Nursing Process 101 - ADPIE Cheat Sheet

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NURSING PROCESS

Systematic guide to patient-centered care
> involves critical thinking skills and data collection
1. Assessment
2. Diagnosis/Analysis
3. Planning
4. Implementation
5. Evaluation
*although the steps are ordered, nursing is not linear and care is both cyclic and bidirectional
DOCUMENT! DOCUMENT! DOCUMENT! *If it wasn't documented, it wasn't done*

Assessment

first function of the nurse: data collection and documentation
explore the pt's viewpoint
> interview, physical examination, observation, functional assessment
> initial, focused, organized, emergent
> collect subjective & objective data
> pt demographics, past medical history, past surgical history
> utilize database: patient medical records, labs and diagnostic results
> gather info about pt's condition HPI, cc, vital signs and/or lab results
> comprehensive ROS review of systems
> risk assessment: identify any potential health problems
> inquire about related goals, experiences, values & expectation about healthcare system
> cluster cues and data, make inferences & identify patterns & problems
> must be: purposeful, prioritized, complete, systematic, factual, relevant, documented
collect, analyze, validate, communicate

Diagnosis/Analysis

Nursing diagnosis vs medical diagnosis
> nursing diagnosis is human response to illness; unique to each patient
Use clinical judgement and analyze data; actual vs potential health problem, wellness
clarify exact nature of problem or risk to achieve overall outcome

Diagnosis/Analysis (cont)

> Identify how pt responds to health or life processes
> Identify factors contributes to problem; specific, critical and related
> Identify resources & strengths of pt
health problem prevented or resolved
> problem focused (actual)
> identify "at risk for" problems
> health promotion (wellness)
- problem NANDA
- etiology "related to" or "r/t"
- symptoms "as evidenced by" or "AEB"
*use nursing standards to help determine nursing diagnosis
One-part (diagnosis), two-part (diagnosis + etiology) and three-part statements (diagnosis + etiology + s/s)

Planning

Plan of care
Design of plan of care results in prevention, reduction, resolution of pt health problems
> Priorities: high, intermediate, low
> MASLOW: physiological, safety, love/belonging, esteem, self actualization
> SMART goals: Specific, Measurable, Attainable, Realistic, Timed
> Short-term and long term
Steps
1. establish priorities and develop outcomes
- individualized
- culturally appropriate
2. identify and document expected outcomes
3. identify and select nursing interventions: integrate EBP and nursing standards
4. communicate and document care plan
Identify expected outcomes and goals and criteria for success related to the pt's needs

Implementation

Implement the plan of care, nursing intervention actions
Specify the nursing actions and interventions, who, what, when, how
> plans are carried out, safely and timely
> plans are evidence based
> coordinate care delivery
> provide health teaching and health promotion
> document implementation and any modifications

independent, dependent, and collaborative/interdependent
- independent: nurse initiated, w/o MD orders
- dependent: MD orders (all medications)
- interdependent: PT, OT, social worker, RT, dietician

direct and indirect
- direct: interaction with the patient (ie. v/s, medication administration)
- indirect: no interaction with the patient (ie. speaking with MD, creating plan of care)

Implementation (cont.)

Direct	Indirect
ADLS	manage and collaboration
physical care	communicate nursing intervention
lifesaving measures	delegating
counseling	supervising
pt teaching and education	evaluating
prevention	
medication administration; monitor for adverse effects	

Evaluation

Re-assessment of how well pt has achieved expected therapeutic outcomes
ongoing through nursing process
> resolve health problems
> prevent potentially new problems
> collect data
> maintain a healthy state/ health promotion
> document findings using clinical judgement
> terminate, continue, modify
> goals met, partially met, unmet
*Include the pt and their family by interpreting and summarizing findings
if the goal(s) has not been met, reassessment and revision of plan of care

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