Chapter 9

Nursing Process: Your Role

Chapter 9

Lesson 9.1

Learning Objectives

1) Discuss how the nursing process has evolved from the 1950s to now.

2) Define your role in the nursing process according to the nurse practice act of your state, territory, or country.

3) Describe assisting with the four phases of the nursing process for the practical/ vocational nurse:

   a) Phase 1: Data Collection

   b) Phase 2: Planning

   c) Phase 3: Implementation

   d) Phase 4: Evaluation

Nursing Process: Evolution (p. 97-98)

- 1950s
  - Four-step process
    - Data collection, planning, intervention, and evaluation
  - Based on the scientific method
    - Identifies the problem first and then gathers data
  - Most important outcome: think before acting

Nursing Process: Evolution (cont'd) (p. 98)

- 1970s-1990s
  - Five-step nursing process for the RN
    - Assessment (data collection)
    - Nursing diagnosis (the new step for RNs)
    - Planning
    - Intervention
    - Evaluation
  - The problem-solving format replaced with a reasoning model
  - Provided organized, unique way of contributing to patient care

Nursing Process: Evolution (cont'd) (p. 98)

- 2000 and Beyond
  - ➢ NCSBN integrated the nursing process into all areas of the NCLEX-PN® examination
    - Data collection
    - Planning
    - Implementation
    - Evaluation
    - Definition

Role Differences Between RNs and LPN/LVNs (p. 98-99)

- RN
  - Nursing diagnosis
  - Independent role in all five steps of the nursing process
  - Uses an established list of current nursing diagnoses
- LPN/LVN
  - No nursing diagnosis
  - Dependent role in the planning and evaluation phases
  - Independent role in the data collection and implementation phases

Five-Step RN Nursing Process (p. 98-99)

1) Assessment (data collection)
2) Diagnosis
3) Planning
4) Implementation
5) Evaluation

Four-Step LPN Nursing Process (p. 98-99)

1) Assessment (data collection)
2) Planning
3) Implementation
4) Evaluation

Developing Your Plan of Care for Assigned Patients (p. 99)

- Patient care is a learning experience
- Plan for patient care assignments
- Internalize your role in four phases of the nursing process
- Improve your ability to think critically

LPN Nursing Process Phase 1: Data Collection (p. 99)

- Systematic Way of Gathering Information
  - Begins on admission and continues with each patient encounter
  - Patient is the primary source of information
    - Subjective information—based on patient's opinion
    - Objective information—data nurse can verify

LPN Nursing Process Phase 1: Data Collection (cont'd) (p. 99-100)

- Verify the information
- Communicate information to appropriate health care team members
  - Emergency data—report immediately

LPN Nursing Process Phase 1: Data Collection (cont'd) (p. 100-101)

- Continuing data collection
- Accuracy in data collection
- Courtesy during data collection
- Explain the need to ask certain questions

LPN Nursing Process Phase 1: Data Collection (cont'd) (p. 101)

- Barriers in Data Collection
  - ➤ Insufficient time
  - ➤ Poor skills in data collection
  - ➤ Communication failure

Question 1

Which of the following statements is not true?

1.   The nursing process was designed to organize thinking.

2.   The nursing process includes data collection, planning, intervention, and evaluation for LPNs.

3.   The American Nurses Association added a five-step nursing process for RNs to include nursing diagnosis.

4.   Licensed practical nurses can initiate nursing diagnoses.

Question 2

When Madison is admitting a patient, the patient states, "I am having some mild pain." This is known as:

1. subjective information.
2. objective information.
3. a barrier in data collection.
4. emergency data.

Chapter 9

Lesson 9.2

Learning Objectives

3) Describe assisting with the four phases of the nursing process for the practical/vocational nurse (continued):

   a) Phase 1: Data Collection
   b) Phase 2: Planning
   c) Phase 3: Implementation
   d) Phase 4: Evaluation

4) Describe nursing diagnosis as the exclusive domain of the registered nurse (RN).

5) Explain why the nursing process and critical thinking are part of the practical/vocational nursing program curriculum.

6) Briefly describe how NANDA, NIC, and NOC can be used together to plan patient care.

LPN Nursing Process Phase 2: Planning (p. 101)

- Assist RN in Developing Nursing Diagnosis
  - Assist in determining a significant relationship between data and patient needs or problems
  - Focus is on patient functions that will benefit from nursing interventions
  - Collect and organize data
  - RN makes the nursing diagnosis and formulates plan of care

LPN Nursing Process Phase 2: Planning (cont'd) (p. 101-103)

- RN formulates plan of care
- Characteristics of a realistic, useful nursing care plan
  - Establish priorities
  - Take care of potentially life-threatening problems immediately
  - Flexible to accommodate changing priorities per patient's condition
- Collect data for any new problems, and collaborate with the RN, who formulates a new nursing diagnosis

LPN Nursing Process Phase 2: Planning (cont'd) (p. 103)

- Assist RN in Developing Outcomes
  - Build on patient strengths
    - Provides a sense of contribution and some control for the patient
  - Goals and outcomes
    - Realistic
    - Measurable
    - Time-referenced

LPN Nursing Process Phase 2: Planning (cont'd) (p. 104)

- Assisting RN to Develop Nursing Interventions
  - ➢ Identify specifics to do that assist the patient to reach desired outcomes
  - ➢ Specify who, what, where, when, and how much to nursing personnel

LPN Nursing Process Phase 2: Planning (cont'd) (p. 102-105)

- Types of Care Plans
  - Standardized care plans
    - Based on research of the best possible options for a nursing diagnosis
  - Computerized care plans
    - Individualized plans that can be entered into the computer
  - Multidisciplinary (collaborative) care plans
    - Developed by a multidisciplinary team
    - Reflect specific interventions used by each discipline

LPN Nursing Process Phase 2: Planning (cont'd) (p. 105)

- Maintain patient safety
  - ➢ Data that alerts on potential patient safety should be communicated to the RN immediately
- Documenting the care plan
  - ➢ If a plan is not charted, then legally, it is not done
  - ➢ Document on computer, in nurse's notes, on flow sheets, or on the plan itself

LPN Nursing Process Phase 3: Implementation (p. 105)

- Nursing Action
  - ➤ Follow the established plan of care
  - ➤ Participate in the patient care conference and offer input
  - ➤ Review the procedure before preparing the patient

LPN Nursing Process Phase 3: Implementation (cont'd) (p. 105)

- Maintain Patient Safety
  - Use appropriate, safe techniques during patient care
  - Use precautionary and preventive interventions in providing patient care
  - Institute nursing interventions to compensate for adverse responses
  - Initiate life-saving interventions for emergency situations
  - Monitor care given by unlicensed personnel
  - Collect data during every patient contact

LPN Nursing Process Phase 3: Implementation (cont'd) (p. 105)

- Teaching in Support of RN's Teaching
  - Encourage patients to follow their plan of care and treatment regimen
  - Assist patients to maintain or enhance optimal functioning
  - Provide an environment conducive to attaining observable patient outcomes
  - Reinforce teaching of principles, procedures, and techniques for maintenance and promotion of health

LPN Nursing Process Phase 3: Implementation (cont'd) (p. 106)

- Reporting and Documenting
  - Collect data during every patient contact
  - Report observations to relevant members of the health team
  - Document the patient's response to nursing intervention, therapy, or teaching

LPN Nursing Process Phase 4: Evaluation (p. 106)

- Assist in Determining Patient Progress
  - ➢ Collect data during every patient contact
  - ➢ Compare actual outcomes with desired patient outcomes
  - ➢ Assist in determining patient's response to nursing care
  - ➢ Assist in identifying factors that may interfere with patient's ability to implement the plan of care

LPN Nursing Process Phase 4: Evaluation (cont'd) (p. 106-107)

- Communicate Findings
  - ➤ Document patient's responses to care, therapy, or teaching
  - ➤ Report findings to relevant members of the health care team

Nursing Process Standards (p. 107)

- Nursing Interventions Classification (NIC)
  - ➢ Standardizes, defines, and assists in choosing the appropriate nursing interventions
- Nursing Outcomes Classification (NOC)
  - ➢ Standardizes terminology and criteria for measurable or desirable outcomes of nursing interventions

LPN/LVN Nursing Curriculum (p. 99)

- Nursing process education
- Critical thinking education

Question 3

Madison is reviewing a care plan. Which of the following is not a type of care plan?

1.   Individualized written care plan
2.   Community-based care plan
3.   Standardized care plan
4.   Multidisciplinary care plan

Question 4

Madison is conversing with her patient. Which statement is appropriate to use in patient care?

1.   "I am not sure I understand what you mean by that statement."

2.   "That's right."

3.   "I am sure everything will be just fine."

4.   "You know you shouldn't have done that."

Question 5

Which of the following is not a characteristic of a goal?

1. realistic
2. measurable
3. time-referenced
4. objective