Louisiana State Board of Nursing

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GUIDELINES FOR IMPLEMENTATION OF LEGAL STANDARDS OF NURSING PRACTICE

In 1977, the Board of Nursing adopted Legal Standards of Nursing Practice. The following guidelines are suggestions for implementing the Legal Standards.

STANDARD I: Data concerning an individual's health status must be systematically and continuously collected, recorded and communicated in order to determine nursing care needs according to the following criteria:

1. The format for the collection of data provides for systematic collection, frequent updating, accessibility and appropriate confidentiality as evidenced by:
   a. Assessment of the individual's condition on admission and documentation of same.
   b. Additions or revisions of data as individual's condition changes.
   c. Storage of records where relevant personnel may utilize them.
   d. Prevention of access to records by persons not involved in individual's care.

2. The appropriate data include:
   a. Growth and development factors, as evidenced by:
      (1) Notations of major deviations beyond the range of effective/normal in the following areas:
         (a) Cognitive (mental) status.
         (b) Affective (emotional or feeling tone) status.
         (c) Physiological (body functions) status.
      (2) Identification of normal growth and development characteristics which have particular relevance to the individual's current health needs. (Ex: Normal range of motion of arms important if individual will use trapeze.)
   b. Biophysical status, as evidenced by:
      (1) Record of vital signs on admission and at recurrent intervals.
      (2) Record of age, height and weight.
      (3) Identification of anatomical and/or physiological deviations from normal which have relevance for nursing care. (Sensory or motor impairment; malfunction of any body system.)

(4) Statement about allergies.

(5) Statement about condition of the skin, teeth, eyes, etc.

(6) Statement about apparent nutritional status. (Ex: underweight, obese, well-nourished)

(7) List of medications taken at home, including over-the-counter drugs.

(8) Record of complaints verbalized by the individual.

c. Emotional status documented as follows:

(1) Orientation to time, place and person.

(2) Coherence (reasonable connectedness of thought in speech or other communication.)

(3) Psychological status. (Ex: alert, talkative, anxious, depressed, frightened, calm, etc.)

d. Cultural, religious, socioeconomic background, as evidenced by:

(1) Record of religious preference.

(2) Statement of either occupation, hobbies or interests.

(3) Statement of living conditions (adequacy or inadequacy) in terms of shelter, food and clothing.

(4) Record of marital status.

(5) Record of number of dependents.

(6) Record of educational status of individual or family.

(7) Statement of individual's preference for visiting of family and friends.

e. Performance of activities of daily living documented as follows:

(1) Level of independence in bathing, dressing, toileting, transfer, continence, feeding.

(2) Record of any prosthetic devices, such as dentures, glasses or contact lenses, hearing aids, orthopedic braces, artificial limbs or eyes.

(3) Description of history of elimination patterns.

(4) Statement of diet or food preferences and dislikes.

(5) Statement of personal hygiene factors, such as preferences for tub bath or shower, time of bath, etc.

f. Patterns of coping with chief complaint. (What does individual do to relieve chief complaint?)

g. Interaction patterns. (Repetitive, inappropriate, overt verbal and non-verbal communication)

h. Individual's perception of and satisfaction with his health status documented by statement that individual sees his health as good, average or poor, and whether he is satisfied with this level of health.

i. Individual's health goals documented if verbalized, or non-verbalization of goals documented.

j. Environmental factors which obviously have relevance to present health problems:

(1) Physical factors, such as housing conditions, and working conditions.

(2) Social factors, such as community relationships or family relationships.

(3) Emotional factors, such as job or family tensions.

(4) Ecological factors, such as pollution from industrial wastes, smoking, water and food contaminants.

k. Statement confirming presence or absence of available and accessible human and material resources.

(1) Evidence of ability and willingness of family to give assistance to individual, if needed.

(2) Evidence of availability of community resources, if needed.

(3) Evidence of availability of physical aids which are necessary for rehabilitation.

(4) Evidence of availability of food, clothing and normal material comforts.

3. The recorded data are collected by the nurse through:

a. Interview

b. Examination

c. Observation

d. Reading of records and reports

4. The recorded data are collected by the nurse from:

a. The individual

b. Family members

c. Pertinent others

d. Other health care personnel

STANDARD II: Nursing care goals are derived from an analysis of the health status data according to the following criteria:

1. The individual's health status is compared to the norm to determine if there is a significant abnormality in the following areas: (Refer to Standard I, Criterion 2, for an interpretation of the areas that follow.)
   a. Growth and development factors.
   b. Biophysical status.
   c. Emotional status.
   d. Performance of activities of daily living.
   e. Patterns of coping.
   f. Interaction patterns.
2. The individual's capabilities and limitations are identified (in relation to current major health problems).
3. Short and long term goals are mutually set with the individual and pertinent others. These goals are:
   a. Congruent (in agreement) with other planned therapies.
   b. Stated in realistic (achievable) and measurable terms.
   c. Assigned a time period for achievement. (Deadline)
4. Goals are established to maximize functional capabilities and are congruent (in agreement) with the data collected relative to the following:
   a. Growth and development factors.
   b. Biophysical status.
   c. Behavioral patterns (social interaction, coping, affect).
   d. Human and material resources.

STANDARD III: The plan for nursing care must include priorities and nursing actions to achieve the established goals according to the following criteria:

1. The plan includes priorities for nursing action.
2. The plan includes a logical sequence of actions to attain the goals.

3. The plan is based on current scientific knowledge.

4. The plan incorporates available and appropriate resources (human and material).

5. The plan can be implemented (is realistic).

6. The plan reflects consideration of the dignity of man.
   a. Involves the individual and pertinent others in planning nursing care.
   b. Provides the individual with information needed to make informed decisions about care.
   c. Protects the individual's right to privacy.

7. The plan includes measures to manage specific patient problems. It specifies:
   a. What is to be done.
   b. How to do it.
   c. When to do it.
   d. Where to do it.
   e. Who is to do it.

8. The plan is communicated to the individual, to family, to pertinent others and to health personnel as appropriate.

STANDARD IV: The plan for nursing care is implemented according to the following criteria:

1. Nursing action is consistent with the plan for nursing care. (Actions are not different from plan.)

2. Nursing action is documented by written records reflecting:
   a. Activities of the registered nurse.
   b. Observations of nursing performance (activities by others.)
   c. Report of nursing action by the individual or pertinent others (when action is not observed).

STANDARD V: The plan for nursing care is evaluated according to the following criteria:

1. Current data about the individual are used to measure progress toward established goals. (The individual's current status is compared with goals.)

2. Nursing actions are analyzed for their effectiveness in achievement of established goals. (Do planned nursing actions help individual move toward goals?)

3. The individual, family and other significant health care personnel participate in evaluation of established goals, if appropriate. (Goal achievement jointly evaluated.)

4. The individual's response is compared with observable outcomes which are specified in the established goals to determine progress toward goal achievement.

5. Determination is make of the long term effects of nursing care on the individual, as evidenced by:

   a. Evaluation of progress toward long term goals.

   b. Referral to other agencies when necessary to achieve long term goals. (Includes any recommendation for further care.)

STANDARD VI: The planning for nursing care is a continuous process of reassessment and modification according to the following criteria:

1. The input of additional data determines new or revised approaches as evidenced by revision of all succeeding steps in the nursing process when new information is obtained at any step in the process. (Ex: new physical findings on reassessment are followed by revision of goals, plan of action and activities.)

2. New nursing actions are accurately and appropriately initiated, as evidenced by:

   a. Documentation of new activities.

   b. Deletion of nursing orders which are no longer appropriate.