Nursing Process

• Assess
• Determine Nsg. Dx.
• Plan
• Implement
• Evaluate

Greiben and Lavin, 1974

Assess

• Systematically gather data:

  – Subjective data (what the patient tells you, also called SYMPTOMS)

  – Objective data (what you see, hear, feel, smell; also called SIGNS)

Symptoms

• What, when, where
• PQRST
  – Provoking factors
  – Quality (sharp, dull)
  – Relieving factors
  – Severity (scale of 1 to 10 for pain)
  – Time/duration
Signs

• What you see, hear, feel, smell
  – Inspection
  – Auscultation
  – Percussion
  – Palpation

Nursing Diagnosis (NANDA)

• The diagnosis and treatment of human responses to actual or potential health problems.  (American Nurses Association, 1980)

• Nursing diagnosis facilitates communication among health care providers and the recipients of care and provides for initial direction in the choice of treatments and subsequent evaluation of the outcomes of care.  (American Nurses Association, 1995)


• Provides the basis for selected interventions and outcomes.

• Potential = At risk for
Nursing Interventions Classification (NIC)

- A standardized classification of interventions which nurses perform.
- Includes interventions by nurses: both independent and collaborative
- Seven (7) domains: physiological, basic, physiological, complex, behavioral, safety, family, health system, community

Nursing Outcomes Classification (NOC)

- Standardized classification of patient outcomes which evaluate effectiveness of nursing interventions. (Those sensitive to independent and interdependent nursing interventions)
- Uses a likert scale 1 – 5, so can measure progress.
- OUTCOMES have become increasingly important. General Patient outcomes refer to outcomes in terms of patient, cost, effectiveness, patient satisfaction.

Domains of NOC

- Functional Health
- Physiological health
- Psychological Health
- Health Knowledge and Behavior
- Perceived health
- Family Health
- Community Health
Planning

• What you PLAN to do for the patient, to get them
  A                                B
• Can have immediate plan, short and long range plan
• Where you work will determine the definition of your short, intermediate and long range plans

Immediate Plan

• Airway, breathing, circulation (ABC) problem (take care of the problem, don’t spend time writing about your plan!!)
• Acute pain: take care of the patient first
• Acute psychiatric crisis: make the patient safe

Intermediate Range Plan

• For that shift or the next few days:
  – Monitor for….improvement, stability, deterioration….
  – Management: fluid, pain, anxiety
  – Obtain: consent, specimens, more data from family, etc.
Long Range Plan

• The ultimate outcome for the patient, to resolve the problem

• Situational: must be realistic and acceptable for the patient. Should be set with the patient (family).

Methods for Problem Solving

• Trial and error (inefficient)
• Scientific method*: 
  – problem identification
  – Data collection
  – Hypothesis formulation
  – Plan of action
  – Hypothesis testing
  – Interpretation of results
  – Evaluation: conclusion or revision of above

• Intuitive Method (must be an expert to have intuition)

Skills of an Excellent Nurse

• Cognitive
• Technical skills
• Interpersonal Skills
• Ethical/legal skills (professionalism)
• Always promote HUMAN DIGNITY and RESPECT
Implementation

Dependent, independent and interdependent functions which nursing does:

- Independent: actions which do not require an order from another discipline (turn and position, pulmonary toileting, reduce anxiety)

- Interdependent: implement an interdisciplinary protocol which was developed collaboratively

- Dependent: actions which require a specific order from another discipline

Nursing Outcomes Classification

- Patient state, behavior, response or feeling in as a result of the care provided.

- Many variables effect outcome, including: nursing care, medical care, access to care, patient/family actions, natural course of events, etc.

- Can be at the level of the patient, family or community.

Example: Patient with Recent CVA

- **Ndg. Dx.:** Potential for skin integrity impairment

- **NIC:** Turn and position patient Q 2 hrs
  - Nutrition: ensure adequate caloric intake
  - Keep skin clean, dry
  - Use pull sheet
  - Monitor skin status q shift

- **NOC:**
  - Patients skin will remain intact (no breakdown)
Example: Chest Pain
[with deviation from formal nomenclature]

• Nsg Dx.: Chest pain r/t cardiac ischemia

• NIC: (Activities targeted towards: decrease cardiac workload and increase perfusion to myocardium, detect + or - changes in status):
  – Bed rest, calm environment
  – Administer nitrites
  – Supplemental O2
  – Pain medication: Morphine
  – IV access
  – Monitoring: pain, cardiac rhythm, V/S, output…..

• NOC: Patient CP will resolve, maintain stable rhythm & V/S

Documentation

Written, legal record of important transactions pertinent to a patient’s care.

• Reasons for:
  Baseline data about patient, from which other can gauge change in status or condition (+ or -)
  Means of communicating with other practitioners, so can be continuous and coordinated
  Care planning
  Reimbursement
  Quality Improvement activities
  Historical documentation

Important Elements

• Legibility
• Dated, timed, signed entries
• Logical, pertinent information
• Do not argue with other practitioners in a patient’s chart! (EVER)
• Use correct abbreviations (vary by organization)
• For entry error, one line thru, with error and initial above.
• Medical Records are CONFIDENTIAL
Many formats….

• POMR [SOAPIER]: subjective, objective, assessment, plan, intervention, evaluation, re-evaluation

• PIE: problem, intervention, evaluation

• FOCUS: data, action, response

• Critical pathway documentation

Subjective Data

• S (subjective): [What you are told] patient (or surrogate: family EMS, friends) report regarding illness / health state
  – Current problem when began, (PQRST) or current status
  – Past med/surg hx. (if first encounter)
  – Current meds/tx. therapies (include OTC and home remedies), compliance with meds/tx. regime
  – Current status r/t problem: LMP, last drink
  – Allergy hx.
  – Preference hx.

Depending upon where you work, and nature of encounter with the patient, some or all of this information will be collected.

Objective Data

• What you observe:
  – Inspection
  – Palpation
  – Auscultation
  – Percussion
  – Testing data (lab, imaging, etc.)
  – Physiological parameters: V/S, urine output
Assessment

• Your conclusion as a result of collection of the subjective and objective data.

• Here is your nursing diagnosis

Plan

• What you are going to do for the patient:
  – Can be in the form of monitoring or actual interventions

Interventions

• Sometimes are merged with Plan, other times are separate (by the time you have documented, have done plan and intervention

• Can be dependent, interdependent and independent interventions
Evaluation / Re-evaluation

- Evaluate the patient OUTCOME, and may or may not change your plan and interventions.

Documentation

Institution specific, and then unit specific, can include:
- Assessment forms
- Plan forms: NCP, critical pathways
- Kardex: communicates the plan to all disciplines
- Progress notes
- Consult form
- Procedure report form
- Flow sheets (special care units love them)
- Order form
- Medication record
- I and O sheets
- Discharge summary form
- Patient education form

Charting Practice: Pt. With Acute Exacerbation of Asthma

6/20/01 0700
S. 32 y.o. female, to E.D. c/o SOB, which has increased in severity over course of past 4 hours. PM HS of Asthma X 5 years, well controlled, never intubated, has not taken asthma meds (proventyl inhaler) since last month, can’t afford the meds. Appears anxious, difficulty with speaking.
O. Pale, RR 32, P 120, PF: 140 (baseline?),
A. Airway clearance impairment: severe (r/t asthma)
P1. Nasal 32: started
A1. Albuterol tx. X2: initiated/in progress
IV access: to left hand
monitor P/F and respiratory status, complete V/S after tx. completed
will call S. W. re: obtaining d/c meds
Columbia Nurse, RN
6/20/01 0800
S. Pt reports feeling better, SOB has markedly decreased.
O. Skin, warm, dry, pink, RR 20, P 92, T 100.8, B/P: 120/60 PF: 230
A. Respiratory status improved. Self care deficit r/t inability to obtain asthma meds
P. Will continue to monitor resp. status, hydration, S. W. referred re: meds.
I. P.O. fluids provided, S. W. called, Asthma literature provided.
Columbia Nurse, RN