NURSING PROCESS AND CRITICAL THINKING

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5 STEPS

- ASSESSMENT
- DIAGNOSIS
- PLANNING
- IMPLEMENTATION
- EVALUATION

WHY?

- ORGANIZE AND PRIORITIZE CARE
- FOCUS ON PATIENT HEALTH STATUS AND QUALITY OF LIFE
- FORM CRITICAL THINKING HABITS

CHARACTERISTICS

- PURPOSEFUL
- HUMANISTIC
- SYSTEMATIC
- STEP-BY-STEP
- RESULTS-ORIENTED
- PROACTIVE
- EVIDENCED-BASED
- INTUITIVE
- REFLECTIVE

NATIONAL PRACTICE STANDARDS

- SET BY AMERICAN NURSES ASSOCIATION (ANA)
- UTILIZED BY MAGNET HOSPITALS (RECOGNIZED BY AMERICAN NURSES CREDENTIALING ASSOCIATION)

ALL NURSES ARE ACCOUNTABLE FOR MAINTAINING NATIONAL PRACTICE STANDARDS.

ASSESSMENT

- COLLECT AND RECORD ALL NECESSARY INFORMATION TO :

  - IDENTIFY HEALTH PROBLEMS
  - DEVELOP OUTCOMES
  - DEVELOP A COMPREHENSIVE CARE PLAN

DIAGNOSIS

- ANALYZE DATA
- DETERMINE ACTUAL AND POTENTIAL HEALTH PROBLEMS

PLANNING

- DEVELOP EXPECTED OUTCOMES OR GOALS

- DETERMINE THE INTERVENTIONS TO ACHIEVE THESE GOALS SAFELY AND EFFICIENTLY

IMPLEMENTATION

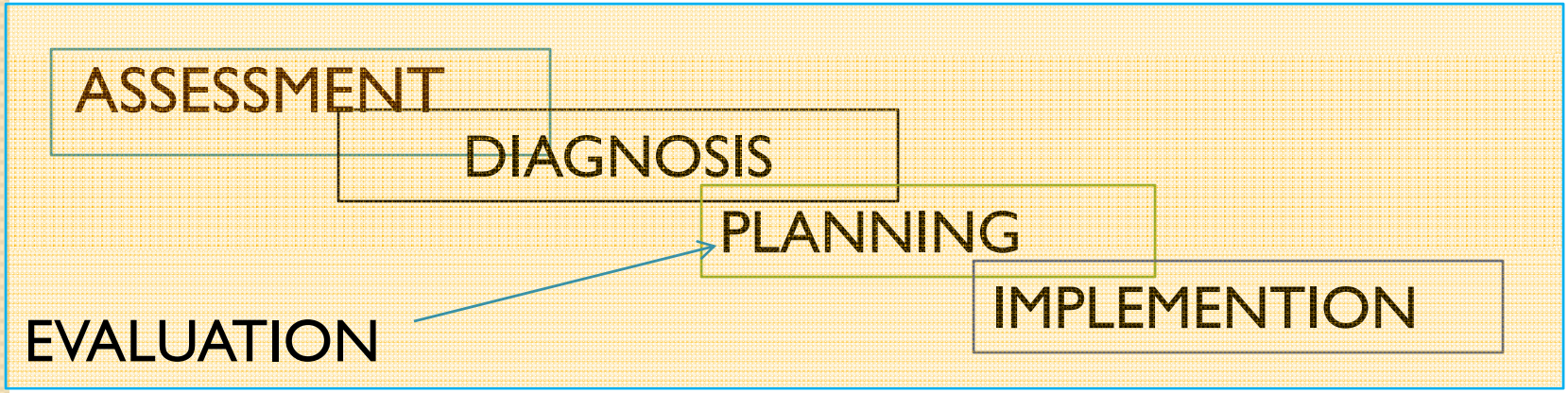
- PUTTING THE PLAN INTO ACTION
- PERFORMING THE INTERVENTIONS
- CHARTING PROGRESS

EVALUATION

- REASSESSING PATIENT TO SEE IF EXPECTED OUTCOMES HAVE BEEN MET.

- MODIFYING PLAN AS NEEDED

ALL STEPS OF THE NURSING PROCESS OVERLAP



BENEFITS OF THE NURSING PROCESS

- HOLISTIC
- ADDRESSES HUMAN RESPONSE TO HEALTH PROBLEMS
- PROMOTES QUALITY OF LIFE
- PROMOTES FLEXIBILITY
- TAILORS INTERVENTIONSTO THE INDIVIDUAL

NURSING ROLES/RESPONSIBILITIES

- DIVERSE RESPONSIBILITIES
- LEADERSHIP ROLES
- MONITORING RESPONSIBILITIES
- NEW ILLNESSES
- LIFELONG LEARNING
- STANDARDS AND PRACTICE GUIDELINES
- PRIVACY LAWS (HIPAA)
- SPIRITUAL NEEDS
- COMPUTERS

ETHICS

- ETHICAL PRINCIPLES
  - AUTONOMY
  - BENEFICENCE
  - JUSTICE
  - FIDELITY
  - VERACITY
  - ACCOUNTABILITY
  - CONFIDENTIALITY

- NURSING CODE OF ETHICS

CRITICAL THINKING

- WHAT IS IT?
  - PURPOSEFUL, FOCUSED THINKING
  - BASED ON PRINCIPLES OF NURSING PROCESS
  - REQUIRES KNOWLEDGE SKILLS AND EXPERIENCE
  - IMPROVES WITH **PRACTICE**

CRITICAL THINKING

"THE ART OF THINKING WHILE YOU ARE THINKING IN ORDER TO MAKE YOUR THINKING BETTER: MORE CLEAR, MORE ACCURATE, OR MORE DEFENSIBLE." (Paul, Binker, Adamson, and Martin)

CRITICAL THINKING

- *4-CIRCLE CT MODEL*
  - CHARACTERISTICS
  - KNOWLEDGE AND INTELLECTUAL SKILLS
  - INTERPERSONAL SKILLS
  - TECHNICAL SKILLS

CARING

REQUIRES COMMITMENT

CARING

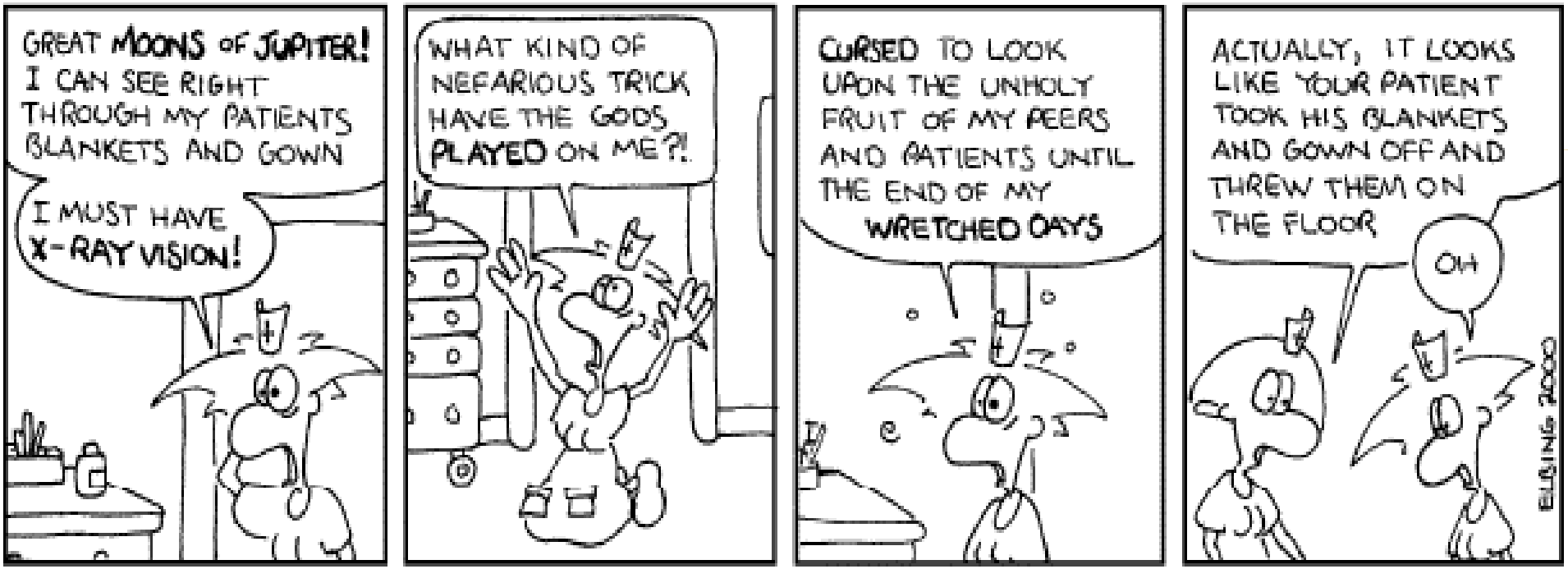
- WILLINGNESS TO CARE
  - i.e: practicing "ANA Professional Practice Behaviors"
- ABILITY TO CARE
  - i.e: understanding personal biases and habits
- EMPATHY
  - The ability to see things from the patient's perspective.

ASSESSMENT

FIRST STEP OF THE NURSING PROCESS

Nurstoons

by Carl Elbing



www.nurstoon.com

ASSESSMENT

- 6 activities
  - COLLECTING DATA
  - IDENTIFYING CUES AND INFERENCES
  - VALIDATING DATA
  - ORGANIZING DATA
  - IDENTIFYING PATTERNS
  - REPORTING AND RECORDING DATA

COLLECTING DATA

- *ONGOING*
- RESOURCES
  - PATIENT
  - SIGNIFICANT OTHERS
  - HEALTH RECORDS
  - CONSULTATIONS
  - DIAGNOSTIC/LAB STUDIES

COLLECTING DATA

- COMPREHENSIVE ASSESSMENT
  - PROVIDES A DATA **BASE**
  - START OF CARE
  - ALL ASPECTS OF HEALTH STATUS

- FOCUSED ASSESSMENT
  - FOCUSES ON SPECIFIC CONDITION
  - MAY BE NEEDED DURING COMPREHENSIVE EXAM

COLLECTING DATA

- INTERVIEW
  - SAME AS "HISTORY"
  - GUIDES PHYSICAL EXAM
  - REQUIRES COMMUNICATION SKILLS

COLLECTING DATA

- GUIDELINES FOR PATIENT INTERVIEW:

  - RAPPORT – *ORGANIZED, FOCUSED,PRIVATE, NOT RUSHED, SIT DOWN!*
  - LISTENING – *EMPATHY, PATIENCE, ALLOW FOR PAUSES*

COLLECTING DATA

- GUIDELINES (CONT.)
  - QUESTIONING – *FOCUS, USE COMMUNICATION TECHNIQUES*
    - OPEN-ENDED VS. CLOSE-ENDED QUESTIONS, RESTATING, SILENCE, BODY LANGUAGE, ETC.
  - TERMINATING THE INTERVIEW – *GIVE WARNING, AVAILABILITY, END ON POSITIVE NOTE.*

COLLECTING DATA

- PHYSICAL ASSESSMENT
  - **INSPECTION**
  - **PALPATION**
  - **PERCUSSION**
  - **AUSCULTATION**

COLLECTING DATA

- PHYSICAL ASSESSMENT (CONT.)
  - ORGANIZATION – GUIDED EITHER BY PT COMPLAINT OR DONE IN A ROUTINE FLOW PATTERN (HEAD-TO-TOE OR SYSTEMS)
  - **DEVELOP AN APPROACH AND USE IT CONSISTENTLY.**

COLLECTING DATA

- Physical exam
  - GENERAL APPEARANCE
    - MAY INCLUDE HEIGHT AND WEIGHT
  - VITAL SIGNS
    - TPR, BP
    - INCLUDES PAIN
    - MAY INCLUDE COUGH

COLLECTING DATA

- PHYSICAL EXAM (CONT.) –
  - SYSTEMS

  - **NEURO** - LOC, ORIENTATION, PUPIL REACTION
    - (Example of documentation.: Alert, oriented x 3, PERRL, speech clear .

COLLECTING DATA

- **CARDIOVASC** - HT RHYTHM/SOUNDS, PULSES, CAPILLARY REFILL
  - (Doc. ex: HR 78 & regular, pedal pulses palpable bilaterally, cap. refill <3 sec.)

- **RESP** - RESP, LUNG SOUNDS, PULSE OX
  - (Doc. ex: Resp. easy, lungs clear bilaterally, non-productive cough. SpO2 98 on room air.)

COLLECTING DATA

GI - ABD SHAPE, BS, TENDERNESS, BM

- (Doc. ex: Abd soft and non-distended, BS auscultated x 4 quads. No tenderness on palpation. Soft brown, formed BM.

- GU - URINE, FOLEY?,
  - (Documentation: Voided clear yellow urine.

COLLECTING DATA

- SKIN - TEMP, MOISTURE, COLOR, LESIONS?
  - (Doc. ex: Skin warm, dry, and fleshtone.)

- MS - range of motion, active/passive?
  - (Doc. ex: Active, full ROM in all 4 ext..)

COLLECTING DATA

- Assessment includes both subjective and objective data.
- **SUBJECTIVE** – STATED DATA, USUALLY ON INTERVIEW

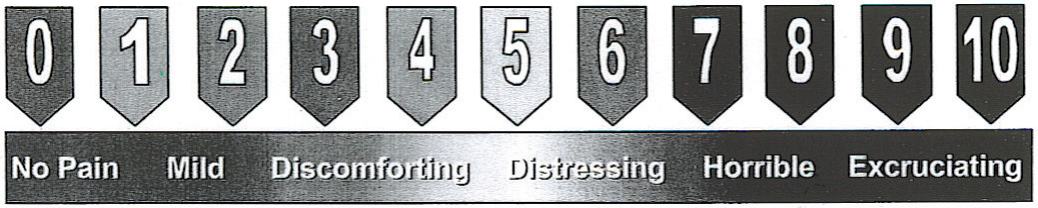
- **OBJECTIVE** – OBSERVED DATA , FOUND ON PHYSICAL EXAM

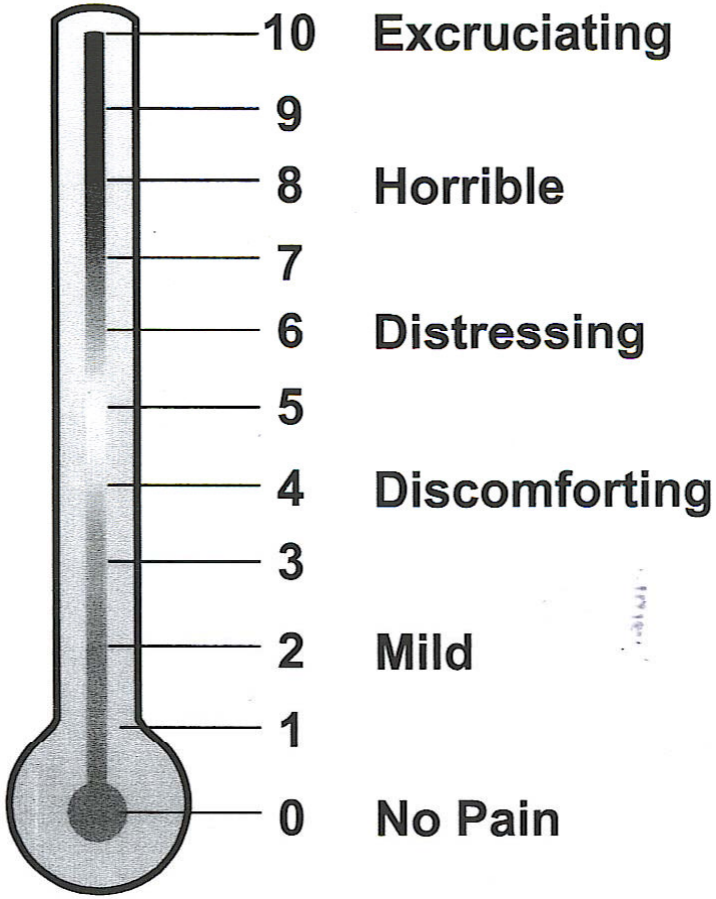
Identifying Cues and Making Inferences

- Cues – from subjective and objective data.

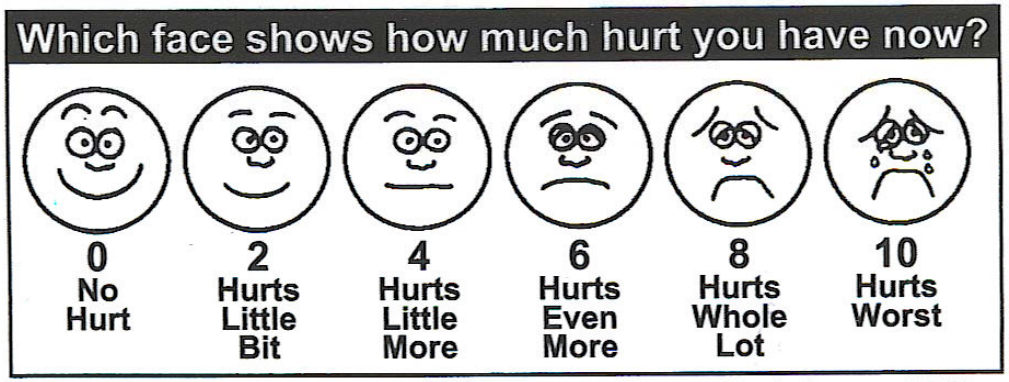
- Inferences – your interpretation of the cues. Influenced by skills, knowledge, and clinical expertise.

Choose a Number from 0 to 10 That Best Describes Your Pain





Faces Pain Rating Scale



Source: Wong-Baker FACES Pain Rating Scale at www.us.elsevierhealth.com/WOW *Reproduced with permission* 02/15/05.

Pain Assessment in Advanced Dementia PAINAD Scale

(Warden, Hurley, Volicer, 2003)

	0	1	2	Score
* **Breathing** independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
* **Negative vocalization**	None	Occasional moan or groan. Low-level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
* **Facial expression**	Smiling or inexpressive	Sad. Frightened. Frown.	Facial grimacing.	
* **Body language**	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	
* **Consolability**	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
				Total

* Definitions of these items can be found: http://www.geriatric-resources.com/html/painad_definitions.html

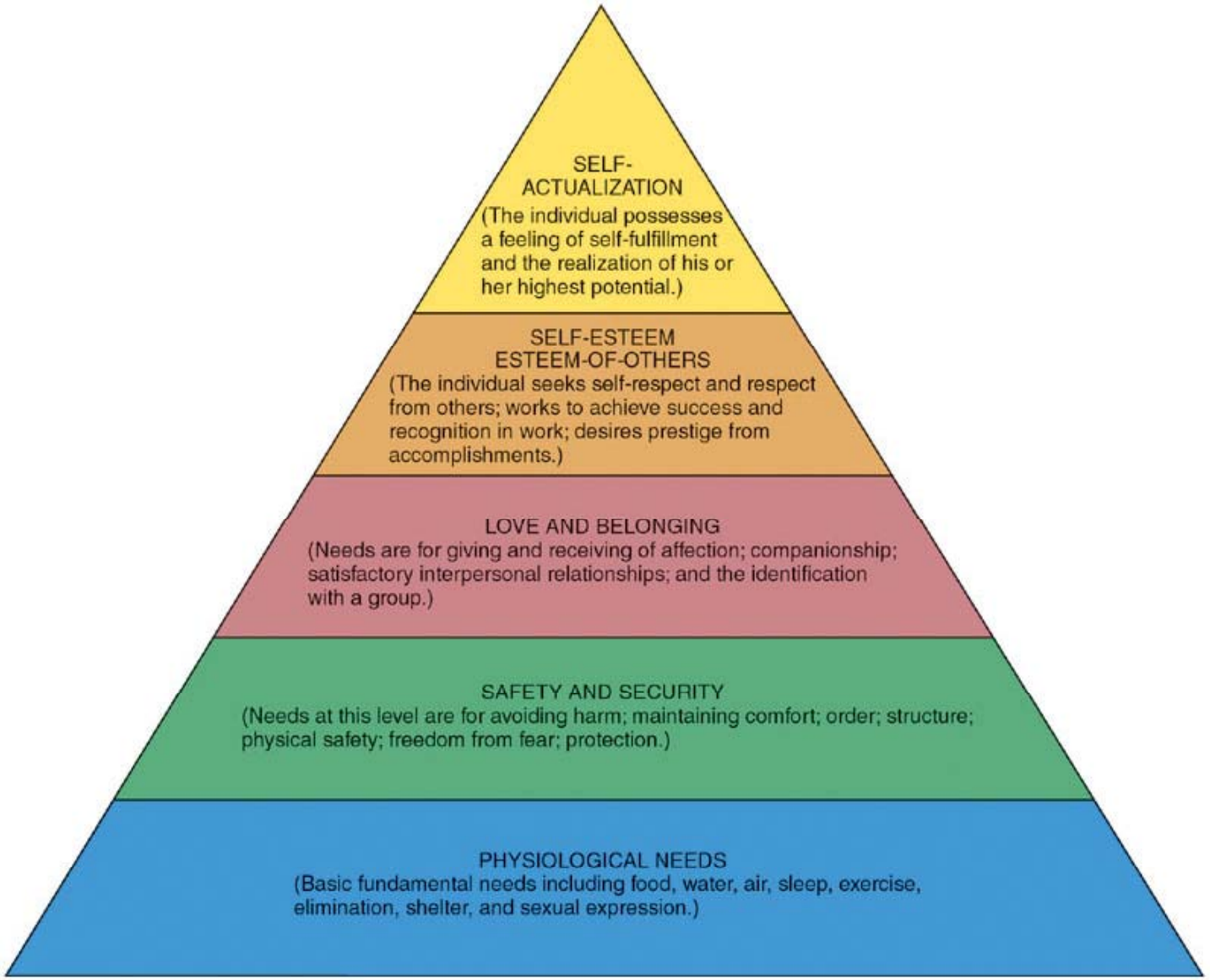
VALIDATING DATA

- VERIFYING THAT INFO IS ACCURATE AND COMPLETE
  - AVOIDS SERIOUS (OR DEADLY) MISTAKES

  - MEASURABLE DATA USUALLY FACTUAL
  - INDIRECT DATA IS QUESTIONABLE

ORGANIZING DATA

- USE CRITICAL THINKING TO CLUSTER DATA TOGETHER THAT IS RELATED.
  - FUNCTIONAL HEALTH PATTERNS
  - HUMAN NEEDS
  - BODY SYSTEMS



IDENTIFYING PATTERNS

- DECIDE WHAT IS RELEVANT AND WHAT IS NOT.

- BE SURE THAT PATTERN IS CLEAR – eliminate other contributing factors

REPORTING (assessment findings)

- Deciding WHAT to report.
  - All suspected abnormalities
  - KNOW NORMALS!
  - If unsure, consult w/ reliable reference
  - Report abnormal ASAP
  - Have ALL necessary info available
  - Give facts
  - Phone reports: Identify, repeat orders, check policies.

RECORDING (data base)

- If reported, record it!
- Follow policies/procedures of your facility
- Written: ink, **legible**, on-time, ONE LINE THROUGH MISTAKES!
- Chart objectively, quotes for subjective data.
- Coherent, defensible

DIAGNOSIS (Nursing)

- Second step of nursing process.
- Based on assessment findings.
- Clearly and specifically identifies problems and risk factors that must be managed by nursing.

DIAGNOSIS

- ANA Standards
  - Diagnosis vs. "Issues"
- PPMP Model
  - 1) If known problem, predict complications and take action.
  - 2) Identify evidence of risk factors, and control them
  - 3) Promote optimum functioning.
- Critical Pathways
  - Standard plans

DIAGNOSIS

- NURSING DIAGNOSIS IS THE HUMAN RESPONSE TO CHANGE IN HEALTH (EX: ILLNESS) OR LIFE CIRCUMSTANCE (EX: PARENTHOOD).

TERMINOLOGY

- North American Nursing Diagnosis Association International (NANDA, International)
- Ex:
  - *Actual*: Impaired Skin Integrity
  - *Potential*: Risk for Injury

NURSING VS. MEDICAL DIAGNOSIS

- NURSING DIAGNOSIS – nurse is primary manager. The problem (diagnosis) is within the nursing domain.

- MEDICAL DIAGNOSIS – physician or APN is the primary manager. The main focus is a disease or trauma. The nurse does not have the legal authority to make the determination.

Nursing Diagnosis

- Examples:
  - Constipation
  - Pain
  - Diarrhea
  - Impaired gas exchange
  - Deficient knowledge (of medications)
  - Impaired verbal communication
  - Risk for impaired skin integrity

Writing a Nursing Diagnosis

- **P-E-S Statement – 3 part statement**
  - **P**roblem - Diagnosis according to NANDA
  - **E**tiology - the cause or risk factors, stated as "related to"-
  - **S**igns and symptoms – called defining characteristics, the evidence that showed your diagnosis or problem. Stated as "as evidenced by"
  -
- ***PROBLEM* <u>R/T</u> *ETIOLOGY* <u>AEB</u> *SIGNS AND SYMPTOMS.***
  - (No "S" if *potential* problem)

Writing a Nursing Diagnosis

- **(P)** Constipation R/T **(E)**use of opioid analgesics AEB **(S)** no abdominal discomfort and hard, small stools.
- Impaired verbal communication R/T aphasia AEB inability to communicate basic needs.
- Imbalanced nutrition: Less than body requirements R/T vomiting AEB weight loss of 3 lbs over 2 days.

Writing a Nursing Diagnosis

- Knowledge deficit of med administration R/T lack of recall AEB patient statement "I can never remember to take those pills"
- Risk for fluid volume deficit R/T fluid loss secondary to NGT to continuous suction.

Nursing Diagnosis

- Identifying potential problems
  - Look up all medications
  - Identify common complications of patient's admitting diagnosis
  - Look up common complications associated with the patient's other medical conditions
  - Review policies and procedures for guidelines.
  - Review recent treatments.

PLANNING

- Key activities
  - Attending to priorities
  - Clarifying expected outcomes/goals
  - Deciding what to record
  - Determining nursing interventions
  - Adequately recording plan
- Applying standards – must apply nurse practice law, ANA standards, organization and employer standards, etc.

PLANNING

- Attending to urgent priorities
  - First determine which of your problems take priority
  - Then decide what absolutely needs to be accomplished.

PLANNING

- Clarifying expected outcomes/goals
  - Always start with "the patient…"
  - Measuring sticks for success of plan
  - Direct interventions
  - Provide time frame to motivate those involved

  - USE INDICATORS – THESE HELP MAKE OUTCOMES SPECIFIC!

PLANNING

- Outcome statements:
  - Specific to patient!

  - Subject (ex. Patient)
  - Verb (measurable verb)
  - Condition (if necessary)
  - Criteria (ex. 50% of meal, for ½ hour, etc.)
  - Target time (by when!!!!)

PLANNING

- Short-term goals/outcomes – accomplished in short period of time.

- Long-term goals – benefits will be seen after a longer period of time

PLANNING

- The patient will report a reduction in frequency of stools to <3/day by 11/2/07.
- Patient will exhibit balance of fluid volume by intake equal to output within 1 week.
- Patient will demonstrate ability to transfer from bed to wheelchair without assistance in 3 days.

PLANNING

- Deciding which problems must be recorded
  - What *must* be done.
  - What are the patient's priorities?
  - Are there any standards of care that need to be applied?
  - Ask the negative – "WHAT WILL HAPPEN IF I DON'T DO …"

PLANNING

- Determining nursing interventions.
  - Prevent or minimize the risk or cause of problem.
  - To manage the problem
  - To meet the expected outcome/goal.
  - Desired response – not adverse response.

PLANNING/IMPLEMENTATION

- INDIVIDUALIZE NURSING ORDERS
  - Use assessment findings
  - Check medical orders
  - Standard plans are guides only!
  - Decide on monitoring
  - Interventions must be congruent with other therapies
  - Weigh all risks and benefits
  - SPECIFIC

Remember evidence-based practice.

Sample Interventions (Nursing Orders)

- Obtain weight each day before breakfast
- Keep HOB elevated >30 degrees at all times
- Refer patient to social service to ensure continued care.

- Keep all necessary objects on patient's right side.

- Administer O2 @ 2L/min via NC to maintain pulse ox >93%

- Instruct patient not to strain for bowel movement.

Recording the plan

Use standard or recognized terminology (ex: NANDA)

Computerized charting – as legal as manual charting

Multidisciplinary plans – all disciplines working on same plan (common in LTC)

IMPLEMENTATION

- Guided by planning
- Includes all of the following
  - Preparing/getting report
  - Setting daily priorities
  - Assessing appropriateness of interventions
  - Performing interventions and reassessing
  - Making immediate changes as needed
  - Charting
  - Giving report

IMPLEMENTATION

- Getting Report
  - Prep – look up info, read chart, arrive early, etc.
  - Use worksheets to organize info.
  - Taped reports can be reviewed as needed.

Setting Daily Priorities

- Make initial rounds
- Verify critical information
- Identify urgent problems
- Determine which problems to handle
- Determine interventions
- What can the patient do? What can be delegated?
- Make (and follow) a worksheet

Assessing appropriateness of interventions

- Delegation does NOT change responsibility.
  - Appropriate tasks
  - Patient condition

- Always remember your practice standards

Performing Interventions/ Reassessing

- Always assess before *and after* interventions
  - Use each encounter as an opportunity
- Preparation!
  - Know what you need to do
  - Know policies/procedures
  - Dealing with problems
  - KNOW THE RATIONALE BEHIND THE ACTION!

Changing when needed

- CRITICAL THINKING – When things go wrong!

  - Was the intervention performed correctly?
  - Has the problem changed?
  - Is there something else I should do in addition?
  - What am I missing?

Charting

- Assessment-Interventions-Responses

- Purpose of charting:
  - Communicate care
  - Help identify patterns
  - Provide basis for evaluation (quality)
  - Create a legal document
  - Supply validation for insurance

Charting

- Principles:
  - INITIAL and ongoing assessments
  - Interventions and nursing care performed
  - Patient RESPONSE

  - All charting should reflect nursing process.

Charting

- Guidelines
  - Chart as soon as possible
  - Follow facility policy
  - Reflect
  - Record important action immediately
  - **Record ALL variations from norm**
  - **Precise**
  - Focus on significant events
  - *Stick to facts*
  - *Sign*

Giving Report

- Must be accurate and organized.
- Guidelines:
  - Use a guide
  - Begin with identifying (general) information
  - Be specific
  - Include status of all invasive lines
  - Stress any abnormals.
  -

Evaluation (Chap. 6)

- HAS THE PATIENT ACHIEVED THE OUCOMES/GOALS THAT WERE DETERMINED IN "PLANNING"?
  - *Look at the patient.*
  - *Determine the extent of outcome achievement.*

- Requires examination of all of the steps of the nursing process.
  - *What factors affected outcome achievement?*

Evaluation

- Discharge planning/Terminating the plan of care
  - Decisions to be made:
    - Continue the plan?
    - Change the plan?
    - Terminate the plan?

Quality Improvement

- How can things be improved?

- 3 types of evaluation:
  - Outcomes – the results
  - Process - performance
  - Structure - setting