Chapter 10 - Nursing Process

- Foundation of nursing profession = nursing process
- 6 step nursing process = assessment, diagnosis, outcome identification, planning, implementation, and evaluating (ADOPIE)

Components of the Nursing Process

- Definition of nursing process- a systematic problem-solving approach toward giving individualized nursing care. Used to identify/treat potential or actual health problems.
- Characteristics of the nursing process:
  - framework for providing nursing care to individuals, families, and communities
  - Orderly and systematic
  - Independent
  - Provides specific care for individuals, families, and communities
  - Patient centered, using the patient's strengths
  - Can be used in all settings

Phases – assessment, diagnosis, outcome identification, planning, implementation, evaluating

Assessment – evaluation or appraisal of a patient's health state

- Systematic collection of subjective (what pt. says) and objective data (what nurse finds)
- Considering the physical, psychological, emotional, sociocultural and spiritual factors
- Gather past, present, or potential problems
- Primary source = patient / Secondary source = family, significant others, other providers
- Takes place through observing, interviewing, and examining the patient and interpreting laboratory data and diagnostic tests
- Through assessment data provide the foundation of nursing diagnosis

Diagnosis – to actual or potential health problems.

- Clinical act of identifying problems by analyzing assessment info and deriving meaning from the analysis.
- NANDA – "a clinical judgment about individual, family, or community responses to actual or potential health problems/life processes."
- Provides the basis for selection of nursing interventions to achieve positive outcomes
- Uses cue clustering, cluster interpretation, and diagnostic validation to ensure accuracy in the correct diagnoses

Diagnostic Reasoning Process – used to make accurate clinical diagnoses about patient problems.
Diagnostic Reasoning – the process of gathering and clustering data to draw inferences and propose diagnoses

- 5 steps – organizing the existence of cues, generating possible diagnoses, conducting a focused data collection, and validating the

- Nursing Judgment – what to do next. Diagnosis leads to nursing plans and intervention diagnosis.

Outcomes and Planning

- Outcome identification = formulating and documenting measurable, realistic, patient-centered goals
- Planning = preparing a plaitent plan of care, which directs the activities of the nursing staff in the provision of patient care
- Must have a written patient plan of care – which includes establishing patient goals, outcome criteria, and determining nursing interventions
- Outcomes are then written to see if care is making a difference/ interventions working
- Outcomes must be specific to the patient, realistic, measurable, and have a time frame

Implementation

- Action phase of the nursing process
- Initiation of the plan, evaluation of response to plan, and recording or nursing actions and patient responses to these actions.
- Requires the components of intellectual, interpersonal, and technical skills

Evaluation – rating, grading, and judging

- Nurses discover why the patient plan of care was a success or failure
- Determine the patients reaction to nursing interventions and judge if goals were achieved.
- Involves a detailed/ on-going assessment on the entire plan of care.
- Nurses compare patient assessment after interventions to the patient outcomes written earlier – leads to reevaluation if goals are not met

Interactive Nature of Each Phase

- Each phase of the nursing practice interacts with and is influenced by the other phases

Professional Relevance

- Nursing process is – systematic, adaptable, and organized way of providing care for any patient in any situation.
- Nursing process focuses on patients' unique problem – individualized nursing care
- Nursing process = universally accepted method for providing nursing care

Importance of Critical Thinking in Nursing

- Need critical thinking for effective, creative, and efficient nursing care
- Critical thinking – helps nurses to choose solutions or identify options for patient care situations
- Critical thinking = mode of thinking – about any subject, content, or problem – in which the thinker improves the quality of his/her thinking by skillfully taking charge of the structures inherent in thinking and imposing intellectual standards upon them
- Critical thinking occurs within an existing knowledge base and is paralleled by clinical experience

Learning Styles Affecting Critical Thinking

- Learning in clinical setting = active, kinesthetic, and random
- Learning in classroom = sequential, reflective, and competitive
- Critical thinking involves - technical and experimental skills (learned in clinical/lab setting) Interpersonal skills (communicating with others) Theoretical knowledge (by active reading, writing, and studying)

Skills in Providing Care

Listening: active listening (nurses are responsive to cues patient is sending)

- Involves paying close attention to nonverbal cues and spoken responses

Collaborating: collaborating with all members of a team – to develop and individualized care of plan

- Foundation built on trust and respect

Communicating: important in both written and verbal

Practicing Reflection

- Reflection – "those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understanding and appreciations."

- Include reflection-in-action (occurs in clinical practice) / reflection-on-action (occurs after the event)

Developing Expertise

Novice: learners use rules to guide practice

Advanced Beginner: after more clinical experience. Nurses learn to consider more facts and complex rules.

Competence: nurses devise new rules and reasoning procedure. Feel responsible for outcomes and may question the rules. Occurs through experience

Proficient: nurses realize that the events, context, and patient situation are as important as the nurse's individual resources. Outcomes become more important than the interventions. Thinking is more flexible and intuitive rather than planned and deliberate.

Expert: knows the goal to achieve and how to achieve it. Use sound theoretical thinking to reflect on the goal and decide on the appropriate action. Can link teory, practice, and intuition

Documentation and Communication in the Healthcare Team

- Ongoing effective communication assures the pt. receives care that is safe, timely, and responsive to pt. needs
- Documentation = written or typed. Serves as a permanent record of pt. info and care. Provides info on current visit and can be consulted in future to review pt. history, research, education, and legal purposes
- Reporting = when 2 or more people share info about a pt. (face-to-face, telephone, audiotape, or voicemail)
- Documentation and pt. reporting = confidential

Patient Medical Record

- Must be clear, up-to date, and accurate for safe care delivery
- Pt. record promotes a coherent plan of care, communication of common and individual goals, and progress of the pt. toward those goals
- Documentation on medical record is essential related to assessment, interventions, and goals

Purposes of the Medical Record – legal document, communication, assessment, care planning, quality assurance, reimbursement, research, and education

Legal Document: pt. record serves as a legal document of pt. health status and care received

- "If it was not documented, it was not done."
- Important to document both normal and abnormal findings

Communication: clearly documented info on pt. record communicates the plan of care and pt. progress to all members of the healthcare team

- Communication helps to ensure continuity of care and provides essential data for revision or continuation of care

Assessment: Nurses and other team members gather assessment data from the pt. record

Care Planning: Formulation of a plan of care flows from assessment data in the pt. record