals, families, groups, or communities*

Smoking Cessation Assistance (individual) SMOKE – *helping the patient to stop smoking through an individual process*

Smoking Cessation Assistance (group) SMOKEG – *helping the patient to stop smoking in a group process*

Substance Use Prevention (individual) SUBAB – *prevention of an alcoholic or drug use life-style through an individual process*

Substance Use Prevention (group) SUBABG – *prevention of an alcoholic or drug use life-style through a group process*

Weight Management WGTMGT – *facilitating maintenance of optimal body weight & percent body fat*

HEALTH PROMOTION/PROTECTION

Environmental Management ENVMGT – *manipulation of the patient's surroundings for therapeutic benefit, sensory appeal & psychological well-being*

Health System Guidance HGUIDE – *facilitating a patient's location & use of appropriate health services*

Immunization Management IZMGT – *monitoring status & facilitating access to immunization*

Infection Protection INFPRO – *prevention & early detection of infection in a patient at risk*

Progressive Muscle Relaxation MURELX – *facilitating the tensing & releasing of successive muscle groups while attending to the resulting differences in sensation*

Seizure Precautions SZRPRE – *prevention or minimization of potential injuries sustained by a patient with a known seizure disorder*

Suicide Prevention PRESUI – *reducing risk of self-inflicted harm with intent to end life*

Surveillance: Safety SAFE – *purposeful & ongoing collection & analysis of information about the patient & the environment for use in promoting & maintaining patient safety*

Sustenance Support SUST – *helping a needy individual/family to locate food, clothing, or shelter*