Chapter 5
Nursing Process and Critical Thinking

Introduction

• Nursing defined
• Nursing process
  ➢ Organizational framework for the practice of nursing
  ➢ Problem solving
  ➢ Six phases
  ➢ ANA Nursing Scope and Standards of Practice

Introduction (Cont.)

• Nursing process consists of six phases:
  ➢ Assessment
  ➢ Diagnosis
  ➢ Outcomes identification
  ➢ Planning
  ➢ Implementation
  ➢ Evaluation
Assessment Data

- ANA definition, “systematic, dynamic process by which the registered nurse, through interaction with the patient, family, groups, communities, populations and health care providers, collects and analyzes data”
- Information is gathered to identify the condition of the patient’s health
- Review and physical examination of ALL body systems
- Cognitive, psychosocial, emotional, cultural, and spiritual components
- Focused assessment is advisable if patient is critically ill, disoriented, or unable to respond
- The LPN/LVN assists the registered nurse (RN)

Assessment Data (Cont.)

Types of data
- Cue
  - Piece(s) of data
- Subjective
  - Verbal statements provided by the patient
- Objective
  - Observable and measurable signs
  - Can be recorded

Assessment Data (Cont.)

Sources of data
- Primary source
  - Patient
  - Most accurate
- Secondary sources
  - Family members, significant other, medical records, diagnostic procedures, and nursing literature
  - When the patient is unable to supply information, secondary sources are used
Assessment Data (Cont.)

- Methods of Data Collection
  - Interview
    - Biographic data
    - Reason patient is seeking health care
    - History of present illness
    - Past health history
    - Environmental history
    - Psychosocial history
  - Physical exams
    - Head-to-toe format

- Data clustering
  - Related cues are grouped together
  - Attention is then focused on health concerns that need support and assistance
  - This assists in the identification of nursing diagnoses

Diagnosis

- Identify the type and cause of a health condition
- American Nurses Association defines as "A clinical judgment about the patient’s response to actual or potential health conditions or needs. Diagnoses provide the basis for determination of a plan of care to achieve expected outcomes"
- The LPN or RN may both observe and collect data
- Once the initial assessment has been completed, the data requires analysis
Diagnosis (Cont.)

Nursing diagnosis

- Is a type of health problem that can be identified
- North American Nursing Diagnosis Association (NANDA) in 1990
- North American Nursing Diagnosis Association International (NANDA-I) in 1992
- Approves the official definition for a nursing diagnosis

Diagnosis (Cont.)

Nursing diagnosis

- NANDA-I
  - A clinical judgment about an individual, family, or community response to actual or potential health problems or the processes
  - Provides the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable
  - Nurses can legally identify and prescribe the primary interventions to treat or prevent problems that are nursing diagnoses

Diagnosis (Cont.)

- Components of a nursing diagnosis
  - Four components addressed
    - Nursing diagnosis title or label
    - Definition of the title or label
    - Contributing, etiologic, or related factors
    - Defining characteristics
Diagnosis (Cont.)

- Components of a nursing diagnosis
  - Title or label
    - Problem that is identified based on a pattern of related cues; this analysis is given a title or label
    - Called the nursing diagnosis
    - Provides a concise name for the identified health problem
    - Lists of nursing diagnoses are often presented in alphabetical order

Diagnosis (Cont.)

- Components of a nursing diagnosis
  - Definition
    - Presents a clear, precise description of the problem
    - Helps to identify the difference between similar nursing diagnoses

Diagnosis (Cont.)

- Components of a nursing diagnosis
  - Contributing/etiologic/related factors and risk factors
    - Conditions that might be involved in the development of a problem and are found in the nursing diagnosis handbooks
    - May become the focus for nursing interventions
    - Written as "related to" in the actual nursing diagnosis
    - Risk factors are those that increase the susceptibility of a patient to a problem
Components of a nursing diagnosis

- Defining characteristics
  - Cues that tell how the diagnosis is manifested
  - Clinical cues, signs, and symptoms that furnish evidence that a problem exists
  - Written as “manifested by” in the nursing diagnosis statement

Actual nursing diagnosis

- Represents a condition that is currently present
- Cues from nursing assessment indicate problem exists
- Usually represented by a three-part statement
  - The nursing diagnosis label from NANDA-I
  - The contributing/etiological/related factor
  - The specific cues, signs, and symptoms from the patient’s assessment

Connecting phrases are used to join the three parts of the statement:
- “Related to” links the first and second parts
- “Manifested by” joins the second and third parts
Diagnosis (Cont.)

- Risk nursing diagnosis
  - A clinical judgment that an individual, family, or community is more vulnerable to develop the problem than others in the same or similar situation
  - The assessment indicates that risk factors are present that are known to contribute to the development of the problem
  - Written in a two-part statement
    - The nursing diagnosis label from NANDA-I
    - The risk factor
  - “Related to” connects the two statements

Diagnosis (Cont.)

- Syndrome nursing diagnosis
  - Used when a cluster of actual or risk nursing diagnoses are predicted to be present in certain circumstances
  - Current syndrome diagnoses: Posttrauma syndrome, Rape-trauma syndrome, Risk for disuse syndrome, Impaired environmental interpretation syndrome, and Relocation stress syndrome
  - These are one-part statements

Diagnosis (Cont.)

- Health promotion nursing diagnosis
  - Wellness nursing diagnosis
    - A clinical judgment about an individual, group, or community in transition from a specific level of wellness to a higher level of wellness
    - Written in a one-part statement
    - The words “readiness for enhanced” are used in a wellness nursing diagnosis
Other Types of Health Problems

- Collaborative problems
  - Certain physiologic complications that nurses monitor to detect onset or changes in status
  - Nurses manage problems using health care provider-prescribed and nurse-prescribed interventions to minimize the complications of the event

- Medical diagnosis
  - The identification of a disease or condition through a scientific evaluation of physical signs, symptoms, history, laboratory tests, and procedures

Other Types of Health Problems (Cont.)

- Differentiating medical and nursing diagnoses
  - Nursing diagnoses address human responses to health problems and life processes
  - The nurse addresses the patient's concerns about the medical problem
  - Nursing diagnosis may change or resolve as care is provided or the condition changes

Outcomes Identification

- Outcomes statement indicates the degree of wellness desired, expected, or possible for the patient to achieve
- Alternative names are
  - Patient goal
  - Patient-centered goal
  - Objective
  - Behavioral objective
  - Patient outcome
- Provides a description of the specific, measurable behavior the patient will exhibit in a given time frame
Planning

- The nurse establishes priorities of care and nursing interventions are chosen that will best address the nursing diagnosis
- Information is communicated through care plan so that all health care personnel will be directly involved in the care of the patient
- The nurse decides what interventions will be effective after working with the patient and significant others

Planning (Cont.)

- Priority setting
  - Nursing diagnoses are ranked in order of importance for the patient's life and health
  - Physiologic needs come before safety and security
  - Safety and security needs come before love and belonging needs
  - Life- and health-threatening problems are ranked before other types of problems
  - Actual problems may be ranked before risk problems
  - Priorities change as the patient progresses in the hospitalization; as some problems are resolved, new ones can be addressed

Planning (Cont.)

- Selecting nursing interventions
  - Nursing interventions
    - Activities that promote the achievement of the desired patient outcome
    - Classified as physician-prescribed or nurse-prescribed
  - Physician-prescribed interventions are ordered by a physician for a nurse or other health care professional to perform
  - Nurse-prescribed interventions are any actions a nurse is legally able to order or begin independently
Planning (Cont.)

- Selecting nursing interventions
  - Physician-prescribed interventions
    - Actions ordered by a physician for a nurse or other health care provider to perform
    - Medications, wound care, diagnostic tests
    - Nursing judgment still used
    - Assessing, teaching, and validating the safety of physician orders expected of nursing professionals

- Nurse-prescribed interventions
  - Actions the nurse can legally order or begin independently
  - Providing a back massage, turning patient every 2 hours, monitoring for complications
  - When determining interventions, the nurse should consider the contributing/etiologic/related factors, risk factors, patient-centered goal/desired outcomes, and the nursing diagnosis label

Planning (Cont.)

- Writing nursing interventions
  - Because nursing interventions in manuals and textbooks are often broad, general statements, it is often necessary to convert these into more specific, instructional statements
  - Nursing interventions must be written to reduce the likelihood of misinterpretation
  - Should include the subject, action verb, and qualifying details
Writing nursing orders
- Nursing orders should include
  - Date
  - Signature of the nurse responsible for the plan of care
  - Subject (who will carry out the activity)
  - Action verb
  - Qualifying details

Communicating the nursing care plan
- Written nursing care plan is the product of the nursing process
- It is important to have written guidelines to promote the continuity of patient care
- Formats for the written nursing care plan vary among institutions
- Nursing care plans may be prepared for each patient, be standardized for a group of patients, or be computerized

Linear care plans versus concept maps
- Common components in the educational setting
  - NANDA-I diagnostic labels
  - Patient-centered goals and desired patient outcomes
  - Nursing interventions
  - Orders
- One of two types of care plans are noted in the educational setting
  - Care plan in a 4- or 5-column format
  - Concept map
Implementation

- Fifth phase of the nursing process
- The nurse and other members of the team put the established plan into action to promote outcome achievement
- Using evidence-based interventions, the plan is implemented in a timely and safe manner

Implementation (Cont.)

- Phase of the nursing process in which the established plan is put into action to promote achievement of the outcome
  - This phase includes ongoing activities of data collection, prioritization, performance of nursing interventions, and documentation
  - Both nurse- and physician-prescribed therapy are included
  - Documentation is a vital component of the implementation phase
  - "If it was not charted, it was not done" is a constant principle of nursing

Implementation (Cont.)

- Evidence-based practice
  - Nursing research is the basis for evidence-based practice
Evaluation

- Establishing desired patient outcomes
  - The nurse predicts the condition of the patient following nursing interventions
  - This prediction is expressed in a statement that indicates the degree of wellness desired, expected, or possible for the patient to achieve
  - Outcome: A statement provides a description of the specific, measurable behavior that the patient will be able to exhibit in a given time frame following the intervention
  - Goal: A statement about the purpose to which an effort is directed

Evaluation (Cont.)

- A well-written patient-centered goal/desired outcomes statement
  - Uses the word “patient” as the subject of the statement
  - Uses a measurable verb
  - Is specific for the patient and the patient’s problem
  - Is realistic for the patient and the patient’s problem
  - Includes a time frame for patient reevaluation

Evaluation (Cont.)

- A determination is made about the extent to which the established outcomes have been achieved
  - Review the patient-centered goals/desired patient outcomes that were established in the planning phase
  - Reassess the patient to gather data indicating the patient’s actual response to the nursing intervention
  - Compare the actual outcome with the desired outcome and make a critical judgment about whether the patient-centered goal/desired patient outcome was achieved
Evaluation (Cont.)

- The nurse should make one of three judgments or decisions:
  - The outcome was achieved
  - The outcome was not achieved
  - The outcome was partially achieved
- The plan of care is changed during this phase of the nursing process
- Modifications can be made if the outcome has been achieved, partially achieved, or not achieved

Standardized Languages: NANDA-I, NIC, NOC

- The NANDA-I has formed a relationship with two other groups:
  - Nursing Intervention Classification (NIC) is a research group working at the University of Iowa to standardize the language used to organize and describe interventions.
  - Nursing Sensitive Outcome Classification (NOC) is a research group working at the University of Iowa that has developed a standardized system to name and measure the results of patient outcomes.

Role of the Licensed Practical/Vocational Nurse

- The nursing process may vary from state to state; review the state’s nurse practice act.
- Provide direct bedside nursing care.
- This direct care position allows the LPN/LVN to closely observe, prioritize, intervene, and evaluate the care provided to and for the patient.
Role of the Licensed Practical/Vocational Nurse (Cont.)

- Role of the licensed practical/vocational nurse in the nursing process
  - Assessment
    - Observe and report significant cues to the charge nurse or health care provider
  - Diagnosis
    - Assist with the determination of accurate nursing diagnoses
    - Gather data to confirm or eliminate problems

- Planning
  - Assist with setting priorities
  - Suggest interventions
  - Assist with the development of realistic patient-centered goals/desired patient outcomes

- Implementation
  - Assist with the establishment of priorities
  - Carry out physician and nursing orders
  - Evaluate the effectiveness of nursing activities

- Evaluation
  - Assist with reevaluation of the patient's health state after nursing interventions
  - Suggest alternative nursing interventions when necessary
Nursing Diagnosis and Clinical Pathways

• Managed care
  ➢ A health care system whose aim is to enhance specific clinical and financial outcomes within a specific time frame

• Case management
  ➢ A certified nursing specialty; refers to the assignment of a health care provider to a patient so the care of that patient is overseen by one individual
  ➢ Assists the patient and family to receive required services, coordinates these services, and evaluates the adequacy of these services

Nursing Diagnosis and Clinical Pathways (Cont.)

• Clinical pathways
  ➢ Multidisciplinary plan that schedules clinical intervention over an anticipated time frame for high-risk, high-volume, high-cost types of cases
  ➢ Includes such elements as diagnostic tests, treatment, activities, medications, consultations, education, daily outcomes, and discharge planning

• Variance
  ➢ Patient does not achieve the projected outcome

Critical Thinking

• Critical thinkers think with a purpose
• They question information, conclusions, and points of view
• They are logical and fair in their thinking
• Critical thinking is a complex process, and no single simple definition explains all of the aspects of critical thinking
• The nurse must be able not only to perform skills, but also think about what he or she is doing
• Nurses use a knowledge base to make decisions, generate new ideas, and solve problems
Critical Thinking (Cont.)

- Characteristics of critical thinkers
  - Reflect or think about what is being learned
  - Look for relationships among concepts or ideas
  - Analyze or critique behaviors
  - Make self-correction
  - Realize they do not know everything
  - Involve creative thinking

Question 1

What is a primary source of data?
1. Family members
2. Significant others
3. Diagnostic procedures
4. The patient

Question 2

Which are components of a nursing diagnosis? (Select all that apply.)
1. Nursing diagnosis title or label
2. Definition of the title or label
3. Contributing, etiologic, or related factors
4. Defining characteristics
Question 3
A systematic method by which nurses plan and provide care for patients is known as:
1. nursing process.
2. nursing diagnosis.
3. medical diagnosis.
4. nursing scope of practice.

Question 4
Which type of nursing diagnosis is the following? "Describes human responses to health conditions/life processes that may develop in a vulnerable individual/family/community"
1. Syndrome
2. Risk
3. Actual
4. Potential

Question 5
A well-written patient-centered goal or desired patient outcome statement: (Select all that apply.)
1. uses a measurable verb.
2. is specific for the patient and the patient’s problem.
3. is realistic for the patient and the patient’s problem.
4. includes a time frame for the patient’s reevaluation.
5. uses the word patient as the subject of the statement.