

Continue





























Written By: Darby Faubion BSN, RN One of the most important tools a nurse can use in practice is the nursing process. Although nursing schools teach first-year students about the nursing process, some nurses fail to grasp the impact its proper use can have on patient care. In this article, I will share information about the nursing process, its history, its purpose, its main characteristics, and the 5 steps involved in carrying out the nursing process. After reading this article, you will be able to answer the question, what is the nursing process and understand what is involved in each of the 5 steps of the nursing process. Additionally, throughout this article, after discussing a step of the nursing process, I will share an example of how the nurse would proceed with that step. For this articles purposes, we will use information about the following patient: Mr. Collie, a fifty-four-year-old white male being admitted to the Medical-Surgical floor for acute congestive heart failure. What is the Nursing Process in Simple Words?The nursing process is a series of steps nurses take to assess patients, plan for and provide patient care, and evaluate the patients response to care. It is considered the framework upon which all nursing care is based. The earliest version of the nursing process was introduced in 1955 by Lydia Hall. Ms. Hall identified three steps of the nursing process: observation, administration of care, and validation. Other versions of the nursing process appeared throughout the next decade. Dorothy Johnson, in 1959, described nursing as "fostering the behavioral functioning of the client. Ms. Johnsons version of the nursing process included the three steps: assessment, decision, and nursing action. Finally, in 1961, Ida Jean Orlando-Pelletier introduced the version of the nursing process known to nurses today. The nursing process as we know it today is based upon the Deliberative Nursing Process Theory developed by Ida Jean Orlando-Pelletier. Ms. Orlando-Pelletier's version of the nursing process includes five steps: Assessment, Diagnosis, Planning, Implementation, and Evaluation. The purpose of the nursing process is to establish a standard of care where nurses assess patients and create plans of action to address individualized patient needs. The nursing process has other purposes, as well, including but not limited to the following. Establishes plans to meet patient needsGuides nurses in the delivery of high-quality evidence-based careProtects nurses against potential legal problemsPromotes a systematic approach to patient care that all members of the nursing team can follow There are several characteristics associated with providing nursing care. The following is a list of the seven main characteristics of the nursing process and an explanation for each one. Perhaps the most essential characteristic of the nursing process is that it should be used within the nurses legal Scope of Practice. Effective use of the nursing process requires the nurse to utilize nursing knowledge and skills to identify and resolve problems. Nurses should develop and continuously strengthen critical thinking skills and the use of evidence-based nursing interventions. A well-thought-out approach to patient care leads to organized, systemic patient care that is delivered efficiently and in order. It is imperative that nurses understand the importance of client-centered nursing care. The nursing process characteristic of client-centered care helps nurses plan care that is individualized to the patient. It also supports patient autonomy, which is every patients right. As the title suggests, goal-directed care is a form of nursing care delivery based on achieving individualized goals to achieve desired patient outcomes. Goals are created through the collaborative efforts of nurses, other members of the healthcare team, and patients. When planning patient care, it is necessary to identify all health issues and risk factors and prioritize patient care, focusing on the most serious issues first. As you learn about the nursing process steps later in this article, it will become evident that the process is continuous, and nurses must repeat steps. As continued assessments and evaluations occur, and depending on the patients response to care, the order of priorities in the care plan may change. The nursing process is a dynamic process as it is constantly affected by the patient's needs, circumstances impacting their needs, and the environment in which care is applied. It encompasses emotional, physical, social, and medical aspects. Each phase of the nursing process interacts with and is influenced by other phases in a cycle of activity. From the time of admission until the patient is discharged from care, the dynamics of the cycle of nursing care continues. The nursing process consists of five steps which encompass the care provided. The five nursing process steps are: 1. Assessment2. Diagnosis3. Planning4. Implementation5. Evaluation The following are explanations for each step of the five steps of the nursing process, information about why each is important, the main objectives of each step, the skills needed to complete each step, challenges nurses may face in each step, and a real-life example for each step. The first phase of the nursing process is the assessment phase. In this phase, the nurse collects and organizes data related to the patient. Data includes information about the patient, family, caregivers, or the patient's community or environment as it is relevant to his health and well-being. All phases of the nursing process are essential. The following are a few reasons why the assessment phase is important for nurses to provide care. 1. In the assessment phase of the nursing process steps, the nurse gathers all pertinent information that will be used to establish a care plan.2. Every other step of the nursing process builds upon the previous. Without a thorough assessment, the other steps of nursing care may be negatively impacted, resulting in unfavorable outcomes.3. When assessments are performed correctly, they help reduce risks to patient safety which could occur when symptoms or other factors are not considered. The assessment phase of the nursing process involves gathering information about the patient which is used to guide planning care, setting goals for recovery, and evaluating patient progress. Nurses can obtain information about the patient by implementing the following objectives. The patient is the nurses main source of information. Therefore, it is essential to establish rapport with them as soon as possible, with the patient's family or caregivers when appropriate. Family members, friends, or other caregivers often offer insight into what is going on with the patient. It is important for nurses to listen to the patients support people and gather any information available. When the patient feels comfortable, it makes it easier to get the necessary information that will be used to establish a plan of care. The patient interview is one of the main sources of information used to plan patient care. Any information that is measurable or observable such as vital signs and test results is considered objective data. Subjective data is information gathered from the patient. Assessments are vital to the nursing process. The information gathered in the assessment phase impacts every component of patient care. Nurses must demonstrate excellent verbal and written communication skills, strong attention to detail, and possess an in-depth understanding of body systems. The most frequently used clinical skills for patient assessment are inspection, percussion, palpation, and auscultation. The assessment phase is a critical component of the nursing process. Information gathered in this phase is used to establish a foundation upon which all patient care moving forward is established. Remember, it is normal for patients to feel nervous or fearful when they are sick and in an unfamiliar place, like a hospital. Therefore, the nurse needs to establish an environment conducive to patient comfort. The assessment may include but is not limited to, the following aspects: environmental, physical, cultural, psychological, safety, and psychosocial assessments. The following is a guideline of what should happen during the assessment phase. During the assessment phase, the nurse collects objective and subjective data using proven methods to assess the patient. The most common methods for collecting data are the patient interview, physical examination, and observation. The patient interview is a deliberate or intended communication or conversation with the patient. It is used to obtain information, identify problems that concern the patient and/or the nurse, evaluate changes, provide support, and educate the patient and family/caregivers. The nurse will also conduct a head-to-toe nursing assessment addressing each body system and noting any abnormalities, complaints, or concerns. Observation requires the nurse to use all their senses (sight, touch, smell, hearing) to learn about the patient. After collecting data, the nurse must organize and validate data and document about the patient's health status. Validation is the process of verifying data to be sure it is factual and accurate. Nurses must be careful to not come to conclusions without adequate data to support their conclusion. It is also necessary to understand the difference between inferences and cues. Cues are signals the patient uses to alert the nurse about a concern or question or objective data the nurse can observe or measure. Inferences are the nurse's conclusion or interpretation based on cues. For example, the patient may complain about a painful incision two days post-operatively, and the nurse may observe the incision site is red and feels hot. These are cues. The nurse then makes an inference that the operative incision is infected. After data from the assessment is collected, organized, and validated, it must be recorded. One thing I always tell nursing students and cannot stress enough to any nurse is, "If you didn't document it, you didn't do it." While that may seem harsh, from a legal standpoint, if a nurse is asked to verify care or treatment and there is no supporting documentation, there is no way to prove the care occurred. Thorough documentation is one of the best ways for everyone involved in patient care to be aware of changes in the patient's status, and it helps promote effective collaboration within the interdisciplinary team. While all the nursing process steps are essential, without a thorough assessment, the other steps of the nursing process are not as easy to follow through. Nurses must recognize barriers that could impede the assessment phase and find ways to overcome them. The following are five common challenges you may face during the assessment phase and some suggestions on how to overcome them. There are days when nurses feel as though there aren't enough hours to accomplish all the work that needs to be done. When you are short-staffed or have several patients waiting for a nursing assessment before you can initiate care, it can feel a bit overwhelming. Even on the busiest of days, it is important for nurses to perform thorough nursing assessments for all patients assigned to them. That means it is necessary to learn to manage time efficiently. The first step in overcoming limited time is to be familiar with the format or forms your employer uses to record assessments. For example, the Health Information Technology for Economic and Clinical Health Act of 2009 advanced the adoption and use of electronic health records. Nearly one hundred percent of hospitals use some type of EHR. Electronic health records have helped improve workflow by eliminating time spent pulling physical charts or documenting in paper charts. It is not uncommon for interruptions to occur when nurses are performing assessments. While some interruptions may be necessary, all are not. Interruptions during patient assessments can delay care and could result in errors or omissions. The best way to overcome the challenge of interruptions during the assessment step of the nursing process is to provide for privacy before you begin the assessment. Whether you are working in triage, assessing a patient newly admitted to your floor, or in a busy emergency room, it is possible to reduce interruption. Pull the privacy curtain closed if you are in an area with more than one patient or several staff close by. Some facilities use "Do Not Disturb" or "Room in Use" signs to provide privacy for nurses and patients. Every nurse knows the importance of a good nursing assessment. Newly graduated nurses are less experienced than other nurses and may feel uneasy about performing a nursing assessment alone. Additionally, if your facility changes its documentation format or implements a new program for charting, and you've not yet used the program, your inexperience could pose a challenge when doing an assessment. The only way to overcome inexperience is to become experienced. Nursing assessments are typically classified as either a Complete Health Assessment or a Problem-Focused Assessment. Know which type of assessment you need to perform. Gather basic equipment: gloves, thermometer, blood pressure cuff, stethoscope, penlight, and watch. Establish a sense of trust and respect between the patient and yourself. No matter which type of assessment you perform, it should be systematic, making sure you cover each body system. If you assess each body system and make notes about what is normal/abnormal, you decrease the chances of omissions in documentation. Remember, take your time, trust your instincts, and if you need help, ask for it. Patient anxiety can create a significant challenge for nurses during a patient assessment. Anxiety can hinder communication making it difficult to gather all the necessary data. If anxiety is bad enough, it can cause changes in vital signs, which could be misinterpreted as something more than an anxious reaction. Before beginning an assessment, take the time to make your patient comfortable. While you may not have time for a long conversation or "get to know you" session, you can ease your patient's anxiety by being calm and friendly. Some questions may make patients feel uncomfortable, especially teenagers. Allow them time to answer your questions without feeling rushed. Verify their understanding by asking if they can explain what you've discussed in their own words. Remember, everyone gets nervous or anxious at times, and when we are sick, it can be worse. It's nothing personal against you or your skills. Make everything about the patient. Whether it is fear of the unknown, embarrassment, or another reason, there are times when patients may be apprehensive about sharing personal information. Lack of information or omission of details that the patient may think is irrelevant may negatively impact the process of care planning. Therefore, while it is easy to understand a patient's apprehension, it is crucial for nurses to gather as much information as possible when performing a nursing assessment. It can be easy to feel frustrated if a patient is not forthcoming about symptoms during an assessment. Keep in mind, being sick and needing medical care can be frightening. The best way to get patients to talk to you is to be accepting of them, no matter what. Be sure to tell your patient you are there for them and will work with them to help them get better. When you say things like you will "work with them," it lets your patient know you are going to do your part, but you expect them to do theirs as well. If you feel like your patient is withholding information, instead of making an accusation, try to rephrase the question. Make your questions clear so the patient knows what information you need. The format for recording nursing assessment data may vary from one facility to another. However, the information gathered for the assessment is relatively similar. The following are examples of content the nurse should include in the initial nursing assessment phase of the nursing process. Date of Admission: 04/19/22 Time: 13.30Transported By: J. Mock, LPNAge: 54 yrs. 2 mos. Sex: MHeight: 62 Weight: 268lbs 4ozAttending Physician: Dr. Michael CoulvanDate of Birth: 03/04/1968 Admitting Diagnosis: CHF, acuteVital Signs on Admission: Temp 98.8, Resp. 20, Pulse 76, BP 136/80 Allergies: NKDA, no food allergies Patient Name: Jerold R. Collie Address: 123 Blakely Lane, Clayton, MO. 1234 Phone: (318) 555-1234 Neurological: Alert & Oriented x3; PERRLA, Unaided hearing; Bilateral hand grips equal; Bilateral foot push equal; no evidence of tremors; denies tingling, burning, loss of consciousness, hallucinations, disorientation, visual disturbances, or hx/o brain injury or stroke. Cardiovascular: Pulses present, regular, and strong; x2 upper extremities (Radial); present X2 lower extremities (Pedal); heart rate regular, strong; capillary refill