## 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



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## 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

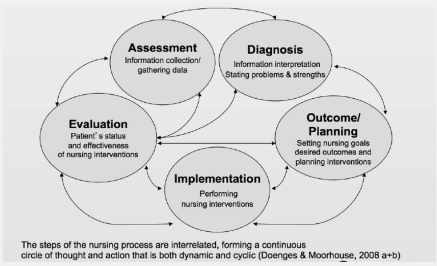
> terminate, continue, modify

> 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*

## Graph



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