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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| Surveillance: Safety                   |                          |        |
| Sustenance Support                     |                          |        |
**Abuse Protection Support: Child (ABUSE)**

**Definition**: 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 parents who have a history of domestic violence or a mother who has a history of numerous “accidental” injuries

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)

Monitor the child for role reversal or overactive or aggressive behavior

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 older children for concrete information on how to provide for the basic care needs of their younger siblings

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 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

Determine whether the child demonstrates signs of physical abuse, including numerous injuries in various stages of healing; unexplained bruises & welts; unexplained pattern, immersion, & friction burns; facial, spinal, shaft, or multiple fractures; unexplained facial lacerations & abrasions; human bite marks; intracranial, subdural, intraventricular, & intracerebral 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

Monitor child for role reversal, such as passive submission to invasive procedures

Monitor child for extreme compliance, such as passive submission to invasive procedures

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, and 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, hotlines, and domestic abuse shelters

**Background Readings:**


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:**

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:**
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 (SaO₂ and SvO₂ 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:
**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:**
**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:**


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¹ Delaware definition differentiates between individual or group intervention.
Artificial Airway Management (ARTAIR)

**Definition:** Maintenance of endotracheal 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/tracheostomy cuff using minimal occlusive volume technique or minimal leak technique
- Maintain inflation of the endotracheal/tracheostoma cuff at 15 to 20 mm 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 tracheostomy obturator 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
- 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
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- 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:**
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:**
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:
**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:**
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:
**Body Mechanics Promotion (BODY and BODYG)**

*Definition*: 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:**

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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:
**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:*
**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 SaO₂, respiratory rhythm and rate, cardiac rhythm and rate, and comfort levels

**Background Reading:**
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:
Counseling (COUNSEL and COUNSELG)

Definition¹: 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:

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:
Emergency Care (ERILL and ERINJ)

Definition¹: 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:

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:**
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:**
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:

\(^1\) Delaware definition differentiates between individual or group intervention.
Feeding (FEED)

Definition: 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:

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:
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:
**Health Care Information Exchange (INFOILL and INFOINJ)**

*Definition*: 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:**

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1 Delaware definition differentiates between intervention related to illness or injury.
Health Education (HLTHED and HLTHEDG)

**Definition**: 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, telecommunication, 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 health 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:**

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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:**
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:**

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\(^1\) 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:
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:
**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 erythematosus, herpes, hepatitis, HIV, and epilepsy)
Review obstetrical history for pregnancy-related risk factors (e.g., prematurity, postmaturity, preeclampsia, multifetal pregnancy, intrauterine growth retardation, abortion, 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:**
**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:**
**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:**
**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:**
**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:**
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:**
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:**
**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:**

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:**
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 Glasgow 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:
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)

Definition¹: 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
- Ascerten 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 dairy, 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:**
Nutrition, Special Diet (SPDIET)

Definition: 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:

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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:
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, acupuncture, 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:
**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:**
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:

\(^1\) 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:**
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:**

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\(^1\) 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:**
Rest (REST)

*Definition*: Providing environment and supervision to facilitate rest/sleep after nursing evaluation.

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

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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:
**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:**
**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:**

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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:**

\(^1\) NIC terminology is “Skin Care: topical treatments”
Smoking Cessation Assistance (SMOKE and SMOKEG)

**Definition**: 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:**

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1 Delaware definition differentiates between individual and group intervention.
**Substance Use Prevention (SUBAB and SUBABG)**

*Definition*: 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:**

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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
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
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:
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:**
**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:**
**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:**
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:**
**Telephone Consultation (TC)**

**Definition**: 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**:

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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: 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)

Definition¹: 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:**
**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:**
**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:**
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 pulsum paradoxus
Monitor for pulsum 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:
**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.
Mosby.
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:**
<table>
<thead>
<tr>
<th>NURSING CARE</th>
<th>Medication Management MEDMGMT–facilitation of safe/effective use of prescription &amp; over-the-counter drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Care ADMINCARE – facilitating entry of student into school (health needs)</td>
<td>Multidisciplinary Care Conference (illness) CONFILL–planning &amp; evaluating patient care with health professionals from other disciplines</td>
</tr>
<tr>
<td>Airway Management AIRMGT–facilitation of patency of air passages</td>
<td>Multidisciplinary Care Conference (injury) CONFINJ–planning &amp; evaluating patient care with health professionals from other disciplines</td>
</tr>
<tr>
<td>Airway Suctioning AIRSUC–removal of airway secretions by inserting a suction catheter into the patient’s oral airway &amp;/or trachea</td>
<td>Nausea Management NAUSEA – prevention &amp; alleviation of nausea</td>
</tr>
<tr>
<td>Allergy Management ALLERGY–identification, treatment, &amp; prevention of allergic responses to food, medications, insect bites, contrast material, blood, &amp; other substances</td>
<td>Neurologic Monitoring NEURO–collection &amp; analysis of patient data to prevent or minimize neurological complications</td>
</tr>
<tr>
<td>Artificial Airway Management ARTAIR–maintenance of endotrachial/tracheostomy tubes &amp; prevention of complications associated with their use</td>
<td>Non-Nursing Intervention NONNURSE – providing service not requiring nursing skills/expertise</td>
</tr>
<tr>
<td>Aspiration Precautions ASPIR–prevention/minimization of risk factors in the patient at risk for aspiration</td>
<td>Nursing Assessment, No Intervention NASS – providing assessment requiring professional nursing knowledge &amp; skills without related intervention</td>
</tr>
<tr>
<td>Asthma Management ASTHMA–identification, treatment and prevention of reactions to inflammation/constriction of the airway passages</td>
<td>Nursing Intervention NURSE – intervention requiring professional nursing knowledge and skills (not available on current list)</td>
</tr>
<tr>
<td>Bleeding Reduction: Nasal NOSEBL– Limitation of blood loss from the nasal cavity</td>
<td>Nutrition, Special Diet SPDIET–modification &amp; monitoring of special diet</td>
</tr>
<tr>
<td>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</td>
<td>Ostomy Care OSTO– maintenance of elimination through a stoma &amp; care of surrounding tissue</td>
</tr>
<tr>
<td>Bowel Management BWL–establishment &amp; maintenance of a regular pattern of bowel elimination</td>
<td>Pain Management PAIN–alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient</td>
</tr>
<tr>
<td>Cast Care: Maintenance CAST–care of a cast after the drying period</td>
<td>Positioning POSI–deliberative placement of the patient or a body part to promote physiological &amp;/or psychological well-being</td>
</tr>
<tr>
<td>Chest Physiotherapy CHEST–assisting the patient to move airway secretions from peripheral airways to more central airways for expectoration &amp;/or suctioning</td>
<td>Referral Management REFMTG – arrangement for services by another healthcare provider or agency</td>
</tr>
<tr>
<td>Contact Lens Care EYECL – prevention of eye injury &amp; lens damage</td>
<td>Respiratory Monitoring RESP–collection &amp; analysis of patient data to ensure airway patency &amp; adequate gas exchange</td>
</tr>
<tr>
<td>Diarrhea Management DIARR – prevention &amp; alleviation of diarrhea</td>
<td>Rest REST – providing environment &amp; supervision to facilitate rest/sleep (NON-nursing)</td>
</tr>
<tr>
<td>Emergency Care (illness) ERILL–providing life-saving measures in life-threatening situations caused by illness</td>
<td>Seizure Management SZR–care of a patient during a seizure &amp; the postictal state</td>
</tr>
<tr>
<td>Emergency Care (injury) ERINJ–providing life-saving measures in life-threatening situations caused by injury</td>
<td>Self-Care Assistance, Nursing SELFNUR–assisting another to perform activities of daily living</td>
</tr>
<tr>
<td>Enteral Tube Feeding TUBEFEED–delivering nutrients &amp; water through a gastrointestinal tube</td>
<td>Self-Care Assistance, Non-Nursing SELFNON–assisting another to perform activities of daily living</td>
</tr>
<tr>
<td>Feeding FEED – feeding of patient with oral motor deficits</td>
<td>Skin Care SKIN–application of topical substances or manipulation of devices to promote skin integrity &amp; minimize skin breakdown</td>
</tr>
<tr>
<td>Fever Treatment FVR–management of a patient with hyperpyrexia caused by nonenvironmental factors</td>
<td>Surveillance SURV - purposeful/ongoing acquisition, interpretation, &amp; synthesis of patient data for clinical decision making</td>
</tr>
<tr>
<td>First Aid WOUNDFA–providing initial care for a minor injury</td>
<td>Surveillance: Skin SKINSRV–collection/analysis of patient data to maintain skin &amp; mucous membrane integrity</td>
</tr>
<tr>
<td>Health Care Information Exchange (illness) INFOILL–providing patient care information to other health professionals related to illness</td>
<td>Telephone Consultation TC–for purpose of updating medical information</td>
</tr>
<tr>
<td>Health Care Information Exchange (injury) INFOINJ–providing patient care information to other health professionals related to injury</td>
<td>Treatment Administration TXADM–preparing, giving, &amp; evaluating the effectiveness of prescribed treatments</td>
</tr>
<tr>
<td>Heat/Cold Application (injury) HTCLD–stimulation of the skin &amp; underlying tissues with heat or cold for the purpose of decreasing pain, muscle spasms, or inflammation</td>
<td>Treatment Management TXMGT–facilitation of safe &amp; effective prescribed treatments</td>
</tr>
<tr>
<td>Heat Exposure Treatment HEATX–management of patient overcome by heat due to excessive environmental heat exposure</td>
<td>Tube Care TUBECARE–management of a patient with an external drainage device exiting the body</td>
</tr>
<tr>
<td>Hemorrhage Control HMRR–reduction or elimination of rapid &amp; excessive blood loss</td>
<td>Tube Care, Gastrointestinal TUBECAREGI–management of a patient with a gastrointestinal tube</td>
</tr>
<tr>
<td>High-Risk Pregnancy Care PREG–identification &amp; management of a high-risk pregnancy to promote healthy outcomes for mother &amp; baby</td>
<td>Urinary Catheterization CATH–insertion of a catheter into the bladder for temporary or permanent drainage of urine</td>
</tr>
<tr>
<td>Hyperglycemia Management HYPGR–preventing &amp; treating above-normal blood glucose levels</td>
<td>Vital Signs Monitoring VS–collection/analysis of cardiovascular, respiratory, &amp; body temperature data to determine/prevent complications</td>
</tr>
<tr>
<td>Hyperglycemia Management HYPGPO–preventing &amp; treating low blood glucose levels</td>
<td>Wound Care (Ongoing) WOUNDON–prevention of wound complications &amp; promotion of wound healing</td>
</tr>
<tr>
<td>Medication Administration MEDADM–preparing, giving, &amp; evaluating the effectiveness of prescription &amp; nonprescription drugs</td>
<td></td>
</tr>
</tbody>
</table>
### 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 lifestyle through an individual process

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

**Weight Management WGMTG** – 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

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

**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

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**NIC Definition & Activities Appendix A**

9-2006