Nursing Process Outline- N101

- The Nursing Process
  - Cyclic, critical thinking process
  - 5 Steps to achieve optimal client outcomes
  - Helps organize nursing care
  - Applies evidence to care
  - *Purposeful, goal-oriented, systematic*
  - Dynamic, continuous, client-centered, problem-solving, and decision making
  - Framework for nursing care
  - Helps nurses apply knowledge, experience, judgment, and skills
  - Standards of nursing practice- ANA
  - Creates a plan of care: individuals, groups, families, and communities
  - Critical thinking
  - Nursing judgments
  - All based on reason
  - Promotes professionalism
  - Differentiates scope of practice from other healthcare professionals

- Sequential but overlapping 5 steps:
  - Assessment (data collection)
  - Diagnosis (analysis)
  - Planning
  - Implementation
  - Evaluation

- Results in: comprehensive, individualized, client-centered plan of care

<u>Assessment/ Data Collection</u>

  - Systematic collection of information
  - Present health status to identify needs and additional data to collect based on findings
  - Collection through:
    - initial assessment (baseline)
    - focused assessment
    - ongoing assessments
  - Methods:
    - Observation
    - Interviews
    - Client

        - Families
        - PMH
        - Physical Exam
        - Diagnostic/Lab reports
        - Collaboration (nurses, PT, OT, MD)

- Must collect effectively:
    - Ask appropriate questions
    - Listen carefully
    - Great Assessment Skills
- Must employ clinical judgment and critical thinking
- Recognize need to collect data prior to interventions

- Subjective Data (symptoms):
    - Clients' feelings, perceptions, and descriptions of health status
    - In "quotation marks"
    - Only client can describe and verify own symptoms

- Objective Data (signs):
    - Observe and measure (physical exam)
    - Collected through observation or physical assessment
    - 5 senses: feel, see, hear, and smell

- Sources of data
- Primary or Secondary:
    - Client
    - Family/ Significant Other
    - Healthcare Team
    - Health Records
    - Literature Review

Example

- <u>Primary</u>
- Subjective:
- What the client tells the nurse
  "My shoulder is really sore."

- Objective*:*

- Nurse collects through observation and examination
  Client grimaces when lifting arm to brush hair

- <u>Secondary</u>
- Subjective:
- What others tell the nurse based on what the client tells them
  She told me that her shoulder is sore every morning

- Objective:
- Data the nurse collects from other sources (family, friends, caregivers, medical records)
  PT note in chart indicates decreased ROM to left shoulder

  Examples
- "I feel tired today."
- Blood pressure 180/96
- Speaks only when spoken to
- "She seems nervous."
- "My leg hurts."
- Dirt under nails
- Rash on flank
- "I need help."
- Absent bowel sounds
- Respiratory rate 24

- Nurse: validates, interprets, and clusters data
  - <u>Validation</u>: directly with client, compare finding with chart, use references
    - VALIDATE DATA if discrepancies between subjective data, PE, or when statements differ
  - <u>Interpretation:</u> to determine its meaning
    - Cues: acquired through 5 senses
    - Inferences: nurses judgment or interpretation; assign meaning to cue/cluster of cues
    - The greater the number of cues grouped together is a greater potential for accurate judgments/diagnosis

<u>Diagnosing/Analysis</u>

- Critical thinking skills to identify health status or problems
- Interpret or monitor the collected data
- Reach a nursing judgment
- Provide direction for nursing care

- Nurse looks at the data:
    - Recognize patterns or trends
    - Compare data with reference ranges or expected standards
    - Arrive at conclusions to guide nursing care

- Gathered & Interpreted, now: Cluster/Organize the data:
    - No problems to be addressed
    - Problems identified
    - At risk for developing
    - Use of NANDA List

Planning

- Establish priorities & optimal outcomes of care
- These help direct nurses in selecting interventions to include in the plan of care = promote, maintain, or restore health
- Nurses set priorities, determine client outcomes, and select specific interventions

- *Which helps with ACUTE PAIN ?*
    - *Apply ice to LLE q2 hrs for 20 minutes on then remove during my time of care*
    - *Educate on low-fat diet during my time of care*

- Three types of planning:
    - Comprehensive: based on assessments
    - Ongoing: throughout the provision of care; obtaining new information and evaluating responses to care, nurses modify and individualize the initial plan of care
    - Discharge: anticipating and planning for needs after discharge; must begin during admission

- **Planning : Priority Problem**
- Preferential order of problems (priority)
- Cannot have *an at risk before an actual problem*

- Nursing diagnoses are classified as:
    - High: Requires immediate attention; life threatening
    - Intermediate: Does not directly threaten a person's life but may result in unhealthy physical or emotional consequence
    - Low: Can be resolved with minimal intervention

- **<u>Planning : Expected Outcomes / EO</u>**
- Work with clients to establish goals & outcomes
- Goals: identify optimal status
- Outcomes: identify observable criterion to state **success or failure of goal**
- Concise, measurable goals help evaluate progress
- Short & long-term goals
- Descriptive statements about what the client's state will be after the nursing interventions are carried out

- **<u>Planning : Interventions</u>**
- Nurses identify actions and interventions that will help achieve desired goal/outcome (EBP)
- **<u>Objective of NI's > individualize care</u>**

- Strategies the nurse uses to accomplish the EO and correct the problem (assessment, diagnostic, therapeutic, educational)

- Different types of interventions:
    - Nurse-initiated / Independent
    - Provider initiated / Dependent
    - Collaborative
- End product of planning phase = nursing care plan

- Types of NI's
    - <u>Independent</u>
        - Nurse-prescribed
        - Reducing or eliminating
        - Counseling
        - Teaching
        - Monitoring

    - <u>Dependent</u>
        - Physician-prescribed
        - Diet & activity restrictions
        - Medications
        - IV fluids
        - Providing treatments
        - Scheduling diagnostic studies

    - <u>Interdependent / Collaborative NI's</u>
        - Physician and nurse prescribed interventions

    - Nurse is responsible for monitoring possible or actual complications
    - Actions carried out with other health team members (i.e.- protocols, PT, dieticians, social workers)

Implementation

- Base care on previous steps
- Must use problem solving, clinical judgment, and critical thinking to implement appropriate therapeutic interventions
- Nurses use therapeutic communication and technical skills to implement
- Therapeutic interventions include those that help reduce risk to nurse (PPE)
- Evidence-based rationale
- Nurses perform nursing actions, delegate tasks, supervise other staff, and document the care & clients' responses
- Nurse assumes responsibility for implementation and includes family, and other team members as appropriate

Evaluation

- Nurses evaluate response to nursing interventions and form a clinical judgment about EO's
- Continuous- progressing towards goal? Modify plan?
- Determine effectiveness of care plan based on data

- Evaluate EO's:
    - Did the client meet the outcomes?
    - Were they specific to the client?
    - Were they measurable and realistic?

- Evaluate NI's:
    - Were the nursing interventions appropriate and effective?
    - Are they specific to the client?
    - Do they provide clear instructions?

- Evaluate the Nursing Diagnosis:
    - Does the diagnosis still exist?
    - Does a risk diagnosis still exist?
    - Has the current diagnosis been resolved?
    - Does a new diagnosis need to be added

- Factors that can lead to lack of goal achievement:
    - Incomplete data

    - Unrealistic outcomes
    - Nonspecific nursing interventions
    - Inadequate time to achieve outcome
- Nursing process: continuous process of reassessing needs, modifying priorities and outcomes, and revising plans when EO's are not achieved or when the client's condition changes

Nursing Diagnoses

- NANDA (North American Nursing Diagnosis Association)
- *A statement that describes an actual or potential problem and its underlying, direct, or indirect cause or causes*

Differentiating Nursing diagnosis from Medical diagnosis

- Nursing
    - Describes human response
    - May change as reactions change
    - Treatable by nurses within scope of practice
    - Responses = nursing need
    - Nursing interventions
    - May apply to alterations in individuals or groups

- Medical
    - Describes a disease
    - Stays the same as long as disease present
    - Treatable by MD within scope of medical practice
    - Clinical manifestations= medical need
    - Medical interventions
    - Applies to diseases in individuals only

- <u>Diagnosing: Steps in Developing a Nursing Diagnosis</u>
    - Identify: problem
        - describes the health problem or response for which nursing therapy is provided

    - Determine your clinical reasoning:
        - <u>Signs (O) & Symptoms (S)</u>
        - cluster of signs and symptoms that indicate the presence of a particular problem.
        - For risks: what factors?

- <u>Components: Nursing Diagnosis</u>
  Example:
  - Client comes in with pneumonia
  - Identified <u>priority problem</u> is **<u>impaired gas exchange</u> (problem - NANDA)**
  - **Clinical Reasoning:** (S&O) low pulse ox level, high respiratory rate, crackles in lungs

  -
- Types of Nursing Diagnoses
    - Actual/problem- focused
        - Ex: *Constipation*
    - Risk
        - Ex: *Risk for Constipation*
    - Health promotion
        - Ex: *Readiness for enhanced health management*

- Actual/ Problem-focused NDx
    - Validated by: characteristics
    - *Actual* does not appear in the statement
    - NANDA list
    - NI's focus to reduce or eliminate the problem

Examples – Actual

<u>Constipation</u>
(no BM x 72 hours)

Acute pain
(groaning, verbal complaints of pain)

Impaired physical mobility
(difficulty getting in and out of bed independently)

Excess Fluid Volume
(edema + 3 in LE's, wet productive cough)

- Risk NDx
  - Hasn't developed into an actual problem
  - Patient is vulnerable to develop based on factors present
  - ie: Risk for falls (fatigue, altered gait, pain medication)

Establishing Expected Outcomes

- Outcomes reflect a focus on observable, measurable changes in a person's health status.
- Describes a measured behavior of the client which causes the problem status to be changed, maintained, or prevented after nursing care has been delivered
- EOs are descriptive statements about what the client's state will be after the NI's are carried out
- Developed with the client
- Evaluated daily and modified PRN

- Criteria For Writing EO's
  - Clear and concise
  - Specific
  - Written in terms of client behavior
  - Realistic for client
  - Time frame - measurable
  - **S.M.A.R.T.**

- Components of an EO
  - Subject
  - Verb = client behavior
  - Qualifier = criterion of performance and conditions if needed
  - Time Frame = to be completed by

- Verbs – EO
- *Measurable*
    - Administers
    - Demonstrates
    - Performs
    - Verbalizes
    - Identifies
    - States
    - Has an increase/decrease in

- *Not Measurable*
    - Accepts
    - Appreciates
    - Knows
    - Understands

- Which examples are correct?

- _____ Mr. D. will walk 50 feet down the hall without SOB by the end of my shift.
- _____ Mrs. P. will feel better each day.
- _____ Mrs. T. will understand diabetes mellitus by discharge.
- _____ Mr. B. will drink 800 ml of fluids between 0700 –1900.
- _____ Mrs. J. will improve her relationship with her husband.
- _____ Mr. H. will demonstrate correct use of crutches on flat surfaces & stairs by discharge.

Example

- ND: Impaired skin integrity
  (2 cm intact erythematic ulcer on left heel)

- EO: Mr. W. will demonstrate a healed, non-measurable pressure ulcer in 1 week.

- Assessments:
- Assess & record the status of the ulcer q 8 hours.
- Assess nutritional status daily.
- Monitor mobility throughout my shift.
- Assess bony prominences q 8 hours.

- Interventions:

1) Turn q 2 hours.
2) Wash ulcer gently with wound cleanser, rinse, & pat dry BID.
3) Maintain bed setting in preventive mode at all times.
4) Apply heel protectors with removal only for assessments during my care.
5) Cover with tegaderm dressing prn.

- Example 2
- NDx: Risk for constipation
  (inadequate dietary fiber & fluid intake)
- EO: Mrs. C. will have a BM daily during her hospitalization.

- Assessments:
- Assess frequency and consistency each BM.
- Assess bowel sounds q 4 hrs.
- Assess I & O q 8 hrs.

- Interventions

1) Administer stool softeners po BID.
2) Encourage fluid intake (water) of at least 2 liters per day.
3) Teach the effects of inadequate fiber & fluid intake on BMs before discharge.
4) Review foods high in fiber before discharge.
5) Encourage ambulation in hallway TID.

Writing a Nursing Care Plan (NCP)

- Encompasses all of the components of the nursing process.
- Step by step approach of focusing on treating human responses to actual or potential health problems
- Allows the nurse to:
  - Assure sufficient data collected to substantiate the dx
  - Identify eo's that are measurable
  - Plan NI that are individualized and designed specifically to meet the identified goal
  - Support each NI with scientific rational
  - Evaluate the process

- Types of care plans:
  - Standardized
  - Collaborative
  - Student

Evidence-Based Practice

- Current standards of professional performance for nurses include using evidence and research findings in practice.
- All nurses are expected to use evidence and research to determine proper nursing actions, to engage in research activities as appropriate to their abilities, and to share knowledge with other nurses. (American Nurses Association, 2010)
- Historically, nursing based on experience, tradition, intuition, common sense and untested theories
- Requires critical thinking and scientific reflection
- Practice, theory, and research are the basis for nursing knowledge
- Protocols and procedures based on research and best evidence
- Best problem-solving approach to delivery of care that produces the highest quality outcomes
- **Research evidence, clinical expertise, clinical preference**