The Nursing Process

The common thread uniting different types of nurses who work in varied areas is the nursing process—the essential core of practice for the registered nurse to deliver holistic, patient-focused care. One definition of the nursing process…"an assertive, problem solving approach to the identification and treatment of patient problems. It provides an organizing framework for the practice of nursing and the knowledge, judgments, and actions that nurses bring to patient care."

Assessment

An RN uses a systematic, dynamic, rather than static way to collect and analyze data about a client, the first step in delivering nursing care. Assessment includes not only physiological data, but also psychological, sociocultural, spiritual, economic, and life-style factors as well. For example, a nurse's assessment of a hospitalized patient in pain includes not only the physical causes and manifestations of pain, but the patient's response—an inability to get out of bed, refusal to eat, withdrawal from family members, anger directed at hospital staff, fear, or request for more pain medication.

Diagnosis

The nursing diagnosis is the nurse's clinical judgment about the client's response to actual or potential health conditions or needs. The diagnosis reflects not only that the patient is in pain, but that the pain has caused other problems such as anxiety, poor nutrition, and conflict within the family, or has the potential to cause complications—for example; respiratory infection is a potential hazard to an immobilized patient. The diagnosis is the basis for the nurse's care plan.

Planning / Goal / Outcome

Based on the assessment and diagnosis, the nurse sets measurable and achievable short- and long-range goals for this patient that might include moving from bed to chair at least three times per day; maintaining adequate nutrition by eating smaller, more frequent meals; resolving conflict through counseling, or managing pain through adequate medication. Assessment data, diagnosis, and goals are written in the patient's care plan so that nurses as well as other health professionals caring for the patient have access to it.

Implementation

Nursing care is implemented according to the care plan, so continuity of care for the patient during hospitalization and in preparation for discharge needs to be assured. Care is documented in the patient's record.

Evaluation

Both the patient's status and the effectiveness of the nursing care must be continuously evaluated, and the care plan modified as needed.

Component and Description	Purpose	Activities
Assessment Collecting, organizing, validating, and documenting client data.	To establish a database about the client's response to health concerns or illness and the ability to manage health care needs	Establish a database: Subjective data (not measurable) Objective data (measurable) ▪ Obtain a nursing health history ▪ Review client records ▪ Review nursing literature ▪ Consult support persons ▪ Consult health professionals Update data as needed Organize data Validate data Communicate/document data
Diagnosis Cluster, Analyze and synthesize data. Problem identification Nursing diagnosis label	To identify client strengths and health problems that can be prevented or resolved by collaborative and independent nursing interventions. To develop a list of nursing diagnoses and collaborative problems.	Interpret and analyze data: ▪ Compare data against standards ▪ Cluster or group data (generate tentative hypotheses) ▪ Identify gaps and inconsistencies Determine client's strengths, risks, and problems Formulate nursing diagnoses and collaborative problem statements **<u>Actual Nursing Diagnosis</u> (3-part)** PES = **Problem** related to the **Etiology** (cause) as evidenced/manifested by the **Signs and Symptoms** (defining characteristics). **<u>Potential Nursing Diagnosis/Risk</u> (2-part)** PE = **Potential problem** related to the **Etiology** (cause). There are no signs and symptoms, because the problem has not occurred yet.

Planning/Goal/Outcome Determining how to prevent, reduce, or resolve the identified client problems; how to support client strengths; and how to implement nursing interventions in an organized, individualized, and goal-directed manner	To develop and individualized care plan that specifies client goals/desired outcomes and related nursing interventions. Outcome statement must be patient centered, specific, and measurable.	Set priorities and write goals/outcomes in collaboration with client. Consult with other health professionals Write nursing orders and nursing care plan Communicate care plan to relevant healthcare providers Short term and long term goals
Implementation Carrying out the planned nursing interventions	To assist the client to meet desired goals/outcomes; promote wellness and disease; restore health; and facilitate coping with altered functioning.	Select nursing strategies/interventions Determine need for nursing assistance Perform or delegate planned nursing interventions Communicate what nursing actions were implemented: ▪ Document care and client responses to care ▪ Give verbal reports as necessary ▪ Carry out the plan; "DO" what it takes to meet goals. ▪ Nurse initiated – Physician initiated – Collaborative.
Evaluation Measuring the degree to which goals/outcomes have been achieved and identifying factors that positively or negatively influence goal achievement	To determine whether to continue, modify, or terminate the plan of care.	Collaborate with client and relate nursing actions to client outcomes Determine if goals/outcomes have been met/achieved. If not, re-evaluate: • Data – did you collect enough/correct data? • Diagnosis – did you analyze the data accurately? • Etiology – is it accurate? • Outcome – patient centered, measurable and realistic? • Interventions – realistic and doable? • Revise/modify the care plan as indicated.