Nursing Process

- Based on standards
  - ANA
  - JCAHO
    - Joint commission on Accreditation of Healthcare Organizations
  - OSHA
  - Agency policy & procedures
  - Standards of care/Standards of practice (SOC/SOP)

Relationship of Nursing Practice to the Nursing Process and Standards of Practice

- Standards of nursing practice
- Defining characteristics of nursing practice
- Nursing process
- Evaluation
- Implementation
- Planning
- Nursing action
- Theory application
- Phenomena

1. The collection of data should be done with the client's comfort and cooperation. Data are accurate, complete, and recorded.
2. Nursing diagnosis: Define health status data.
3. The plan of care is derived from the nursing diagnosis.
4. The plan of care is derived from the diagnosis.
5. Nursing actions: Outline the details of care and health promotion and prevention. The plan of care is developed for the client.
6. The client's progress is evaluated and implemented. The plan of care is developed for the client.
Nursing Process

Purpose
- Identify, diagnose & treat human responses to health & illness
- Integrates critical thinking to make judgments & take action
- Organize & deliver nursing care
- Organize, systematize, and conceptualize nursing practice

Nurse Practice Act mandates "Accurate data collection and recording as independent functions essential to the role of the professional nurse"

Significance
- Client - Individualized care
  - Assists nurse to respond in a timely & reasonable manner to ↑ or maintain the client's health
- Nurse - Enables organization and delivery of care

Steps of the Nursing Process
- Assessment – assess individual, family, or community health status
- Diagnosis – identify individual, family, or community response to actual or potential health problems
- Planning – identify interventions to modify or change those responses
- Implementation – implement interventions
- Evaluation – evaluate effectiveness of interventions
Assessment

- **Purpose**
  - Establish a database about health problems and responses to these problems
  - Systematically collect, verify, analyze, and communicate data about a client

- **General information**
  - Related experiences
  - Health practices
  - Goals
  - Values
  - Lifestyle
  - Expectations from the health care system

Assessment cont.

- **Sources of information**
  - Primary (client)
  - Secondary (family, health professionals, other)
  - Initial -
    - Initiated for a specific purpose & focused on a specific content area
      - Nursing health Hx
    - Identify health needs & risk factors
    - Determine changes in level of wellness
  - Ongoing - Dynamic
Assessment cont.
- Interview techniques
  - Direct -
    - Establish therapeutic relationship
    - Gain insight
    - Obtain cues that require in-depth investigation (branching)
  - Indirect -
    - Observation
    - Nonverbal = verbal communication?
- Types of interview techniques - refer to Unit III Communication

Kinds of data: Subjective Objective

<table>
<thead>
<tr>
<th>Subjective data</th>
<th>Objective data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can only be spotted by the client, medical test or exhibited</td>
<td>Can be observed by others</td>
</tr>
</tbody>
</table>

| States never been pregnant |
| Skin warm & dry |
| Hears spoken word @10' |
| States has asthma |
| Blood sugar - 124 |
| Says takes a bulk laxative daily |
| BP 120/80 rt. arm |
| States mother had cervical cancer |
| AP 80 and regular |
| Pain level 5/10 |
| Says smokes 1/2 pd for 16 years |
| Alert & oriented to time, place & person (A&Ox3) |
| States vision is 20/20 with glasses |
| Full ROM of neck |
| “I’m about five feet, five inches tall” |
| Lungs clear to auscultation |
| Says allergic to penicillin |
Assessment cont.

- Systematic process
- Database formats
  - Incorporates 4 components:
- Components
  - Step 1: Interview
  - Communication initiated for a specific purpose & focused on a specific content area

Assessment cont.

- Step 2: Nursing Health History
  - Personal data
  - Health & Illness patterns
  - Chief complaint
  - History of present illness
  - Prior health History

Assessment cont. (Nsg Health Hx cont.)

- Medications
- Health promotion patterns
- Habits, activities at home
- Diversity considerations
- Allergies
- Psychosocial History - Support system, stress responses, and coping patterns
- Spiritual Health - Philosophy, source for guidance
- ROS - a systematic method for collecting data on all body systems
Assessment cont.

- Step 4. Diagnostic testing
  - X-Rays, CBC, etc.
- Nursing responsibilities
  - Safe, informed care
  - Advocate
  - Effective communication
  - Follow established protocols
  - Incorporate nursing process

Assessment cont.

Phases of diagnostic testing

- Pretest: Preparation & education
- Intratest: Medications & specimen collection
- Post test: Monitoring & preventing complications
- Types of diagnostic tests
- Influencing factors

Critical Thinking: Case Study

- Mr. Michaels was admitted 2 days ago with chest pain. He states, "I feel much better today, it is a relief to get rid of that discomfort." He appears pale and diaphoretic; lungs clear to auscultation, +1 bilateral pitting ankle edema. He denies being weary. He chooses 2 on a pain scale with a range of 0 - 10. His vital signs are:
  - T: 98.6
  - P: 74 & regular
  - R: 16
  - BP: 120/80
  - Pain: 2/10
- List subjective data:
- List objective data:
Types & Components of Nursing Diagnosis (ND)

Actual ND has 4 major components:

- **Label**
  - Describes diagnosis

- **Definition** (not written)
  - A clear, precise meaning of the diagnosis. Helps differentiate a specific ND from a similar ND

- **Related factors**
  - Etiologic factors (causes) that have influenced the health status change

- **Defining Characteristics**
  - Subjective and objective signs and symptoms

Example of a three-part “Actual” ND

- **Label**
  - Impaired skin integrity

- **Definition (this part is not included when writing your ND)**
  - Impaired skin integrity: A state in which the individual experiences or is at risk for damage to the epidermal and dermal tissue

- **Related factors**
  - Related to immobility

- **Defining Characteristics**
  - As evidenced by a 2-cm sacral lesion

This is what an “actual” ND looks like:

- Impaired skin integrity related to immobility as evidenced by a 2-cm sacral lesion
**Risk** and **High-Risk** Nursing Diagnosis

- One's more "vulnerable" to develop a problem
- Two-part statement
- Example:
  - Risk for impaired skin integrity related to immobility
- High-risk
  - For high-risk populations, "High Risk for..."
  - Example: *High Risk for* impaired skin integrity related to immobility

---

**Wellness** Nursing Diagnoses

- Wellness ND a “clinical judgment about an individual, group, or community in transition from a specific level of wellness to a higher level of wellness”
- Wellness diagnosis:
  - Three part statement (label)
    - Begins with "Potential for enhanced..." or "Readiness for enhanced..."

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**Actual** Nursing Diagnosis

- Must contain 3 parts:
  - (1) Diagnostic label (problem)
  - (2) Related to (contributing factors or etiology)
  - (3) As evidenced by (signs & symptoms = defining characteristics)
- Example:
  - Noncompliance related to knowledge deficit of the need for weekly blood pressure measurements, as evidenced by "I don't keep my BP √ appointments if I am busy."
**Actual ND**

- Impaired skin Integrity related to prolonged immobility, Braden score = 5, incontinent of bowel and bladder, c/o numbness at site, as evidenced by a 2 cm sacral lesion,
- Broken down into components:
  - Impaired skin integrity(label)
  - related to prolonged immobility Braden score = 5, incontinent of bowel and bladder, c/o numbness at site (contributing factors)
  - as evidenced by a 2 cm sacral lesion, (signs and symptoms)

**Interventions and Actual ND**

- Phrase “related to” reflects a relationship between the first and second parts of the statement.
- Phrase “as evidenced by” or “as manifested by” reflects a relationship between the first and third parts of the statement. Signs and symptoms necessary to validate an Actual Nursing Dx
- The label (part 1) or the contributing factors (part 2) may direct the interventions
- The nurse should be able to prescribe the definitive therapy (interventions) for the nursing label or the related factors

**“Unknown Etiology” Diagnostic Statement (DS)**

- Etiologic/contributing factors unknown, DS can include the phrase *unknown etiology*
- Example:
  - Fear related to *unknown etiology*, as evidenced by rapid speech, pacing, and “I’m worried”
Use of Medical Diagnoses

If Medical Diagnosis adds clarity to the Nursing Diagnosis, link with "secondary to"

- Impaired skin integrity r/t prolonged immobility
  secondary to fractured pelvis, aeb a 2-cm sacral lesion...
- A 3-part diagnostic statement with the words
  secondary to (link) fractured pelvis (Medical diagnosis)

Types of Diagnostic Statements

- Two-part (Risk, High Risk and Possible Nursing Diagnosis)
  - Label
  - Contributing factors
- Three-part (Actual Nursing Diagnosis or unknown etiology)
  - Label
  - Contributing factors (or unknown etiology)
  - Signs and symptoms of the diagnosis

Incorporating Critical Thinking

- Is data accurate & complete?
- Do you have evidence for problems you suspect?
- Consider other problems that the evidence might signify
- Look for flaws in your thinking
- Identify cause(s) of problem(s)
Critical Thinking (cont.)

- Include what client sees as problems
- Choose the diagnostic label(s) that best describes the problem(s)
- Inform client (& significant others) what you see as problems
- Double check when unsure
- Validate diagnosis with client

Examples

**Nurses Can Prevent**
- Pressure ulcers
- Thrombophlebitis
- Complications of immobility
- Aspiration

**Nursing Diagnosis**
- Risk for Impaired Skin Integrity
- Risk for Altered Peripheral Tissue Perfusion
- Disuse Syndrome
- Risk for Aspiration

**Nurses Can Treat**
- Stage I or II pressure ulcers
- Swallowing problems

**Nursing Diagnosis**
- Impaired Skin Integrity
- Impaired Swallowing

Legal Issues

- Nursing Diagnosis
  - Question degree of cultural sensitivity
  - Unethical to label behaviors
  - Other disciplines may not understand Nursing Diagnosis
Planning Phase

- Includes
  - Outcomes (column 2 of NCP form)
  - Interventions (column 4 of NCP form)
    - The diagnostic label (part 1) or the contributing factors (part 2) of the nursing diagnosis directs the interventions

Steps in Planning Care

- Set priorities
- Establish outcomes
- Record plan of care
Purposes of the Care Plan

- Communication between caregivers
- Directs care & documentation
- Record that can be used for
  - Evaluation
  - Research
  - Legal purposes
  - Insurance reimbursement purposes

Setting Priorities & Critical Thinking

- What needs immediate attention & what can wait?
- Which health problems are your responsibility & which ones need to be referred?
- Use standard plans?
- Which problems aren’t covered but must be addressed?

Setting Priorities According to Maslow’s Hierarchy of Needs

- Problems interfering with:
  - Priority 1: Physiologic needs & life-threatening
  - Priority 2: Safety & security
  - Priority 3: Love & belonging
  - Priority 4: Self-esteem
  - Priority 5: Ability to achieve personal goals
### Maslow’s Hierarchy of Needs

<table>
<thead>
<tr>
<th>Physical Safety Needs Love Needs Self-Esteem Self-Actualization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen, fluids, nutrition, body temperature, elimination, shelter, sex Sleep/rest</td>
</tr>
</tbody>
</table>

### Expected/Desired Outcomes
- What results are expected?
- When are results expected (dated)?
- Are outcomes measurable (criteria)?
- Are outcomes singular?

### Outcome verbs: Which ones are measurable?
- States
- Knows
- Identifies
- Exhibits decreased
- Exhibits increased
- Appreciates
- Accepts
- Reports absence of
- Administers
- Understands
- Specifies
- Performs
Outcomes

- Outcome Criteria/Nursing Goals are also called:
  - Objectives
  - Expected outcomes
  - Outcomes
- Individualize outcomes:
  - What are the problems that must be prevented, resolved or improved?
  - What are the expected outcomes?
  - What are the interventions required to achieve the outcomes?

Standards for Outcomes
(ANA, 1991)

- Outcomes are
  - Derived from nursing diagnosis
  - Documented as measurable goals
  - Mutually formulated with the client
  - Realistic
  - Attainable
  - Include a time estimate for attainment
  - Provide direction for continuity of care

Nursing Interventions

- Any direct care that a nurse performs on behalf of a client:
  - Nurse-initiated care
  - Physician-initiated Rx resulting from medical diagnosis
  - Performance of daily essential functions for the client
  - Collaborative problems - Problems using physician and nurse interventions
Nursing Interventions

- Formulated by nurses for themselves or other healthcare providers to implement
- Any direct care that a nurse performs

Purpose:
- Reduce or eliminate contributing factors or the nursing diagnosis
- Promote higher-level wellness
- Monitor status

Nursing interventions (orders)

- What activities need to be carried out?
- How often?
- When?
- Who needs to carry out activities?

Nursing Orders

Nursing orders are comprised of the following
- Date
- Directive verb
- What, when, how often, how long, where?
- Signature
- Same as nursing actions, which are "standard" interventions that can apply to any number of clients sharing a similar problem
Example

- **Nursing Action**
  - Promote a well-scheduled daytime program activity

- **Nursing Order**
  - Assist the client to dining room for each meal
  - Have another resident accompany client on a daily afternoon walk around the grounds

---

For **risk nursing diagnosis**, interventions seek to:

- Decrease or eliminate risk factors
- Prevent occurrence of the problem
- Monitor for onset

---
Critical Thinking & the Process of Implementing Care

**NURSING PROCESS**
- Assessment
- Diagnosis
- Implementation
- Planning

**KNOWLEDGE**
- Impact of decision on patient outcomes
- Functions of health care disciplines (e.g., local, equipment personnel)
- Anticipated drug/therapeutic outcomes
- Interpersonal skills
-国际协会
- Managing/analyzing medications
- Delegation and supervision principles

**EXPERIENCE**
- Previous client care experience
- Knowledge of successful interventions

**ATTITUDES**
- Independence
- Knowledgeability
- Accountability
- Credibility
- Diligence

**STANDARDS**
- Standards of practice (e.g., ANA, specialty-based practice guideline, e.g., ABA-PSI)
- Agency’s policies/protocols for guidance of nursing position and delegation

**Implementation**
- Involves applying skills needed to implement nursing interventions
- Must possess skills and assess, teach, and evaluate these skills in other nursing personnel
- Often responsible for planning care, but not implementing it
- Requires management skills of delegation, assertion, and evaluation
Skills & Knowledge Necessary
- Performing the activity for or assisting client
- Performing nsg. assessments to identify new problems or monitor existing problems
- Perform client teaching to help gain new knowledge
- Assist client to make decisions
- Consult & refer to other health care professionals
- Provide specific Rx actions to remove, ↓ or resolve health problems
- Assist client to identify risks or problems and to explore options available

Rationale: Document the scientific principles underlying the interventions - include the source and page no.

Implementation
- Establish regular time for elimination
- Adequate exercise (ambulate 15” QID). Enc. AROM (10” QID)
- Balanced diet
- Adequate fluid intake (2 to 3 quarts per day)

Rationale
- A normal bowel elimination pattern is maintained by a daily diet of fiber, 6-8 glasses of water, and daily exercise. The person must be able to establish a toileting routine (McLane & McShane, pp. 30-40,1999)

Nursing Care Plan

<table>
<thead>
<tr>
<th>Dx</th>
<th>Outcomes</th>
<th>Goal</th>
<th>Intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation related to (RT) immobility as evidenced by (AEB) reports of infrequent hard, dry feces</td>
<td>1. Client will describe concepts of therapeutic bowel regimen by 9/26/03</td>
<td>Establish regular time for elimination. Adequate exercise: (ambulate for 15” QID), Enc. AROM (10” QID). Teach about foods high in fiber. Provide and offer fluid intake (2 to 3 quarts per day).</td>
<td>A normal bowel elimination pattern is maintained by a daily diet of fiber, 6-8 glasses of water, and daily exercise. The person must be able to establish a toileting routine (McLane &amp; McShane, 1991)</td>
<td></td>
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</tbody>
</table>
Summary, Nursing Process

- Planning includes outcomes & interventions
- Interventions are focused on part 1 and 2 of the diagnostic label
- Implementation includes interventions to achieve outcomes
- Final phase concludes with an evaluation of your interventions & whether you met your expected outcomes

Evaluation involves 3 considerations:

- Evaluation of client’s:
  - Status
  - Progress toward goal achievement (expected outcomes)
- Care plan’s status
  - Current
  - New data
Evaluating Nursing Diagnosis
- Assess client’s status
- Compare to outcome criteria
- Conclude whether progressing toward outcome achievement

Evaluating Care Plan (CP)
- Nursing Diagnosis
  - Diagnosis still exist?
  - Possible diagnosis confirmed or ruled out?
  - New diagnosis needed?
- Expected outcomes (Goals)
  - Achieved?
  - Reflect present focus of care?
  - Acceptable to client?
- Interventions
  - Acceptable to client?
  - Specific to client?
  - Provide clear instructions for nursing staff?

Evaluation is part of the Entire Nursing Process
Critical Thinking: Case Study

Dana Jeffers is a 32 y/o African-American woman being seen for an annual PE. Last PE & Pap smear 12 months ago. States never misses annual exam. Married school teacher Ø children. Describes health as “good.”

Hx: UTI 18 mo. ago. Reports not using contraception in hopes of conceiving. LMP 38 days ago. No previous pg.

Family Hx of breast cancer: Mother, paternal aunt, & older sister. Performs BSE q mo. but not confident able to detect a mass. Requests info on breast Ca prevention & detection, esp. diet & BSE. Not sure when to have 1st mammogram.

PE: Ht. 5’6”, wt. 125#, VS: T 98.8, P 88, R 16, BP 128/84, pain 0. Breasts soft, nontender, Ø palpable masses or discharge.

Nursing Diagnoses

Health seeking behaviors, r/t family Hx of breast Ca, ae expressed desire to seek a higher level of wellness; expressions of concern about current health & family Hx; and request for info about BSE, mammography, and Ca prevention diets

Fear, risk for, r/t perceived threat of terminal disease

Anxiety, risk for, r/t threat to self-concept secondary to pregnancy

Case Study Mrs. Jeffers (cont.)

Hx: UTI 18 mo. ago. Today c/o: frequency, urgency, urinating small amts. (20cc), burning on urination, dribbling, & a low backache.


Develop 3-part Nursing Diagnoses
Nursing Diagnoses

- Urinary elimination, Impaired, r/t unknown etiology, aeb c/o ↑ frequency of urination, urgency, dribbling, slight distention in LQ abdomen, dull percussion note.
- Urge incontinence r/t unknown etiology aeb urgency followed by incontinence
- Acute pain r/t unknown etiology, aeb report of burning on urination, pain 5/10, CVA tenderness.
- Possible fluid volume deficit

Evaluation

- Evaluation leads to
  - Termination of nursing care or
  - Revision of Care Plan after each preceding step has been evaluated

Nursing Process

- The Nursing Process is a Systematic method
- Directs nurse & client to determine the need for nursing care (assessing and diagnosing) and then plan, implement, and evaluate care
- Steps interrelated
- Each step depends on the accuracy of the preceding step
Time to Think: A Critical Thinking Component of the NCP

Prioritizing your 3 Nursing Diagnosis according to Maslow’s Hierarchy of needs
1. Highest priority
2. Between highest and lowest
3. Lowest priority

Maslow’s Hierarchy of Needs
Problems interfering with the ability to achieve personal goals
Problems interfering with self-esteem
Problems interfering with love & belonging
Problems interfering with safety & security
Life-threatening problems & those interfering with physiologic needs

<table>
<thead>
<tr>
<th>Physical</th>
<th>Safety Needs</th>
<th>Love Needs</th>
<th>Self-Esteem</th>
<th>Self-Actualization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen, fluids, nutrition, body temperature, elimination, shelter, sex, sleep/rest</td>
<td>Physical &amp; psychological security, protection, comfort, peace, order</td>
<td>Acceptance, belonging, love &amp; affection</td>
<td>Recognition/esteem, leadership, achievement, competence, strength, intelligence</td>
<td>Fulfillment of potential, challenge, curiosity, creativity, aesthetic appreciation</td>
</tr>
</tbody>
</table>

Selecting/Prioritizing Nsg Dx
- You are assigned to Mr. Smith who was transferred to your unit last night. You learned from report that he has CHF, 2+ pitting edema of the lower extremities, and increasing SOB. VS: T 97.6, P 62, R 22, BP 130/80.

- Mr. Smith really wants to wash up now, but he says that he does not have the energy like he used to and that he gets tired very easily. He says it's real important for him to wash up before his family visits. You assess the following:
  - Skin cool and dry
  - Lower extremities with 2+ pitting edema
  - Lungs sounds: Some crackles on inspiration; R 22
  - A&OX3
Selecting/Prioritizing ND

- The following Nursing Diagnoses may apply:
  - Risk for infection
  - Activity intolerance
  - Fluid volume excess
  - Impaired tissue integrity
  - Risk for altered tissue perfusion
  - Impaired gas exchange

- Select the Nursing Diagnosis that is of priority at this time

- Provide a rationale for your selection & list appropriate nursing interventions.

Priority: Activity intolerance

Rationale: Diminished cardiac output decreases oxygen to tissues. Activities put a greater demand on the heart

Nursing interventions:
- Space activities with periods of rest
- Monitor VS, color, SOB before & after activity
- Check O₂ sat q 4 hrs & before & after activity
- HOB ↑
- O₂ as needed
- Offer partial bath with assistance to relax & ↓ demand on heart

Suggested Steps for Setting Priorities

- Develop problem list
- Decide what problems managed by
  - Nursing
  - Standard plans
  - Medical orders
  - Multidisciplinary planning
- Assign priorities (Maslow)
- Assign high priority to problems that are contributing factors to other problems

“What needs immediate attention?”
- ID problems with simple solutions
- Know client’s perception of priorities

See whole picture
- Trouble breathing, correct 1st
- Trouble breathing because of anxiety attack, resolving anxiety most important
In Summary,

- The 5 components of the NP are assessment, diagnosis, plan, implementation, & evaluation.
- Apply these concepts to your Care Plan (diagnosis, expected outcome, evaluation, implementation, & rationale).
- The NP is a developmental process—practice, practice, practice!!!!

Study Guide

- Purpose and importance of the nursing interview.
- Differentiate between subjective and objective data.
- Know the importance of planning care for the client.
- Purpose of the nursing process.
- Distinguish between 1, 2, and 3 part nursing diagnoses.

Study Guide

- Differentiate between nursing diagnoses, medical diagnoses, expected outcomes (goals), evaluation, and interventions.
- Apply components of the nursing process to mini case studies.