The Nursing Process

Definition

A systematic method of providing nursing care. It provides a framework for planning and implementing nursing care.

Components

1. **Assessment (ends with the formulation of a nursing diagnosis)**
2. **Planning**
3. **Implementation**
4. **Evaluation**

Assessment

Definition:

The process of gathering, verifying and communicating data about a patient. Data is gathered from a variety of sources and is the basis for actions and decisions.

Data Collection

1. **Begins upon admission**
2. **Is a continual action throughout each phase of the nursing process**
3. **Data is classified as either objective or subjective**

Objective Data

Factual data observed by the nurse.

No conclusions or interpretations are made.

Examples:

B/P 100/62

Voided 200cc dark amber colored urine

Subjective Data

Information given verbally by the patient.

Examples:

“I itch all over.”
“My stomach aches.”
“I’m afraid of going to surgery tomorrow.”

Methods of Collecting Data

1. **Observation**
2. **Interview**
   - **a. Formal**
   - **b. Informal**
3. **Examination**

Analysis and Interpretation of Data

1. **Continually update and revise**

2. Cluster data

3. Identify nursing diagnoses

Nursing Diagnosis

A statement of an actual or potential response to a health problem that the nurse is competent and licensed to treat.

Actual: **a situation that exists in the here and now.**

- **alteration in comfort**
- **ineffective breathing pattern**
- **impaired skin integrity**

Potential: **a situation which may cause difficulty in the future.**

Examples:

- **high risk for injury**
- **high risk for sleep pattern disturbance**
- **high risk for impaired skin integrity**

Nursing Diagnosis Statement

Contains two parts:

1. **The statement of the patient problem**
2. **The contributing factors or probable causes of the problem the etiology.**

The two parts are joined by the words "related to"

Examples:

1. **Ineffective breathing pattern (problem) related to chest pain (etiology).**
2. **High risk for injury (problem) related to poor vision and decreased mobility (etiology).**
3. **Alteration in nutrition (problem) related to nausea (etiology).**

Things to remember:

1. **Only one nursing diagnosis per patient problem.**
2. **Each nursing diagnosis can have more than one etiology.**
3. **The nursing diagnosis is not a medical diagnosis - avoid using a medical diagnosis as part of the etiology.**
4. **Nursing diagnoses identify health problems and enable a plan of care to be developed to achieve a maximal level of wellness.**
5. **Use the NANDA list to help you formulate your nursing diagnosis.**

Planning

The phase of the nursing process in which you develop a plan of care and determine how you are going to solve, lessen or minimize the effects of the patient's problems.

There are 4 steps in this phase.

Step 1: Setting Priorities

1. **Determine which problem poses the greatest threat to the patient's well-being.**

- This becomes priority 1

- Continue to prioritize in this way.

2. **Find out which problems the patient feels are most important.**

Step 2: Writing Goals

1. **A goal is a specific and measurable objective designed to reflect the patient's highest level of wellness and independence in function.**

2. **The goal is derived from the first part of the nursing diagnosis statement.**

3. **There are 2 categories of goals:**

   a. **Short term - can be met fairly quickly (hours or days)**

   b. **Long term - cover a longer time span**

Guidelines for Goal Writing

1. **Write goals in observable or measurable terms.**

2. **Write goals in terms of patient outcomes not nursing actions.**

3. **Keep goals short and specific.**

4. **Designate a time for achievement of the goal.**

Examples of Goals

The patient will be free of infection throughout hospitalization.

The patient's lungs will remain clear post-op.

The patient's skin will be healed by 1/31.

Step 3: Developing the Expected Outcomes

Expected Outcomes define when a patient goal has been met and assist in evaluating the extent to which the nursing diagnosis has been resolved.

They are stated in observable or measurable terms.

Functions:

1. **Provide a direction for nursing activities.**
2. **Indicate what should occur during the time span indicated in the goal.**
3. **Used to evaluate the effectiveness of the nursing interventions.**

Example

Goal: The patient's lungs will remain clear postoperatively.

Expected Outcomes:

- the sputum will remain white.

- the patient will remain afebrile.

- the lungs will be clear to auscultation.

Step 4: Planning Nursing Actions

Nursing Actions are those things the nurse plans to do to help the patient achieve a goal.

Nursing Actions are derived from the etiology of the nursing diagnosis.

Guidelines for selecting nursing actions

1. Be sure the actions focus on the etiology of the nursing diagnosis.
2. Must be safe for the patient.
3. Must be congruent with other therapies.
4. Should be based on principles of nursing and disciplines related to nursing.
5. Must be based on appropriate rationale.
6. Each nursing diagnosis should have its own set of nursing actions.
7. Choose actions most likely to develop the behavior in the goal.
8. Must be realistic.
9. Use the patient as a source for choosing nursing actions.

Types of Nursing Actions

1. **Dependent**
   - a nursing action based on the instruction of another professional

2. **Independent**
   - requires no supervision or direction from others

3. **Interdependent**
   - actions carried out by the nurse in collaboration with another health care professional

Questions Nursing Actions Should Answer:

1. What is the action?
2. When should the action be implemented?
3. How should the action be performed?
4. Who should be involved in carrying out the action?

Implementation Phase

1. **Validating and documenting care.**

2. **Giving nursing care.**

3. **Continuing data collection.**

Evaluation Phase

1. Evaluate goal achievement:

Evaluate only the patient's ability to perform the behavior in the goal - don't evaluate the nursing actions.

2. Three alternatives:

a. **goal met**

b. **goal partially met**

c. **goal not met**

3. **Include a statement of where the patient is now in terms of the expected outcomes.**

4. **When the goal is partially met or not met, then the care plan must be reassessed.**

5. **Possible outcomes:**

    - priorities may change and problems may have to be dealt with.

    - new data may indicate there is a new problem to be dealt with.

    - the goal may be met and the problem no longer exists.

    - the goal may be met, but the problem still exists. May require changing goal, expected outcomes and nursing actions.

    - if the goal was not met, the nurse needs to correct the unsuccessful plan.

NANDA LIST

North American Nursing Diagnosis Association

Below is a complete listing of all NANDA nursing diagnoses through the 12th conference (1996).

http://www.efn.org/~nurses/nanda.html

Activity/Rest
Circulation
Ego Integrity
Elimination
Food/Fluid
Hygiene
Neurosensory
Pain/Discomfort
Respiration
Safety
Sexuality
Social Interaction
Teaching/Learning

Activity/Rest

Activity intolerance (specify level)
Activity intolerance, for
Disuse syndrome, risk for
Diversional activity deficit
Fatigue
Sleep pattern disturbance

Circulation

Adative capacity: intracranial, decreased
Cardiac output, decreased
Dysreflexia
Tissue perfusion, altered (specify): cerebral, cardiopulmonary, renal, pastrointestinal, peripheral

Ego Integrity

Adjustment, impaired
Anxiety (mild, moderate, severe, panic)
Body image disturbance
Coping, defensive

Elimination

Bowel incontinence
Constipation
Constipation, colonic
Constipation, perceived
Diarrhea
Incontinence, functional
Incontinence, reflex
Incontinence, stress
Incontinence, total
Incontinence, urge
Urinary elimination, altered
Urinary retention, (acute/chronic)

Food/Fluid

Breastfeeding, effective
Breastfeeding, ineffective
Breastfeeding, interrupted
Fluid volume deficit (active loss)
Fluid volume deficit (regulatory failure)

Coping, individual, ineffective
Decisional conflict
Denial, ineffective
Energy field disturbance
Fear
Grieving, anticipatory
Grieving, dysfunctional
Hopelessness
Personal identity disurbance
Post-trauma response (specify stage)
Powerlessness
Rape-trauma syndrome (specify)
Rape-trauma syndrome: compound reaction
Rape-trauma syndrome: silent reaction
Relocaction stress syndrome
Self-esteem, chronic low
Self-esteem disturbance
Self-esteem, situational low
Spiritual distress (distress of the human spirit)
Spiritual well being, enhanced, potential for

Pain/Discomfort
Pain
Pain, acute
Pain, chronic
Respiration
Airway clearance, ineffective
Aspiration, risk for
Breathing pattern, ineffective
Gas exchange, impaired
Spontaneous ventilation, inability to sustain
Ventilatory weaning response, dysfunctional (DVWR)
Safety
Body tempurature, altered, risk for
Environmental interpretation syndrome, impaired

Fluid volume deficit, risk for
Fluid volume excess
Infant feeding pattern, ineffective
Nutrition: altered, less than body requirements
Nutrition: altered, more than body requirements
Nutrition: altered, risk for more than body requirements
Oral mucous membrane, altered
Swallowing, impaired
Hygiene
Self-care deficit (specify level): feeding, bathing/hygiene, dressing/ grooming, toileting
Neurosensory
Confusion, aacute
Confusion, chronic
Infant behavior, disorganized
Infant behavior, disorganized, risk for
Infant behavior, organized, potential for enhanced
Memory, impaired
Peripheral neurovascular dysfunction, risk for
Sensory perception alterations (specify): visual, auditory, kinesthetic, gustatory, tactile, olfactory
Thought processes, altered
Unilateral neglect

Sexuality(component of ego integrity and social interaction)
Sexual dysfunction
Sexuality patterns, altered
Social Interaction
Caregiver role strain
Caregiver role strain, risk for
Communication, impaired verbal
Community coping, enhanced, potential for
Community coping, ineffective
Family coping, ineffective
Family coping, potential for growth
Family processes, altered: alcoholism (substance abuse)
Family processes, altered

Health maintenance, altered
Home maintenance management, impaired
Hyperthermia
Hypothermia
Infection, risk for
Injury, risk for
Perioperative positioning injury, risk for
Physical mobility, impaired
Poisoning, risk for
Protection, altered
Self-mutilation, risk for
Skin integrity, impaired
Skin integrity, impaired, risk for
Suffocation, risk for
Thermoregulation, ineffective
Tissue integrity, impaired
Trauma, risk for
Violence, (actual)/risk for:
directed at self/others

Loneliness, risk for
Parental role conflict
Parent/infant/child attachment, altered,
risk for
Parenting, altered
Parenting, altered, risk for
Role performance, altered
Socical interaction, impaired
Social isolation

Teaching/Learning

Growth and development, altered
Health-seeking behaviors (specify)
Knowledge deficit (learning need)
(specify)
Noncompliance (compliance, altered)
(specify)
Therapeutic regimen: community,
ineffective management
Therapeutic regimen: families,
ineffective management
Therapeutic regimen: individual,
effective management
Therapeutic regimen: individual,
ineffective management

See Also
http://es.udmercy.edu/~bottsu/