• **Nursing Process Outline - Kim Baily RN, MSN, PhD**

  • Five Steps of the Nursing Process
    o Method of providing care
    o Purposeful, systematic, and orderly
    o Scope and Standards of Practice
    o Assessment: Nurse collects data
    o Diagnosis: Nurse analyzes data in determining diagnoses
    o Outcome identification: Nurse identifies expected outcomes
    o Planning: Nurse develops a plan of care
    o Implementation: Nurse implements interventions identified in plan
    o Evaluation: Nurse evaluates client’s progress

  • What is a process?
    o Series of planned actions performed to achieve a goal
    o Method of planning and providing care
    o Promotes organization
    o Each step overlaps with previous and subsequent steps
    o Method of problem solving and decision making
    o Scientifically based—understanding of the human body

  • Nursing Process Characteristics
    o Orderly, step-by-step process
    o Client is evaluated
    o Data are collected and analyzed
    o Plan of care is determined and set into motion
    o Client is monitored, evaluated
    o Care plan is revised as needed

  • Nursing Process Characteristics
    o Client centered
    o Assists to plan according to client needs
    o Client participates
    o Promotes collaboration

  • Benefits of the Nursing Process
    o Improved quality of care
    o Continuity of care
    o Promotes client participation in care
    o Delivery of care is organized, continuous, and systematic
    o Efficient use of time and resources

• Expectations of client and standards of care are met

• Holds nurses accountable and responsible

• Step 1: Assessment
  o Key step. Database is compiled involving:
  o Verification and validation of data
  o Organization of data
  o Interpretation of data
  o Documentation of data
  o Objective: observable, measurable data
  o Subjective: communicated data
• Step 2: Diagnosis
  o Involves analysis of data
  o Nursing diagnosis determination
    ▪ Questions Critical Thinkers Ask...
    ▪ What actual problems were identified during assessment?
    ▪ What are possible causes?
    ▪ Is client at risk for developing other problems?
    ▪ What are the factors involved?
    ▪ Did the client indicate a desire to function at a higher level of wellness?
    ▪ Questions Critical Thinkers Ask...
    ▪ What are the client’s strengths?
    ▪ What additional data might be needed to answer these questions?
    ▪ What are possible sources of data collection?
    ▪ Is collaboration needed at this time?
    ▪ What data are pertinent to collect before contacting the physician?
  o Actual Nursing Diagnoses
    ▪ Client demonstrates signs and symptoms
    ▪ An actual problem exists
  o Risk Nursing Diagnoses
    ▪ Problems client is at risk for developing
    ▪ Nursing actions may prevent the problem
  o Wellness Nursing Diagnosis
    ▪ Client desires a higher level of wellness
  o Nursing diagnosis preceded by potential for enhanced

• Collaborative Problems
  o Potential complications arising during treatment
  o Nurse monitors for onset or change in client
  o Prevention or reduction is initiated
  o Example: PC: Hemorrhage

• Medical vs. Nursing Diagnoses
  o Medical Diagnosis
    ▪ Determined by physician
    ▪ Indicates disease, illness
  o Nursing Diagnosis
    ▪ Determined by the nurse
    ▪ Clinical judgment about the client
    ▪ Human responses to disease or treatment

• Step 3: Planning
  o Determining the care plan
  o Documenting the care plan
  o Organizing proposed course of action
  o Prioritize nursing diagnoses
  o Goals and outcomes are identified, constructed, and documented
  o Interventions are identified
  o Goals
    ▪ Client centered
    ▪ Focus on the behavior
    ▪ Describe intended or desired change
  o Expected Outcome
    ▪ Leads to fulfillment of goal
    ▪ Resolution of the problem
- Nursing Interventions
- Planned actions
- Promotes goal attainment

- Step 4: Implementation
  - Executing the care plan
  - Interventions are performed
  - Assessment before, during, and after
  - Report and document
  - Includes:
    - Putting the care plan into action
    - Carrying out planned interventions
    - Assessing, reporting, documenting

- Step 5: Evaluation
  - Client is evaluated
  - Care plan is evaluated
  - Goal attainment is determined
  - Cognitive Skills
    - Nurses Use:
      - Decision making
      - Critical thinking
      - Problem solving

- Chapter 2: Assessment
  - Gathering data
  - Organizing
  - Verifying accuracy
  - Documenting data
  - Data Collection
    - Interview, physical exam, diagnostic exams
    - Communicated and documented
    - Begins when client enters health care system
    - Continues as long as there is a need
  - Types of Data
    - Subjective
    - Objective
  - Complements, clarifies, supports
  - Interpretation of Data
    - Meaning is assigned
    - Compared against standards
    - Prevents inconsistencies
  - Data Clustering
    - Determines relation
    - Finds patterns
    - Documenting Assessment Data
    - Prepares a record
    - Describes client’s health status
    - Promotes communication among others involved in the client’s care

- Chapter 3: Nursing Diagnosis
  - Analysis
  - Problem identification – Actual Diagnosis
Nursing diagnosis
Nursing Process
The diagnostic label
  - Classification list
  - NANDA taxonomy
  - Example of Actual Nursing Diagnosis

- Risk Nursing Diagnoses
  - Possible development of problems
  - Client is more at risk than others

- Characteristics of Nursing Diagnoses
  - Complement physician treatments
  - Separate and distinct
  - Structure of Nursing Diagnoses

- Actual nursing diagnosis
  - existing response to condition
  - problem exists
  - supporting signs and/or symptoms

- Risk Nursing Diagnoses
  - Possible development of problem
  - Has not occurred
  - No signs or symptoms
  - NANDA describes Risk Diagnosis as:
    - “a clinical judgment made when a client is more vulnerable to develop the problem than others in the same or similar situations.”

- Components of Actual Nursing Diagnoses “PES”
  - Problem
    - Label Nursing diagnosis
  - Etiology
    - Related to (R/T) or related factor
    - Involved in development of problem
    - Becomes focus for interventions
    - Cause component
    - Gives direction to problem statement
  - Signs and Symptoms - As evidenced by (AEB) - Defining characteristics
    - Clinical evidence
    - How response is manifested

- Same nursing diagnoses with different etiologies may require different interventions.
  - Constipation, Perceived
    - Related to: inactivity, insufficient fiber intake
      - Intervention: encourage daily activity to stimulate bowel elimination
    - Related to: long-term laxative use
      - Intervention: instruct client on adverse affects of long-term laxative use

- Breast-feeding, Ineffective
  - Related to: inadequate sucking reflex in infant
    - Intervention: assess infant’s ability to latch on and suck effectively
- Related to: inexperience, knowledge deficit
  - Intervention: determine mother’s desire and motivation to breastfeed

- Components of Risk Nursing Diagnoses
  - Potential problem
  - Risk factor
  - No evidence
  - Problem does not exist

- Risk Nursing Diagnoses Examples
  - Cancer patient, Risk for Infection
    - Risk Factors (R/T): inadequate secondary defenses, immunosuppression
  - Client with surgical incision, Risk for Infection
    - Risk Factors (R/T): inadequate primary defenses, invasive procedure

- Wellness Nursing Diagnosis
  - Indication of desire to attain higher level of wellness
    - Example: Potential for Enhanced Nutrition

- Chapter 4: Steps Involved in Planning
  - Determine priority problems
  - Establish goals and expected outcomes
  - Write goals and expected outcomes
  - Plan interventions with scientific rationale
  - Communicate and document the plan

- Goal Definition
  - General statement
  - Indicates intent or desired change

- Expected Outcome Definition
  - Stated in more specific terms
  - Same components as goal

- Goal and Expected Outcomes Example
  - Body image disturbance
    - Goal: Client will demonstrate acceptance of amputation and an ability to adjust to lifestyle change within six months.
    - Expected outcomes:
      - Looks at and touches area of missing body part
      - Participates in wound/stump care
      - Plans for prosthesis
      - Returns to former social involvement

- Characteristics of Goals and Expected Outcomes
  - Measurable: includes time frame
  - Client centered: focus on the client’s action
  - Specific
  - Realistic

- Short-Term Goal
  - Identifies behavior
  - Achieved within hours or days

- Long-Term Goal
  - Identifies desired behavior
  - Achieved within weeks to months
- Overall greater expectations

- Discharge Planning
  - Involves long-term goals
  - Referral
  - Continued recovery

- Expected Outcomes
  - Measurable steps
  - May identify more than one
  - Progress toward goal achievement

- Components of Goals and Expected Outcomes
  - Subject – Client centered
    - Behavior
      - Will verbalize
      - Will ambulate
      - Will report
      - Will eat
      - Will demonstrate
    - Time frame
    - Realistic
  - Criteria of Performance
    - Level of behavior
    - May include a time limit or description
    - How far, how long, how much
    - Criteria of Performance Examples
      - Understanding of medication regime
      - Length of the hall
      - Decrease in pain level of four or less
      - Seventy-five percent of meal
    - Decreased blood pressure within forty-eight hours
  - Goal Application
    - Client (subject)
      - will ambulate (behavior)
      - assisted by physical therapy (PT) to nurse’s station and return to room twice daily (time frame).

- Goal Application
  - Mr. Johnson (subject)
    - will verbalize (behavior)
    - understanding of medication regime (criteria of performance)
    - prior to discharge (time frame).

- Goal Application
  - Ms. James (subject)
    - will lose (behavior)
    - two and a half pounds (criteria of performance)
    - within three weeks (time frame)
    - by using prescribed American Heart Association Diet plan (conditions)
- Interventions Selection Guidelines
  - Guided by regulating organizations
  - Legal realm of practice
  - Client values
  - Consequences of action
- Classification of Nursing Interventions
  - Independent
    - Initiated by the nurse
    - No additional direction required
    - No physician order required
  - Dependent
    - Require an order
- Example
  - Nursing diagnosis: Activity intolerance
  - R/T: bed rest, generalized weakness
  - AEB: verbalization of overwhelming lack of energy, dyspnea on exertion while performing activities of daily living
  - Goal:
    - Client will verbalize improved level of energy when carrying out activities of daily living within one week.
  - Nursing Interventions
    - Assess ability to perform activities of daily living.
    - Evaluate adequacy of nutrition and sleep.
    - Schedule periods of uninterrupted time for client to rest throughout the day.
    - Assist client with activities of daily living as necessary. Promote and encourage ADL independence without causing exhaustion.
- Evaluation Purpose
  - To estimate effectiveness of care
  - To estimate quality of care
  - To estimate client responses
  - To determine if the care plan is working
  - To determine how well the care plan is working
- Characteristics of Evaluation
  - Ongoing
  - Continues as long as care is provided
  - Client responses are compared
  - Focuses on relationship
  - Success of plan is judged
- Evaluative Questions
  - Were the expected outcomes achieved?
  - Is the plan appropriate?
  - Should the plan be modified or terminated?
  - Were goals specific, measurable and realistic?
  - Were nursing diagnoses relevant?
  - Was assessment thorough and accurate?
  - Did the client and family participate in priority problem identification and goal setting?
- Care Plan Modification
  - Progress
    - Favorable
      - May indicate appropriate interventions
      - Expect revisions or modifications
• Lack of Progress
  • Plan needs revision or modification
  • Nursing process steps reactivated
  • Reassess plan
  • Reassess client
  • Compare findings

• Discontinue
  o When goal is achieved
  o Portion of plan
  o Continue with reassessment