

# Standardized Nursing Language: A Self-Learning Module

A Continuing Education Program for Nurses

1.2 contact hours will be provided University of Michigan Health System by The University of Michigan Health System Educational Services for Nursing, which is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Provision of contact hours may continue until December 2004.

**NOTE: CE credit can be obtained in two ways:**

1. an individual can complete the module and apply directly to UM for CE credit, OR
2. sites can coordinate their staff and the coordinator communicates directly to UMHHC for the CE credit.

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# Standardized Nursing Language: A Self-Learning Module

## A Continuing Education Program for Nurses

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#### Resources:

<sup>1</sup>Johnson, M, and Maas, M., Moorhead, S. [Nursing Outcomes Classification \(NOC\), 2<sup>nd</sup> Edition](#). St. Louis: Mosby-Year Book, Inc. 2000.

<sup>2</sup>McCloskey, J.C. and Bulechek, G.M. [Nursing Interventions Classification \(NIC\), 3<sup>rd</sup> Edition](#). St. Louis: Mosby-Year Book, Inc. 2000.

<sup>3</sup>[NANDA Nursing Diagnoses: Definitions and Classification \(1999-2000\)](#) Philadelphia: North American Nursing Diagnosis Association, 1999.

## Instructions for the Coordinator

<p>1. Provide the Self-Learning Module for participants to complete.</p>	<p>You may duplicate as many copies as needed. Please note copyright of material and nurse icon.</p>
<p>2. Provide forms for participants to complete:</p> <ul style="list-style-type: none"> <li>▪ blank answer sheet,</li> <li>▪ selected case scenario</li> <li>▪ blank nursing care plan and</li> <li>▪ evaluation</li> </ul>	
<p>3. Check that the identification information on the answer sheet is complete and legible.</p>	<p>All information is kept strictly confidential.</p>
<p>4. Score the completed answer sheet, or have the participants score test using the answers found on the answer key.</p>	<p>If a score of 80% is not achieved, have participants review the self-learning module and retake the quiz until a score of 80% is achieved.</p>
<p>5. Send a list of the participants including:</p> <ul style="list-style-type: none"> <li>▪ demographics information</li> <li>▪ completed evaluation</li> <li>▪ check for \$10/evaluation</li> </ul>	<p>University of Michigan Health System Educational Services for Nursing (UMHS-ESN) will send the participant a certificate verifying successful completion of the continuing education activity and the number of contact hours</p>
<p>Send to:  Carol Williams, MS, RN, C  Educational Services for Nursing  University of Michigan Health System  300 North Ingalls, 6B12  Ann Arbor, Michigan 48109-0436</p>	<p>For comments or requests for information regarding continuing education credits, contact  Carol Williams  <a href="mailto:cwms@umich.edu">cwms@umich.edu</a>  734-763-6326 phone</p>
<p>6. For questions regarding information presented, contact:  Phyllis Patterson, <a href="mailto:phyllisp@umich.edu">phyllisp@umich.edu</a>  734-936-4731</p>	

## Participant Instructions

<p>1. Print the</p> <ul style="list-style-type: none"> <li>▪ Self-Learning Module</li> <li>▪ Answer Sheet</li> <li>▪ Evaluation</li> <li>▪ Answer Key</li> <li>▪ Selected case scenario for one of the following:             <ul style="list-style-type: none"> <li>▪ Adult Acute Care Medicine.</li> <li>▪ Adult Acute Care Surgery,</li> <li>▪ Adult ICU,</li> <li>▪ Pediatric Acute Care,</li> <li>▪ Pediatric ICU,</li> <li>▪ Perinatal,</li> <li>▪ Psychiatry,</li> <li>▪ Ambulatory Care</li> </ul> </li> </ul>	
<p>2. Complete the identification information on the evaluation.</p>	<p>Your social security number is required for issuance of the CE certificate. All information is kept strictly confidential.</p>
<p>2. Complete the quiz.</p>	
<p>3. Score the test, using the answer key provided at the end of the module.</p>	
<p>4. Read the case scenario and complete the blank nursing care plan.</p>	
<p>5. Complete the evaluation of the educational activity.</p> <p>Send to:</p> <p>Carol Williams, MS, RN, C          Educational Services for Nursing          University of Michigan Health System          300 North Ingalls, 6B12          Ann Arbor, Michigan 48109-0436</p>	<p>After receiving the appropriate materials from either you or your coordinator, the UMHS-ESN will send you a certificate verifying successful completion of the continuing education activity and the number of contact hours.</p> <p>For comments or requests for information, contact          Carol Williams  <a href="mailto:cwms@umich.edu">cwms@umich.edu</a>          734-763-6326 phone</p>
<p>6. If you have a coordinator, give the completed and scored quiz, completed care plan and evaluation to your coordinator who will then submit them for Continuing Education credit.</p>	
<p>7. For questions regarding information presented, contact          Phyllis Patterson, 734-936-4731  <a href="mailto:phyllisp@umich.edu">phyllisp@umich.edu</a></p>	

WELCOME TO THE  
STANDARDIZED NURSING  
LANGUAGE  
(SNL)



SELF-LEARNING MODULE

## **TO COMPLETE THIS SELF LEARNING MODULE:**

- 1. Print and read the self learning module**
- 2. Print and Complete:**
  - a. Quiz (Self-scored)**
  - b. Nursing Care Plan, for a specific Case Scenario**
  - c. Evaluation tool**
- 3. If applicable, submit the completed material to designated person (coordinator) in your area on completion of above process, and the coordinator will submit for CE.**
- 4. To receive a CE certificate for 1.2 contact hours, submit the completed documents and the \$10 fee to:**

Carol Williams, MS, RN, C  
Educational Services for Nursing  
University of Michigan Health System  
300 North Ingalls, 6B12  
Ann Arbor, Michigan 48109-0436

## Goals

To provide the RN with knowledge about the Standardized Nursing Languages, of **NANDA**, Nursing Outcomes Classification (**NOC**), Nursing Interventions Classification (**NIC**).

Provide information for the use of Standardized Nursing Languages in the nursing process and development of nursing care plans.

## Objectives

Upon completion of the Standardized Nursing Language module, the learner will be able to:

1. Describe the rationale for using standardized nursing language (SNL)
2. Describe the benefits to the patient, work site and organization when using SNL
3. Define Nursing Diagnosis (**NANDA**), Nursing Outcomes Classification (**NOC**) and Nursing Interventions Classification (**NIC**).
4. Identify resources that support the use of **NANDA**, **NOC** and **NIC**.
5. Complete a plan of care, integrating **NANDA**, **NOC** and **NIC** vocabularies.

# Chapter 1

## INTRODUCTION

Welcome to the Self-Learning Module on Standardized Nursing Language!

What's with all these acronyms?

SNL

NANDA

NOC

NIC

As you already know SNL is not **Saturday Night Live!**

Standardized Nursing Languages are standardized vocabularies used to describe what nursing does.

*This is an exciting opportunity for nursing!*

### Why?

- Standardized Nursing Language (SNL) provides a mechanism to answer that age-old question "What do nurses do anyway?" SNL takes us from the invisible care provider to the **visible provider of nursing care** that is crucial to health care.
- SNL are tools for systematically studying nursing interventions and determining which ones really work. When we can articulate what a nurse really does, we can then determine the contribution of nursing to patient outcomes.
- Standardized Nursing Language provides the foundation for documentation in a computerized medical record.

### How does Standardized Nursing Language do all of this?

- "Nursing is an information-intensive profession, and nurses are experts in the diagnosis and treatment of human responses to illness, prevention of illness and health promotion"<sup>1</sup>. But, the words that nurses use to describe the nursing process and document nursing care are not consistent. **We all need to describe nursing care the same way!**

- Describing nursing care in the same way facilitates continuity of patient care. It also facilitates communication among nurses, and between nurses and other health care providers and makes it possible to organize information in a manner that can be computerized.
- SNL is being integrated into nursing curricula and orientation programs to help students and novice nurses learn clinical decision-making.

**While there are several standard vocabularies, the nursing department at University of Michigan Hospitals and Health Centers (UMHHC) will be using:**

- **Nursing Diagnosis (NANDA)**
- **Nursing Outcomes Classification (NOC)**
- **Nursing Interventions Classification (NIC)**

**Who has endorsed these vocabularies?**

- **American Nurses Association**
- **Michigan Nurses Association**
- **Joint Commission on Accreditation of Health Care Organizations** recognizes these classification systems as appropriate descriptions of nursing practice.
- **Nursing Administration** at the UMHHC

**Why are we using three vocabularies?**

- When NANDA, NOC and NIC are used together, they describe three elements of the nursing process, namely,

**Diagnosis - NANDA**

**Outcomes - NOC**

**Interventions - NIC**

- And they are the basis for the rest of the nursing process, namely, **implementation and evaluation.**
- They build on the functional health pattern assessment. The vocabularies describe and apply to nursing care across all types of settings.

## Quiz for Chapter 1 Introduction to SNL

Answer the questions below by circling the right answer on the answer sheet.

1. Reasons for implementing SNL are to:
  - a) move towards online documentation and the development of computerized patient records
  - b) provide a foundation for accurately describing what nursing really does
  - c) provide consistency of concepts across clinical, administrative and financial data sets
  - d) all of the above.
  
2. The three Standardized Nursing Language vocabularies endorsed by the Michigan Nurses Association are:
  - a) Nursing Process, **NANDA**, Nursing Outcomes Classification (**NOC**)
  - b) **NANDA**, Nursing Process, Nursing Interventions Classification (**NIC**)
  - c) **NANDA**, Nursing Outcomes Classification (**NOC**), Nursing Interventions Classification (**NIC**)
  - d) Nursing Process, Nursing Interventions Classification (**NIC**), Nursing Outcomes Classification (**NOC**)
  
3. Benefits of using Standardized Nursing Language in clinical practice include:
  - a) facilitating communication among nurses, and between nurses and other health care providers
  - b) making nursing more visible by clearly communicating what nurses do
  - c) facilitating the teaching of clinical decision-making to student and novice nurses
  - d) all of the above

**Proceed to Chapter 2**

## Chapter 2

# Nursing Diagnoses

### (NANDA - North American Nursing Diagnosis Association)

- NANDA, the North American Nursing Diagnosis Association, has developed a classification of nursing diagnoses and has approved over 150 to date. Utilizing the NANDA based nursing diagnoses helps us develop Standard Nursing Care Plans that will become our standard of care for the entire institution.
- By definition nursing diagnoses describe patient, family or community responses to actual or potential health problems/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes, for which the nurse is accountable.
- You may be familiar with the terms nursing problems and with the nursing problem list. These are terms currently used in problem oriented documentation. Nursing 'diagnoses' replace nursing 'problems'.
- After completing the your initial assessment of your patient, you decide which nursing diagnoses best describe the patient's health care issues. (See Appendix A for the current [NANDA Nursing Diagnoses](#) organized by Functional Health Patterns)

#### What will help you make the selection?

- Each nursing diagnosis has a definition with defining characteristics (signs/symptoms) and related/risk factors (etiologies). Table 1 illustrates an example of a nursing diagnosis. More examples can be found in a copy of Nursing Diagnoses: Definitions & Classification, 1999-2000<sup>4</sup>.

Table 1. NANDA -approved Nursing Diagnosis: Knowledge Deficit<sup>4</sup>, (p118)

#### Nursing Diagnosis:

- Knowledge Deficit: Medication<sup>4</sup>(p.118)

#### Definition:

- Absence or deficiency of cognitive information related to a specific topic

#### Defining Characteristics (signs/symptoms):

- |                               |  |
|-------------------------------|--|
| • Verbalization of problem    | • Inaccurate follow-through of instruction   |
| • Inaccurate performance test | • Inappropriate or exaggerated behaviors (e.g. apathetic, hysterical, hostile, agitated) |

#### Risk/Related Factors (etiology):

- |                        |  |
|------------------------|--|
| • Cognitive limitation | • Information misinterpretation            |
| • Lack of exposure     | • Lack of interest in learning             |
| • Lack of recall       | • Unfamiliarity with information resources |

## Quiz Questions for Chapter 2

### Nursing Diagnosis.

After you have answered the questions related to Nursing Diagnosis, proceed to Chapter 3.

4. All of the following facts about **NANDA** and nursing diagnosis are accurate **EXCEPT**:
- a) **NANDA** approves a list of nursing diagnoses
  - b) A nursing diagnosis is a clinical judgement about an individual's response to actual or potential health problem
  - c) Only nurse practitioners can make a nursing diagnosis
5. Which of the following statements about **NANDA** are true?
- A. **NANDA** stands for the "North American Nursing Diagnosis Association"
  - B. **NANDA** develops, refines and promotes a classification system of nursing diagnosis terminology useful to the professional nurse.
  - C. Following the functional health pattern (FHP) assessment, the next step in nursing process incorporates **NANDA** nursing diagnosis terminology.
- a) A, B, C      b) A & B      c) A only
6. The **NANDA** Nursing Diagnosis Classification System provides standard terminology in order to better describe what we used to refer to as "nursing problems", or the "problem list".
- a) True
  - b) False

**Proceed to Chapter 3.**

## Chapter 3

### Nursing Outcomes Classification (NOC)

- The next step after making your nursing diagnosis is to select the nursing outcome(s) appropriate for this diagnosis.
- The **Nursing Outcomes Classification** is a classification of patient outcomes that are responsive to nursing interventions.
- This means that nursing interventions will affect patient outcomes, i.e. are "sensitive to nursing".
- Currently you may be using "patient goal" or "expected outcome(s)" for this step in the nursing process.
- **NOCs** are "status measures" with specific indicators that can be observed and measured and represent a patient's state at a given point in time.
  - To determine your patient's status, you will select the indicators that best measure achievement of the nursing outcome.
  - To help even further, a **five-point measurement scale** will indicate where your patient is in reaching each outcome (patient status).

#### How do you use them?

- After determining the pertinent nursing diagnoses, you decide which outcome(s) you will monitor to evaluate the stage of resolution of each nursing diagnosis.
  - If your patient's nursing diagnosis is **Knowledge Deficit: Medication**, you might choose "**Knowledge: Medication**" and "**Compliance Behavior**" as two of your nursing outcomes\*.

\*You will find a **NANDA/NOC** linkage list on pages 455-533 in reference 2. While this list is not all inclusive, it provides guidance in linking **NANDAs** and **NOCs**.

#### Is there anything that helps you make your selection of nursing outcomes?

- As mentioned above, each outcome has a definition and several indicators that are used to determine patient status.

#### How do you know if your patient has achieved the outcome?

You use a measurement scale!

- You would then rate each indicator for the patient on a scale of 1 to 5, none (1) to extensive (5) for Knowledge: Medication or never demonstrated (1) to consistently demonstrated (5) for Compliance Behavior.

Here is how it might look, when you link the **NANDA** with the **Nursing Outcomes (NOCs)**. Tables 2 and 3 illustrate the two nursing outcomes suggested above and their indicators.

**NANDA: Knowledge Deficit: Medication**

**NOC: Knowledge: Medication:** extent of understanding conveyed about the safe use of medication.<sup>2</sup> (page 279)

<b>Knowledge: Medication</b>	<b>None 1</b>	<b>Limited 2</b>	<b>Moderate 3</b>	<b>Substantial 4</b>	<b>Extensive 5</b>
<b>Indicators:</b>					
Recognition of need to inform health provider of all medication being taken	1	2	3	4	5
Statement of correct medication name	1	2	3	4	5
Description of appearance of medication	1	2	3	4	5
Description of actions of medication	1	2	3	4	5
Description of side effects	1	2	3	4	5
Description of medication precautions	1	2	3	4	5
Description of use of memory aids	1	2	3	4	5
Description of potential interaction with other agents	1	2	3	4	5
Description of proper medication storage	1	2	3	4	5
Description of correct administration of medication	1	2	3	4	5
Description of how to obtain required medication & supplies	1	2	3	4	5
Identification of needed laboratory tests	1	2	3	4	5

**Table 2. NOC: Knowledge: Medication**

After you have reviewed these indicators with the patient and family, you choose the ones that will best measure your patient's achievement of the outcome. Then select the number that best indicates your patient's current level of knowledge.

The second outcome for **NANDA: Knowledge Deficit: Medication** is

**NOC: Compliance Behavior:** actions taken on the basis of professional advice to promote wellness, recovery & rehabilitation<sup>2</sup>.  
(p.188)

Table 3: **NOC: Compliance Behavior**

<b>Compliance Behavior</b>	<b>Never demonstrated 1</b>	<b>Rarely demonstrated 2</b>	<b>Sometimes demonstrated 3</b>	<b>Often demonstrated 4</b>	<b>Consistently demonstrated 5</b>
<b>Indicators:</b>					
Relies on health professional for current information	1	2	3	4	5
Reports following prescribed regimen	1	2	3	4	5
Accepts health professional's diagnosis	1	2	3	4	5
Modifies regimen as directed by a health professional	1	2	3	4	5
Performs self-screening when directed	1	2	3	4	5
Other _____ specify	1	2	3	4	5

Again, you would select the number from the scale that best indicates your patient's current status for each indicator.

**Do the measurement scales have anything in common?**

- All measurement scales used in the Nursing Outcomes Classification system are developed so that **1** is the **least desirable** patient state and **5** is the **most desirable** patient state.
  - **For example:** 1 = extremely compromised and 5 = not compromised or 1 = never demonstrated and 5 = consistently demonstrated.

**How often do you measure progress towards the outcomes?**

You would reevaluate the patient at predetermined intervals.  
By using the measurement scale to rate your patient, you will determine if your patient is making progress towards the outcome(s) and can make changes to the care plan, as appropriate.

**Quiz for Chapter 3**  
**Nursing Outcomes Classification (NOCs)**

7. The **Nursing Outcomes Classification (NOC)** replaces what element of the Nursing Care Plan?
- a) Problem
  - b) Goal
  - c) Nursing Interventions
  - d) Nursing Diagnosis
8. All of the following statements about **NOC** are true **EXCEPT**:
- a) Each Outcome has a definition
  - b) For each Outcome, there are indicators to determine patient status
  - c) A measurement scale from 1-5 must be used to document progress
  - d) To use an outcome, all indicators/outcome should apply to the patient
9. Which of the following would **NOT** be a patient outcome?
- a) Self Care: Oral Hygiene
  - b) Knowledge: Health Behaviors
  - c) Vital Signs
  - d) Social Support
10. In using the **NOC** measurement scale, 1 always equals the most desirable patient state.
- a) True
  - b) False

**Proceed to Chapter 4**

# Chapter 4

## Nursing Interventions Classification (NIC)

Once you have established the **Nursing Diagnoses** and **Nursing Outcomes**, the next step is to select the nursing interventions that will best help the patient achieve those outcomes.

- The **Nursing Interventions Classification (NIC)** is a comprehensive, standardized language that describes treatments that nurses perform in **all settings and in all specialties**.
- Nursing interventions have been classified for ease of access and use
  - Each nursing intervention has a **specific label** and **definition** and a number of **activities** to achieve that intervention.
- These nursing interventions (NICs) are **what YOU do in your daily work!**
- **Nursing interventions** are linked to **Nursing Diagnoses** and **Nursing Outcomes**.
  - A **NIC** that you might choose for the nursing outcome **Knowledge: Medication** is "**Teaching: Prescribed Medication**". Table 4 illustrates the nursing intervention and the selection of activities related to the intervention.
  - A **NIC** that you might select for the nursing outcome **Compliance Behavior** is "**Coping Enhancement**". Table 5 illustrates this **NIC**.

# Nursing Diagnosis: Knowledge Deficit: Medication

**Nursing Outcomes:** Knowledge: Medication  
Compliance Behavior

**Nursing Interventions:** Teaching: Prescribed Medication  
Coping Enhancement

## Nursing Intervention Example (NIC)

Label: **Teaching: Prescribed Medication<sup>3</sup>** (p.650)

### Definition

Preparing a patient to safely take prescribed medications & monitor for their effects

### Activities

Those behaviors/actions that nurses carry out to meet the intervention

### Activity Choices for **Teaching: Prescribed Medication:**

<input type="checkbox"/> Instruct patient to recognize distinctive characteristics of the medication (s)	<input type="checkbox"/> Instruct patient on what to do if dose is missed
<input type="checkbox"/> Inform the patient of both generic & brand names	<input type="checkbox"/> Instruct patient on the proper administration/application of each medication
<input type="checkbox"/> Instruct patient on the purpose & action of each medication	<input type="checkbox"/> Evaluate the patient's ability to self administer medication
<input type="checkbox"/> Instruct patient on the dosage, route & duration of each medication	<input type="checkbox"/> Instruct patient on possible adverse side effects of each medication
<input type="checkbox"/> Instruct patient on which criteria to use when deciding to alter the medication dose/schedule	<input type="checkbox"/> Instruct patient to perform needed procedures before taking a medication (e.g. check pulse)
<input type="checkbox"/> Instruct patient on consequences of not taking or abruptly discontinuing medication(s)	<input type="checkbox"/> Instruct patient on specific precautions to observe when taking medication(s) (e.g. no driving)
<input type="checkbox"/> Inform patient of possible drug/food interactions	<input type="checkbox"/> Instruct patient on how to relieve and /or prevent certain side effects
<input type="checkbox"/> Instruct patient on signs & symptoms of under/over dose	<input type="checkbox"/> Instruct patient on proper disposal of needles & syringes at home & where to dispose of sharps container in their community
<input type="checkbox"/> Provide patient with written information about the action purpose, side effects and so on.	<input type="checkbox"/> Warn patient of risk associated with taking expired medication
<input type="checkbox"/> Provide information on medication reimbursement , as appropriate	<input type="checkbox"/> Caution the patient about giving prescribed medications to others.

Table 4. **Nursing Intervention and Activities: Teaching Prescribed Medication<sup>3</sup>** (p 650)

After reviewing these activities, you would select the ones that will best achieve the intervention for your patient.

## Nursing Diagnosis: Knowledge Deficit: Medication

**Nursing Outcomes:** Knowledge: Medication  
Compliance Behavior

**Nursing Interventions:** Teaching: Prescribed Medication  
Coping Enhancement

### Nursing Intervention Example (NIC)

**Label:** Coping Enhancement<sup>3</sup> (p.234)

**Definition:** Assisting a patient to adapt to perceive stressors, changes or threats, which interfere with meeting life demands & roles.

### **Activity Choices: Coping Enhancement**

<input type="checkbox"/> Appraise the impact of pt's life situation on roles & relationships	<input type="checkbox"/> Encourage pt to identify a realistic description of change in role
<input type="checkbox"/> Appraise pt's understanding of disease process	<input type="checkbox"/> Use a calm, reassuring approach
<input type="checkbox"/> Provide an atmosphere of acceptance	<input type="checkbox"/> Help pt identify the information he/she is most interested in obtaining
<input type="checkbox"/> Provide factual information concerning diagnosis, treatment, & prognosis	<input type="checkbox"/> Evaluate the pt's decision making ability
<input type="checkbox"/> Confront pt's ambivalent feelings	<input type="checkbox"/> Encourage verbalization of feelings , perceptions & fears
<input type="checkbox"/> Assist pt to problem solve in a constructive manner	<input type="checkbox"/> Encourage pt to evaluate own behavior
<input type="checkbox"/> Assist pt to clarify misconceptions	<input type="checkbox"/> Assist pt to identify support systems

Table 5. NIC for Coping Enhancement<sup>3</sup> (page 234)

After reviewing these activities, you would select the appropriate ones for your patient.

**Quiz for Chapter 4**  
**Nursing Interventions Classification (NIC)**

11. The **NIC** classification system is comparable to what part of a documentation system:
- a) Assessment
  - b) Evaluation
  - c) Nursing treatment
  - d) Nursing Problem
12. Which one of the following is **NOT** a Nursing Intervention?
- a) Analgesic Administration
  - b) Electrolyte Management
  - c) Infection Status
  - d) Latex Precautions
13. NICs also include *activities* done for that intervention. Which of the following would be an activity for the **Nursing Intervention: Teaching: Preoperative?**
- a) Instruct the patient how to cough and deep breath
  - b) Monitor vital signs
  - c) Demonstrate quieting techniques for infants
  - d) Monitor for bubbling of suction chamber of the chest tube drainage system and tidaling in waterseal chamber

**Correct your answers against the answer key. If you have not scored 80% or greater, review the material again or consult your resource person. Continue to take the quiz until you have scored 80% or greater.**

**Before proceeding to Chapter 5, please review the next page to get a picture of what a completed care plan will look like using the **NANDA: Knowledge Deficit: Medication.****

**Defining Characteristics (signs and symptoms)**

Verbal, Coded, Observed Report of:

- Verbalizes lack of information about medication
- Inaccurate follow-through of instructions
- Inaccurate self-administration of medication
- Apathetic behavior
- Lack of interest in learning
- Information misinterpretation

**Related/Risk Factors (Etiology)**

- Lack of interest in learning
- Information misinterpretation

**OUTCOMES (NOC)\***

<p><b>Knowledge: Medication</b></p> <p><b>Measurement Scale Score:</b></p> <p>1 = None</p> <p>2 = Limited</p> <p>3 = Moderate</p> <p>4 = Substantial</p> <p>5 = Extensive</p>	<input type="checkbox"/> Description of side effects of medication		
	<input type="checkbox"/> Description of correct administration of medication	2	4
	<input type="checkbox"/> Description of correct name of medication	2	4
	DATE/TIME 1/27/00	1/27/00	1/30/00
	INITIALS	pp	pp

**INTERVENTIONS (NIC)**

<p><b>TEACHING MEDICATIONS</b></p>	<input type="checkbox"/> Informs pt of generic/brand names	
	<input type="checkbox"/> Instruct pt on purpose & action of each medication	
	<input type="checkbox"/> Instruct pt on possible food/drug interactions	
	<input type="checkbox"/> Instruct pt s&s of under/over dose	Instructed pt what to do if dose is missed. 1/31/00
	<input type="checkbox"/> Instruct pt on criteria to use when deciding to alter the medication schedule	
<input type="checkbox"/> Evaluate pt's ability to self administer medication		

<p><b>Compliance Behavior</b></p> <p><b>Measurement Scale Score:</b></p> <p>1= never demonstrated</p> <p>2= rarely demonstrated</p> <p>3= sometimes demonstrated</p> <p>4= often demonstrated</p> <p>5= consistently demonstrated</p>	<input type="checkbox"/> Reports following prescribed health regimen	2	4
	<input type="checkbox"/> Performs self-screening when directed	2	4
	<input type="checkbox"/> Modifies regimen as prescribed by health professional	2	3
	DATE/TIME 1/27/00	1/27/00	1/30/00
	INITIALS	pp	pp

<p><b>COPING ENHANCEMENT</b></p>	<input type="checkbox"/> Appraise the impact of pt's life situation on roles &	
	<input type="checkbox"/> Help pt identify information he/she is most interested in obtaining	
	<input type="checkbox"/> Appraise pt's understanding of disease process	
	<input type="checkbox"/> Confront pt/s ambivalent feelings	
	<input type="checkbox"/> Encourage verbalization of feelings, perceptions, & fears	
<input type="checkbox"/> Assist pt to problem solve in a constructive way		

Other

Interventions

•	•	•	Signature Box
		1/27/00 PPatterson	1/30/00 PPatterson

**\*Nursing Outcomes Classification**

## Chapter 5

### Case Scenarios

How does the use of SNL apply to your setting and the development of care plans?

- Read one of the following Case Scenarios and complete the nursing care plan that immediately follows the case scenario.
- The purpose of this exercise is for you to work through the process of completing a nursing care plan using the standardized nursing languages. You will be reading a case scenario and making decisions based on the functional health assessment data and information provided about **NANDA**, **NOCs** and **NICs**.

#### Case Scenarios

1. Adult Acute Care - Medicine
2. Adult Acute Care - Surgery
3. Adult ICU
4. Pediatric Acute Care
5. Pediatric ICU
6. Perinatal
7. Psychiatry
8. Ambulatory Care

## Appendix A

### NANDA arranged by Functional Health Patterns

<p><b><u>HEALTH-PERCEPTION/HEALTH MANAGEMENT</u></b>          Adult failure to thrive          Dentition, altered*          Development, risk for altered          Growth &amp; development, altered          Health-seeking behaviors (specify)          Home maintenance management, impaired          Infection, risk for          Injury, risk for          Knowledge deficit          Management of therapeutic regimen, ineffective          Noncompliance, (specify)          Poisoning, risk for          Protection, altered          Relocation stress syndrome          Suffocation, risk for          Surgical recovery, delayed*          Trauma, risk for</p>	<p><b><u>NUTRITIONAL/METABOLISM</u></b>          Body temperature, risk for altered          Breastfeeding, effective          Breastfeeding, ineffective, interrupted          Hyperthermia          Development, risk for altered          Hypothermia  <b>Nausea*</b>          Nutrition, altered: less than body requirements          Nutrition, altered: risk for more than body requirements          Oral mucous membrane, altered          Swallowing, impaired          Thermoregulation, ineffective          - <i>SKIN INTEGRITY</i>          Skin integrity, impaired          Skin integrity, risk for impaired          Tissue integrity, impaired</p>	<p><b><u>ELIMINATION</u></b>          Constipation, (risk for*)          Constipation, colonic          Constipation, perceived          Diarrhea          Incontinence, bowel          Incontinence, urinary: functional reflex, stress, total          Urinary elimination, altered patterns of          Urinary retention          Urinary urge incontinence*</p>
<p><b><u>ROLE-RELATIONSHIP</u></b>          Altered family process          Coping, defensive          Development, risk for altered          Family processes, altered          Grieving: anticipatory/dysfunctional          Loneliness, risk for          Parent/Infant/Child attachment, risk for altered          Parental role conflict          Parenting, altered          Parenting, risk for altered          Role performance, altered          Social interaction, impaired          Social isolation          Violence, risk for: self-directed or directed at others</p>	<p><b><u>SEXUALITY-REPRODUCTION</u></b>          Breastfeeding, effective          Breastfeeding, ineffective, interrupted          Disorganized infant behavior, potential for enhanced          Sexual dysfunction          Sexuality patterns, altered          Rape-trauma syndrome          Rape-trauma syndrome: compound reaction, silent reaction</p>	<p><b><u>COPING-STRESS TOLERANCE</u></b>          Adjustment, impaired          Caregiver role strain          Caregiver role strain, risk for          Coping (family), ineffective: compromised, disabling          Coping (family), potential for enhanced          Coping (individual), ineffective          Coping (community), potential for enhanced          Death anxiety*          Post-trauma syndrome (risk for*)          Self-mutilation, risk for          Sorrow, chronic*</p>
<p><b><u>VALUE-BELIEF</u></b>          Decisional Conflict          Spiritual distress (distress of the human spirit) (risk for*)          Potential for enhanced spiritual well-being</p>	<p><b><u>SLEEP &amp; REST PATTERN</u></b>          Development, risk for altered          Sleep pattern disturbance</p>	<p><b><u>SELF PERCEPTION &amp; SELF-CONCEPT</u></b>          Anxiety          Body Image Disturbance          Development, risk for altered          Fear          Hopelessness          Personal Identity Disturbance          Powerlessness          Self-Esteem - Chronic Low, Disturbance, Situational Low          Self-Mutilation, Risk for</p>

<p><b><u>ACTIVITY/EXERCISE</u></b>  Activity intolerance  Activity intolerance, risk for  Bed mobility, impaired*  Diversional activity deficit  Fatigue  Mobility, impaired physical  Perioperative positioning injury  Peripheral neurovascular dysfunction,  risk for  Physical mobility, impaired  Self-care deficit: bathing/hygiene, dressing/grooming, feeding, toileting  Transfer ability, impaired*  Ventilation, inability to sustain spontaneous  Ventilatory weaning response, dysfunctional  Walking, impaired*  Wheelchair mobility, impaired*</p> <p><b><u>OXYGENATION/CIRCULATION</u></b>  Airway clearance, ineffective  Aspiration, risk for  Breathing pattern, ineffective  Cardiac Output, decreased  Dysfunctional ventilatory weaning response  Fluid volume deficit  Fluid volume excess  Gas exchange, impaired  Latex allergy response (risk for)*  Tissue perfusion, altered:  - cardiopulmonary, cerebral, gastrointestinal, peripheral, renal</p>	<p><b><u>COGNITIVE/PERCEPTUAL</u></b>  Adaptive capacity: intracranial, decreased  Anxiety  Autonomic dysreflexia, risk for*  Body image disturbance  Confusion, acute  Confusion, chronic  Decisional conflict  Disorganized infant behavior, potential for enhanced  Disuse syndrome, risk for  Dysreflexia  Energy field disturbance  Environmental interpretation syndrome, impaired  Fear  Hopelessness  Memory impaired  Pain  Pain, chronic  Personal identity disturbance  Powerlessness  Self-esteem disturbance: chronic low; situational low  Sensory/perceptual alterations (specify): visual, auditory, kinesthetic, gustatory, tactile, olfactory  Thought processes: altered  Unilateral neglect</p>	
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# RESOURCES

## I. Resources

- A. Video "Nursing: A Visible Difference" available from the University of Michigan Hospitals and Health Centers. at <http://www.med.umich.edu/i/nursing/snl/video2/video2.html>
- B. SNL Self Learning Module
- C. UMHHC SNL Web Site <http://www.med.umich.edu/i/nursing/snl/>

## II. References

### A. Journals & Books:

1. Henry, Suzanne Bakken, RN, DNSc, FAAN, et.al. "Nursing Data, Classification Systems, and Quality Indicators: What Every HIM Professional Needs to Know: Journal of AHIMA. 69 (5)"48-53. 55-6. 1998 May.
2. Johnson, M, and Maas, M., Moorhead, S. Nursing Outcomes Classification (NOC), 2<sup>nd</sup> Edition. St. Louis, Mosby-Year Book, Inc. 2000.
3. McCloskey, J.C. and Bulechek, G.M. Nursing Interventions Classification (NIC), 3<sup>rd</sup> Edition. St. Louis, Mosby-Year Book, Inc. 2000.
4. NANDA Nursing Diagnoses: Definitions and Classification (1999-2000)  
Philadelphia: North American Nursing Diagnosis Association, 1999.

### C. Other Resources

1. MNA Standardized Nursing Language Task Force (1-517-349-5640)
2. [www.nursing.uiowa.edu/cnc](http://www.nursing.uiowa.edu/cnc). Center for Nursing Classification  
[www.nursing.uiowa.edu/noc](http://www.nursing.uiowa.edu/noc). Nursing Outcomes Classification  
<http://www.nursing.uiowa.edu/nic/index.htm> Nursing Interventions Classification  
[www.nanda.org](http://www.nanda.org) direct link to NANDA  
<http://www.ncbi.nlm.nih.gov:80/entrez/query.fcgi?cmd=> link to automatically search PubMed (MEDLINE)

# Standard Nursing Language Quiz Answer Sheet

## Instructions:

Circle the correct answer(s)

1. A B C D
2. A B C D
3. A B C D
4. A B C D
5. A B C D
6. A B C D
7. A B C D
8. A B C D
9. A B C D
10. A B C D
11. A B C D
12. A B C D
13. A B C D

# Standard Nursing Language Answer Key

1. A B C ●
2. A B ● D
3. A B C ●
4. A B ● D
5. ● B C D
6. ● B C D
7. A ● C D
8. A B C ●
9. A B ● D
10. A ● C D
11. A B ● D
12. A B ● D
13. ● B C D

**Independent Study Evaluation  
Standardized Nursing Language (SNL)**

Name \_\_\_\_\_ Nursing License# \_\_\_\_\_ State \_\_\_\_\_

Mailing Address \_\_\_\_\_,

City \_\_\_\_\_, State \_\_\_\_\_, ZIP \_\_\_\_\_

Social Security Number \_\_\_\_\_ (required for issuance of CE Certificate)

Timed required to complete the activity: \_\_\_\_\_ Date: \_\_\_\_\_

€ I have checked my answers against the answer key and have scored equal to or greater than 80%

€ I have completed **ONE** nursing care plan for (please circle)

1. Adult Acute Care Medicine. 2 Adult Acute Care Surgery, 3 Adult ICU,
4. Pediatric Acute Care, 5. Pediatric ICU, 6. Perinatal,
7. Psychiatry, 8. Ambulatory Care

**PLEASE CIRCLE THE APPROPRIATE LETTER RESPONSE. PLEASE WRITE COMMENTS IN THE SPACE PROVIDED ON THIS FORM.**

<b>Purpose/goal of this educational activity:</b>	To provide the RN with knowledge about the standardized nursing languages of NANDA, NOC and NIC and a case scenario for completion of a nursing care plan utilizing these languages.
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**Objectives:**

Please indicate how well you achieved each of the following objectives:

	A = excellent, strongly agree	B = good, agree	C = fair, disagree	D = poor, strongly disagree
1. Describe the rationale for using standardized nursing language (SNL).	A	B	C	D
2. Describe the benefits to the patient, unit and institution when using SNL	A	B	C	D
3. Define Nursing Diagnosis (NANDA), Nursing Outcomes Classification (NOC), Nursing Interventions Classification (NIC)	A	B	C	D
4. Identify resources that support the use of NANDA, NOC and NIC	A	B	C	D
5. Devise a plan of care, integrating NANDA, NOC and NIC	A	B	C	D
6. The objective <u>related well</u> to the overall purpose/goal of this educational activity	A	B	C	D

<b>Teaching/Learning Resources</b>				
7. Was the self-learning module an effective learning resource?	A	B	C	D
8. Did this particular style, i.e. independent study, meet your needs on gaining information about standardized nursing language	A	B	C	D
<b>Content:</b>				
9. The content was relevant to the objectives.	A	B	C	D

10. What was the most positive thing about the educational activity?
11. What suggestions do you have for improvement?

12. Suggestions for future independent study materials?
<b>Comments:</b>