4.7: Implementation of Interventions

Implementation is the fifth step of the nursing process (and the fifth Standard of Practice set by the American Nurses Association). This standard is defined as, “The registered nurse implements the identified plan.” The RN may delegate planned interventions after considering the circumstance, person, task, communication, supervision, and evaluation, as well as the state Nurse Practice Act, federal regulation, and agency policy.¹

Implementation of interventions requires the RN to use critical thinking and clinical judgment. After the initial plan of care is developed, continual reassessment of the patient is necessary to detect any changes in the patient’s condition requiring modification of the plan. The need for continual patient reassessment underscores the dynamic nature of the nursing process and is crucial to providing safe care.

During the implementation phase of the nursing process, the nurse prioritizes planned interventions, assesses patient safety while implementing interventions, delegates interventions as appropriate, and documents interventions performed.

Prioritizing Implementation of Interventions

Prioritizing implementation of interventions follows a similar method as to prioritizing nursing diagnoses. Maslow’s Hierarchy of Needs and the ABCs of airway, breathing, and circulation are used to establish top priority interventions. When possible, least invasive actions are usually preferred due to the risk of injury from invasive options. Read more about methods for prioritization under the “Diagnosis” subsection of this chapter.

The potential impact on future events, especially if a task is not completed at a certain time, is also included when prioritizing nursing interventions. For example, if a patient is scheduled to undergo a surgical procedure later in the day, the nurse prioritizes initiating a NPO (nothing by mouth) prescription prior to completing pre-op patient education about...
the procedure. The rationale for this decision is that if the patient ate food or drank water, the surgery time would be delayed. Knowing and understanding the patient’s purpose for care, current situation, and expected outcomes are necessary to accurately prioritize interventions.

### Patient Safety

It is essential to consider patient safety when implementing interventions. At times, patients may experience a change in condition that makes a planned nursing intervention or provider prescription no longer safe to implement. For example, an established nursing care plan for a patient states, “The nurse will ambulate the patient 100 feet three times daily.” However, during assessment this morning, the patient reports feeling dizzy today, and their blood pressure is 90/60. Using critical thinking and clinical judgment, the nurse decides to not implement the planned intervention of ambulating the patient. This decision and supporting assessment findings should be documented in the patient’s chart and also communicated during the shift handoff report, along with appropriate notification of the provider of the patient’s change in condition.

Implementing interventions goes far beyond implementing provider prescriptions and completing tasks identified on the nursing care plan and must focus on patient safety. As front-line providers, nurses are in the position to stop errors before they reach the patient.\(^2\)

In 2000 the Institute of Medicine (IOM) issued a groundbreaking report titled *To Err Is Human: Building a Safer Health System*. The report stated that as many as 98,000 people die in U.S. hospitals each year as a result of preventable medical errors. *To Err Is Human* broke the silence that previously surrounded the consequences of medical errors and set a national agenda for reducing medical errors and improving patient safety through the design of a safer health system.\(^3\) In 2007 the IOM published a follow-up report titled *Preventing Medication Errors* and reported that more than 1.5 million Americans are injured every year in American hospitals, and the average hospitalized patient experiences at least one medication error each day. This report emphasized actions that health care systems could take to improve medication safety.\(^4\)

**Note**

Read additional information about specific actions that nurses can take to prevent medication errors; go to the “Preventing Medication Errors” section of the "Legal/Ethical" chapter of the Open RN *Nursing Pharmacology* textbook.

In an article released by the Robert Wood Johnson Foundation, errors involving nurses that endanger patient safety cover broad territory. This territory spans “wrong site, wrong patient, wrong procedure” errors, medication mistakes, failures to follow procedures that prevent central line bloodstream and other infections, errors that allow unsupervised patients to fall, and more. Some errors can be traced to shifts that are too long that leave nurses fatigued, some result from flawed systems that do not allow for adequate safety checks, and others are caused by interruptions to nurses while they are trying to administer medications or provide other care.\(^5\)

The Quality and Safety Education for Nurses (QSEN) project began in 2005 to assist in preparing future nurses to continuously improve the quality and safety of the health care systems in which they work. The vision of the QSEN
project is to “inspire health care professionals to put quality and safety as core values to guide their work.” Nurses and nursing students are expected to participate in quality improvement (QI) initiatives by identifying gaps where change is needed and assisting in implementing initiatives to resolve these gaps. **Quality improvement** is defined as, “The combined and unceasing efforts of everyone – health care professionals, patients and their families, researchers, payers, planners and educators – to make the changes that will lead to better patient outcomes (health), better system performance (care), and better professional development (learning).”

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### Delegation of Interventions

While implementing interventions, RNs may elect to delegate nursing tasks. **Delegation** is defined by the American Nurses Association as, “The assignment of the performance of activities or tasks related to patient care to unlicensed assistive personnel or licensed practical nurses (LPNs) while retaining accountability for the outcome.” RNs are accountable for determining the appropriateness of the delegated task according to condition of the patient and the circumstance; the communication provided to an appropriately trained LPN or UAP; the level of supervision provided; and the evaluation and documentation of the task completed. The RN must also be aware of the state Nurse Practice Act, federal regulations, and agency policy before delegating. The RN cannot delegate responsibilities requiring clinical judgment. See the following box for information regarding legal requirements associated with delegation according to the Wisconsin Nurse Practice Act.

#### Delegation According to the Wisconsin Nurse Practice Act

During the supervision and direction of delegated acts a Registered Nurse shall do all of the following:

(a) Delegate tasks commensurate with educational preparation and demonstrated abilities of the person supervised.

(b) Provide direction and assistance to those supervised.

(c) Observe and monitor the activities of those supervised.

(d) Evaluate the effectiveness of acts performed under supervision.

The standard of practice for Licensed Practical Nurses in Wisconsin states, “In the performance of acts in basic patient situations, the LPN shall, under the general supervision of an RN or the direction of a provider:

(a) Accept only patient care assignments which the LPN is competent to perform.

(b) Provide basic nursing care. Basic nursing care is defined as care that can be performed following a defined nursing procedure with minimal modification in which the responses of the patient to the nursing care are predictable.

(c) Record nursing care given and report to the appropriate person changes in the condition of a patient.

(d) Consult with a provider in cases where an LPN knows or should know a delegated act may harm a patient.
(e) Perform the following other acts when applicable:

1. Assist with the collection of data.
2. Assist with the development and revision of a nursing care plan.
3. Reinforce the teaching provided by an RN provider and provide basic health care instruction.
4. Participate with other health team members in meeting basic patient needs.\(^{[11]}\)

**Note**

Read additional details about the scope of practice of registered nurses (RNs) and licensed practical nurses (LPNs) in Wisconsin’s Nurse Practice Act in [Chapter N 6 Standards of Practice](https://med.libretexts.org/Bookshelves/Nursing/Nursing_Fundamentals_(OpenRN)/04%3A_Nursing_Process/4.07%3A_Imple...).

Read more about the American Nurses Association’s [Principles of Delegation](https://med.libretexts.org/Bookshelves/Nursing/Nursing_Fundamentals_(OpenRN)/04%3A_Nursing_Process/4.07%3A_Imple...).

Table 4.7 outlines general guidelines for delegating nursing tasks in the state of Wisconsin according to the role of the health care team member.

### Table 4.7 General Guidelines for Delegating Nursing Tasks

<table>
<thead>
<tr>
<th></th>
<th>RN</th>
<th>LPN</th>
<th>CNA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
<td>Complete patient assessment</td>
<td>Assist with the collection of data for stable patients</td>
<td>Collect measurements such as weight, input/output, and vital signs in stable patients</td>
</tr>
<tr>
<td><strong>Diagnosis</strong></td>
<td>Analyze assessment data and create nursing diagnoses</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>Identify SMART patient outcomes</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Identification</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Planning</strong></td>
<td>Plan nursing interventions</td>
<td>Assist with the development of a nursing care plan</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Implementing Interventions</strong></td>
<td>Implement independent, dependent, and collaborative nursing interventions; delegate interventions as appropriate, with supervision</td>
<td>Participate with other health team members in meeting basic patient needs</td>
<td>Implement and document delegated interventions associated with basic nursing care such as providing assistance in ambulating or tasks within their scope of practice</td>
</tr>
</tbody>
</table>
**Evaluation**  
Evaluate the attainment of outcomes and revise the nursing care plan as needed  
Contribute data regarding the achievement of patient outcomes; assist in the revision of a nursing care plan  
Not applicable

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**Documentation of Interventions**

As interventions are performed, they must be documented in the patient’s record in a timely manner. As previously discussed in the “Ethical and Legal Issues” subsection of the “Basic Concepts” section, lack of documentation is considered a failure to communicate and a basis for legal action. A basic rule of thumb is if an intervention is not documented, it is considered not done in a court of law. It is also important to document administration of medication and other interventions in a timely manner to prevent errors that can occur due to delayed documentation time.

**Coordination of Care and Health Teaching/Health Promotion**

ANA’s Standard of Professional Practice for Implementation also includes the standards 5A*Coordination of Care* and 5B*Health Teaching and Health Promotion*. Coordination of Care includes competencies such as organizing the components of the plan, engaging the patient in self-care to achieve goals, and advocating for the delivery of dignified and holistic care by the interprofessional team. Health Teaching and Health Promotion is defined as, “Employing strategies to teach and promote health and wellness.” Patient education is an important component of nursing care and should be included during every patient encounter. For example, patient education may include teaching about side effects while administering medications or teaching patients how to self-manage their conditions at home.

**Putting It Together**

Refer to Scenario C in the “Assessment” section of this chapter. The nurse implemented the nursing care plan documented in Appendix C. Interventions related to breathing were prioritized. Administration of the diuretic medication was completed first, and lung sounds were monitored frequently for the remainder of the shift. Weighing the patient before breakfast was delegated to the CNA. The patient was educated about her medications and methods to use to reduce peripheral edema at home. All interventions were documented in the electronic medical record (EMR).

   https://doi.org/10.17226/


https://med.libretexts.org/Bookshelves/Nursing/Nursing_Fundamentals_(OpenRN)/04%3A_Nursing_Process/4.07%3A_Imple...