UNIT 1 SAFE, EFFECTIVE CARE ENVIRONMENT
SECTION: MANAGEMENT OF CARE

CHAPTER 7 *Nursing Process*

The nursing process is a cyclical, critical thinking process that consists of five steps to follow in a purposeful, goal-directed, systematic way to achieve optimal client outcomes. It is a variation of scientific reasoning that helps nurses organize nursing care and apply the optimal available evidence to care delivery.

The nursing process is a dynamic, continuous, client-centered, problem-solving, and decision-making framework that is foundational to nursing practice.

The nursing process provides a framework throughout which nurses can apply knowledge, experience, judgment, and skills, as well as established standards of nursing practice to the formulation of a plan of nursing care. This plan is applicable to any client system, including individuals, families, groups, and communities.

The nursing process helps nurses integrate critical thinking creatively to base nursing judgments on reason.

The nursing process promotes the professionalism of nursing while differentiating the practice of nursing from the practice of medicine and that of other health care professionals.

7.1 Nursing process framework

The nursing process includes sequential but overlapping steps:

- Assessment/data collection*
- Analysis/data collection*
- Planning
- Implementation
- Evaluation

**PNs combine the assessment and analysis steps into a single data collection step.*

The accuracy and thoroughness of assessment/analysis/data collection and planning have a direct impact on implementation and evaluation. Use of the nursing process results in a comprehensive, individualized, client-centered plan of nursing care that nurses can deliver in a timely and reasonable manner. QSEN: PCC

ASSESSMENT/DATA COLLECTION

- Assessment/data collection involves the systematic collection of information about clients' present health status to identify needs and additional data to collect based on findings. Nurses can collect data during an initial assessment (baseline data), focused assessment, and ongoing assessments.
- Methods of data collection include observation, interviews with clients and families, medical history, comprehensive or focused physical examination, diagnostic and laboratory reports, and collaboration with other members of the health care team.
- To collect data effectively, nurses must ask clients appropriate questions, listen carefully to responses, and have excellent head-to-toe physical assessment skills. Nurses also must employ clinical judgment and critical thinking in accurately recognizing when to collect assessment data. They also must recognize the need to collect assessment data prior to interventions.
- Nurses collect subjective data (symptoms) during a nursing history. They include clients' feelings, perceptions, and descriptions of health status. Clients are the only ones who can describe and verify their own symptoms.
- Nurses observe and measure objective data (signs) during a physical examination. They feel, see, hear, and smell objective data through observation or physical assessment of the client. (7.2)
- During this assessment/data collection, the nurse validates, interprets, and clusters data.
- Documentation of the assessment data must be thorough, concise, and accurate.

7.2 Sources of data for collection and assessment

Primary sources

SUBJECTIVE: What the client tells the nurse
"My shoulder is really, really sore."

OBJECTIVE: Data the nurse obtains through observation and examination:
Client grimaces when attempting to brush her hair with her left arm.

Secondary sources

SUBJECTIVE: What others tell the nurse based on what the client has told them:
"She told me that her shoulder is sore every morning."

OBJECTIVE: Data the nurse collects from other sources (family, friends, caregivers, health care professionals, literature review, medical records):
Physical therapy note in chart indicates client has decreased range of motion of left shoulder.

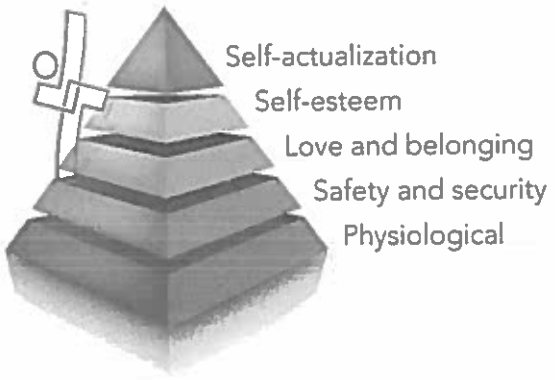
ANALYSIS/DATA COLLECTION

- Nurses use critical thinking skills (a diagnostic reasoning process) to identify clients' health status or problem(s), interpret or monitor the collected database, reach an appropriate nursing judgment about health status and coping mechanisms, and provide direction for nursing care.
- Analysis/data collection requires nurses to look at the data and
  - Recognize patterns or trends.
  - Compare the data with expected standards or reference ranges.
  - Arrive at conclusions to guide nursing care.
- RNs make multiple analyses based on their interpretations of collected data. They decide, using reasoning and judgment, which data account for clients' health status or problems. At times, this requires further data collection and analysis. As nurses again cluster the collected data, a specific finding might serve as an alert to a specific problem that requires planning and intervention.
- As with the assessment/data collection step, complete and accurate documentation is essential. Documentation should focus on facts and should be highly descriptive.

PLANNING

- When planning client care (RN) or contributing to a client's plan of care (PN), nurses must establish priorities and optimal outcomes of care they can readily measure and evaluate. These established priorities and outcomes of client care then direct nurses in selecting interventions to include in a plan of care to promote, maintain, or restore health.
- Nurses do three types of planning. Initially, they develop a comprehensive plan of care for clients based on comprehensive assessments they complete, for example, on admission to a health care facility or to a home health organization.

7.3 Maslow's hierarchy of basic needs



- Nurses do ongoing planning throughout the provision of care. While obtaining new information and evaluating responses to care, they modify and individualize the initial plan of care.
- Discharge planning is a process of anticipating and planning for clients' needs after discharge. To be effective, discharge planning must begin during admission.
- Throughout the planning process, nurses set priorities, determine client outcomes, and select specific nursing interventions.
- Nurses participate in priority setting when they identify a preferential order of problems. This guides the delivery of nursing care. They can use guidelines to set priorities, such as Maslow's hierarchy of basic needs. (7.3)
- Nurses work with clients to identify goals and outcomes.
  - Goals identify optimal status, whereas outcomes identify the observable criterion that will determine success or failure of the goal.
  - Often these terms are interchangeable. With any format, the goal/outcome must be client-centered, singular, observable, measurable, time-limited, mutually agreeable, and reasonable.
  - Concise, measurable goals help nurses and clients evaluate progress:
  - Nurses use short- and long-term goals to guide the client toward the planned outcome and determine the effectiveness of nursing care.
- Nurses identify actions and interventions that help achieve optimal outcomes. Scientific principles provide the rationale for nursing interventions. QEBP
  - **Nurse-initiated/independent interventions:** Nurses use evidence and scientific rationale to take autonomous actions to benefit clients. They base these actions on identified problems and health care needs, and make sure they are within their scope of practice. Nurses perform or delegate the interventions and are accountable for them. An example is repositioning a client at least every 2 hr to prevent skin breakdown.
  - **Provider-initiated/dependent interventions:** Interventions nurses initiate as a result of a provider's prescription (written, standing, or verbal) or the facility's protocol, such as blood administration procedures.
  - **Collaborative interventions:** Interventions nurses carry out in collaboration with other health care team professionals, such as ensuring that a client receives and eats his evening snack. QTC
- The nursing care plan (NCP) is the end product of the planning step. Nurses organize the NCP for quick identification of problems, outcomes, and interventions to implement.

IMPLEMENTATION

- In this step of the nursing process, nurses base the care they provide on assessment data, analyses, and the plan of care they developed in the previous steps of the nursing process. In this step, they must use problem-solving, clinical judgment, and critical thinking to select and implement appropriate therapeutic interventions using nursing knowledge, priorities of care, and planned goals or outcomes to promote, maintain, or restore health. Nurses also use interpersonal skills (therapeutic communication) and technical skills (psychomotor performance) when implementing nursing interventions.
- Therapeutic interventions also include measures nurses take to minimize risk, such as wearing personal protective equipment. Nurses intervene to respond to unplanned events, such as an observation of unsafe practice, a change in a status, or the emergence of a life-threatening situation.
- Nurses use evidence-based rationale for the selection and implementation of all therapeutic interventions. Additionally, caring and professional behavior should be at the center of all therapeutic nursing interventions. QSEP
- During implementation, nurses perform nursing actions, delegate tasks, supervise other health care staff, and document the care and clients' responses.

EVALUATION

- In this step of the nursing process, nurses evaluate clients' responses to nursing interventions and form a clinical judgment about the extent to which clients have met the goals and outcomes.
- Nurses continuously evaluate the client's progress toward outcomes, and use the client data to determine whether or not to modify the plan of care.
- Nurses determine the effectiveness of the nursing care plan. They collect data based on the outcome criteria then compare what actually happened with the planned outcomes. This helps determine what further actions to take. QPCC
- QUESTIONS TO CONSIDER
  - "Did the client meet the planned outcomes?"
  - "Were the nursing interventions appropriate and effective?"
  - "Should I modify the outcomes or interventions?"
- Client outcomes in specific, measurable terms are easier to evaluate.
- FACTORS THAT CAN LEAD TO LACK OF GOAL ACHIEVEMENT
  - An incomplete database
  - Unrealistic client outcomes
  - Nonspecific nursing interventions
  - Inadequate time for the client to achieve the outcomes

Application Exercises

1. By the second postoperative day, a client has not achieved satisfactory pain relief. Based on this evaluation, which of the following actions should the nurse take, according to the nursing process?

A. Reassess the client to determine the reasons for inadequate pain relief.

B. Wait to see whether the pain lessens during the next 24 hr.

C. Change the plan of care to provide different pain relief interventions.

D. Teach the client about the plan of care for managing his pain.

2. A newly licensed nurse is reporting to the charge nurse about the care she gave to a client. She states, "The client said his leg pain was back, so I checked his medical record, and he last received his pain medication 6 hours ago. The prescription reads every 4 hours PRN for pain, so I decided he needs it. I asked the unit nurse to observe me preparing and administering it. I checked with the client 40 minutes later, and he said his pain is going away." The charge nurse should inform the newly licensed nurse that she left out which of the following steps of the nursing process?

A. Assessment

B. Planning

C. Intervention

D. Evaluation

3. A charge nurse is reviewing the steps of the nursing process with a group of nurses. Which of the following data should the charge nurse identify as objective data? (Select all that apply.)

A. Respiratory rate is 22/min with even, unlabored respirations.

B. The client's partner states, "He said he hurts after walking about 10 minutes."

C. Pain rating is 3 on a scale of 0 to 10

D. Skin is pink, warm, and dry.

E. The assistive personnel reports the client walked with a limp.

4. A charge nurse is talking with a newly licensed nurse and is reviewing nursing interventions that do not require a provider's prescription. Which of the following interventions should the charge nurse include? (Select all that apply.)

A. Writing a prescription for morphine sulfate as needed for pain.

B. Inserting a nasogastric (NG) tube to relieve gastric distention.

C. Showing a client how to use progressive muscle relaxation.

D. Performing a daily bath after the evening meal.

E. Repositioning a client every 2 hr to reduce pressure ulcer risk.

5. A nurse is discussing the nursing process with a newly hired nurse. Which of the following statements by the newly hired nurse should the nurse identify as appropriate for the planning step of the nursing process?

A. "I will determine the most important client problems that we should address."

B. "I will review the past medical history on the client's record to get more information."

C. "I will go carry out the new prescriptions from the provider."

D. "I will ask the client if his nausea has resolved."

Application Exercises Key

1. A. **CORRECT:** The nurse should collect further data on the client to determine why he has not achieved satisfactory pain relief, because various factors might be interfering with his comfort. The nursing process repeats in an ongoing manner across the span of client care.

   B. The nurse should not wait longer to see how the client would respond, but should to take action to determine why the client is not reaching achieving satisfactory pain relief.

   C. The nurse should not make random changes to the plan of care without gathering evidence to guide the nurse in knowing what new interventions can be necessary.

   D. The action by the nurse does not acknowledge the client's condition or that the current plan is ineffective.

   NCLEX® Connection: Reduction of Risk Potential, System Specific Assessments

2. A. **CORRECT:** The newly licensed nurse should have used the assessment step of the nursing process by asking the client to evaluate the severity of his pain on a 0 to 10 scale. She also should have asked about the characteristics of his pain and assessed for any changes that might have contributed to worsening of the pain.

   B. The newly licensed nurse used the planning step of the nursing process when she decided that it was appropriate to administer the medication and, recognizing her level of experience in administering pain medication, prepared the dose under supervision from the unit staff.

   C. The newly licensed nurse used the implementation step of the nursing process when she administered the medication.

   D. The newly licensed nurse used the evaluation step of the nursing process when she checked the effectiveness of the pain medication in relieving the client's pain.

   NCLEX® Connection: Health Promotion and Maintenance, Techniques of Physical Assessment

3. A. **CORRECT:** Objective data includes information the nurse measures, such as vital signs.

   B. Subjective data includes a client's reported symptoms, even if told by a secondary source.

   C. Subjective data includes a client's reported symptoms.

   D. **CORRECT:** Objective data includes information the nurse observes, such as skin appearance.

   E. **CORRECT:** Objective data includes information on observations of others, such as family and staff.

   NCLEX® Connection: Health Promotion and Maintenance, Techniques of Physical Assessment

4. A. The nurse must have a prescription from the provider to administer a medication. After obtaining the prescription, the nurse has the flexibility to determine when to administer a PRN medication.

   B. The nurse must have a prescription from the provider for the insertion of an NG tube. This is a provider-initiated intervention.

   C. **CORRECT:** Showing a client how to use progressive muscle relaxation is an appropriate nurse-initiated intervention for stress relief. Unless it is a contraindication for a specific client, the nurse can use this technique with clients without a provider's prescription.

   D. **CORRECT:** Performing a bath is a routine nursing care procedure. Unless it is a contraindication for a specific client, the nurse can determine when bathing is optimal for a client without a provider's prescription.

   E. **CORRECT:** Repositioning a client every 2 hr is an appropriate nurse-initiated intervention for clients. Unless it is a contraindication for a specific client, the nurse can use this strategy without a provider's prescription.

   NCLEX® Connection: Health Promotion and Maintenance, Techniques of Physical Assessment

5. A. **CORRECT:** The nurse should prioritize client problems during the planning step of the nursing process

   B. The nurse should review the client's history during the assessment/data collection step of the nursing process

   C. The nurse should implement nurse- and provider-initiated actions during the intervention step of the nursing process.

   D. The nurse should gather information about whether the client's problems have been resolved during the evaluation step of the nursing process

   NCLEX® Connection: Management of Care, Legal Rights and Responsibilities

PRACTICE Active Learning Scenario

A nurse educator is reviewing with a group of nursing students the actions and thought processes nurses use during the steps of the nursing process. Use the ATI Active Learning Template: Basic Concept to complete this item.

NURSING INTERVENTIONS

- List at three actions to take during the analysis or data collection step.
- List four factors to consider during the evaluation step when clients have not achieved their goals.

PRACTICE Answer

Using the ATI Active Learning Template: Basic Concept

NURSING INTERVENTIONS

Analysis/data collection

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

Factors to consider during evaluation for unmet goals

- An incomplete database
- Unrealistic client outcomes
- Nonspecific nursing interventions
- Inadequate time for the client to achieve the outcomes

NCLEX® Connection: Health Promotion and Maintenance, Techniques of Physical Assessment