



CHAPTER OBJECTIVES

At the end of this chapter, you will be able to:

1. Define the nursing process as it is used by the registered nurse.
2. Describe the various steps of the nursing process.
3. Provide examples of the use of the steps of the nursing process in patient care.
4. Describe the various domains of learning as used in Bloom's taxonomy.
5. Document examples of the various types of nursing interventions.



KEY TERMS

affective domain
assessment
Bloom's taxonomy
cognitive domain
dependent nursing
intervention
domain
emergency assessment
evaluation

focused assessment
independent nursing
intervention
initial assessment
interdependent nursing
intervention
nursing goal
nursing diagnosis
nursing process

objective data
ongoing assessment
outcome criteria
planning
psychomotor domain
subjective data
taxonomy





CHAPTER 3

The Nursing Process

Introduction to the Nursing Process

As the registered nurse (RN) functions daily as a nurse leader, he or she will be called on to exercise critical thinking and nursing judgment. The nurse will be required to demonstrate that he or she can effectively collect the various pieces of information about a patient's presenting symptoms, existing disease processes, support system, medication regimen, and psychological state to formulate a plan of nursing care for the patient. The process by which those pieces are collected, scrutinized as to their value, and analyzed regarding their applicability to the patient is known as the *nursing process*. Implementation of the nursing process and its subsequent documentation result in the development of a plan for the nursing care of the patient (Gardner, 2002).

Why is the nursing process important? Above all, it is centered around the patient or client. It requires the nurse to individualize the plan being developed, because a generic plan may well serve as an effective framework for a patient but requires specific changes to be made based on the needs of each patient. The nursing process helps the RN (Gardner, 2002)

- < Stay organized during collection of data regarding the patient
- < Develop a nursing diagnosis to describe the patient's current situation
- < Plan a regimen of nursing care to assist in resolving the patient's problem to the greatest extent possible



- < Implement the steps involved in the regimen of nursing care
- < Evaluate the effectiveness of the care that was carried out

In addition, the nursing process assists the RN in effective use of time management as well as conservation of resources. Those resources may be financial, personnel, or energy. Therefore, the nursing process can lead to effective assessment, so that fewer supplies are charged to the patient; effective planning, so that fewer personnel are required to be assigned to the patient's care; and effective implementation, so that fewer nurses experience physical or emotional exhaustion in caring for a chronically ill patient.

The advantages of the nursing process when used effectively are as follows: (Alfaro-Lefevre, 2009)

- < To ensure the patient's health concerns and his or her response to them are the focus of the nursing care plan
- < To ensure care that is planned and implemented is individualized for the patient
- < To promote the patient's participation in his or her care by encouraging autonomy as the plan is implemented, and to provide the patient with a sense of control rather than the helplessness that can come with long-term assumption of the patient role
- < To improve communication by providing nurses with a summary of the patient's identified health issues and all current data known about the issues
- < To require accountability for nursing actions that are implemented; such accountability then promotes delivery of the highest quality health care
- < To require the use of critical thinking, problem solving, and use of nursing judgment
- < To focus on the achievement of patient outcomes
- < To minimize errors that can occur during the delivery of patient care

Assessment

Assessment is arguably the most important step in the nursing process because it involves data collection on the various health issues being experienced by the patient.

Both licensed practical nurses and RNs can contribute to data collection, but only the RN analyzes the data and uses them to formulate a comprehensive

assessment of the patient that will ultimately be used in the development of a plan of nursing care (Quan, 2007).

For an assessment to be comprehensive it must be holistic, and this can only occur if the data gathered includes a physical examination and an exhaustive health history. The data gathered through the health history should include subjective data, which is information retrieved from the patient's verbalization, and objective data, which is information retrieved from observation of the patient, including reviewing the results of diagnostic testing. The data gathered through assessment can occur through four variations of this process (Table 3-1):

TABLE 3-1 Types of Assessment

| Type of Nursing Assessment | Characteristics |
|----------------------------|--|
| initial | This occurs upon initial contact with the patient and is usually as comprehensive as possible. It begins with the symptoms that caused the patient to seek assistance from the healthcare community and should culminate in a head-to-toe view of the patient's level of functioning. |
| focused | The focused assessment is performed on each problem once they have been identified. This type of assessment is important because it allows symptoms to be examined in greater detail, promotes the weighing of various etiologies to explain those symptoms, searches for contributing factors, and examines patient characteristics that would also help solve the presenting problem or at least clarify the issue. Focused assessment will be initiated again if a new symptom or problem suddenly emerges. |
| emergency | This is utilized when time is of the essence due to the life-threatening nature of the patient's problem. It will include only essential data that is relevant to the patient's immediate issue. Once the patient's situation is stable and is no longer considered life-threatening, additional data can be gathered. |
| ongoing | This is considered to be occurring continuously throughout a patient's healthcare experience. Data may be gathered with the assistance of electronic equipment such as may be seen in a critical care unit, and the ongoing assessment usually will include periodic episodes of data-gathering that occur routinely, such as every four hours for vital signs, for example. The interval for such ongoing assessment may be able to be changed at the discretion of the RN, in some cases. |

- < **Initial assessment:** This occurs on initial contact with the patient and is usually as comprehensive as possible. It begins with the symptoms that caused the patient to seek assistance from the healthcare community and should culminate in a head-to-toe view of the patient's level of functioning (Harkreader, Hogan, & Thobaben, 2007).
- < **Focused assessment:** This is performed on each problem once identified. This type of assessment is important because it allows symptoms to be examined in greater detail, promotes the weighing of various etiologies to explain those symptoms, searches for contributing factors, and examines patient characteristics that would also help solve the presenting problem or at least clarify the issue. Focused assessment will be initiated again if a new symptom or problem suddenly emerges.
- < **Emergency assessment:** This is used when time is of the essence due to the life-threatening nature of the patient's problem. It includes only essential data relevant to the patient's immediate issue. Once the patient's situation is stable and is no longer considered life-threatening, additional data can be gathered (Harkreader et al., 2007).
- < **Ongoing assessment:** This occurs continuously throughout a patient's healthcare experience. Data may be gathered with the assistance of electronic equipment, and the ongoing assessment usually includes periodic episodes of routine data gathering, such as every 4 hours for vital signs. The interval for such ongoing assessment may change at the discretion of the RN, in some cases (Harkreader et al., 2007).

As the RN begins the process of analyzing the data, he or she will find that it can be classified as either subjective or objective. **Subjective data** are information received from the patient because it cannot be observed directly by the nurse. Examples of subjective data include pain, nausea, and dizziness. In comparison, **objective data** are considered to be information about the client obtained through direct observation. This type of data yields information that is measurable. Examples of objective data are blood pressure, pulse, respiration, and temperature readings (Harkreader et al., 2007).

The data comprising the assessment phase of the nursing process can be gathered through physical examination of the patient, observation of the characteristics of the patient's symptoms, review of the results of laboratory and diagnostic tests, discussion with other health professionals, and, most importantly, through interviewing the patient. Such an interview should focus on the patient's chief complaint that led him or her to seek medical assistance and should include a discussion of the patient's past medical history; family medical history; and pertinent religious, cultural, and psycho-social concerns. The interview should include discussion of the important

information gleaned from the discussion with the patient (Harkreader et al., 2007).

Diagnosis

Once assessment information has been gathered and analyzed and the RN has begun making decisions about patient care, a nursing diagnosis can be selected. The *nursing diagnosis* is both measurable and realistic and is used to direct the nursing process as it is individualized for the patient. A list of accepted nursing diagnoses was developed by the North American Nursing Diagnosis Association (NANDA, 2011). These diagnoses are classified using a system known as *taxonomy*. The classification system yields 13 domains that are then subdivided into classes and, ultimately, into diagnoses (NANDA, 2011). The domains are as follows:

- < Activity/rest
- < Circulation
- < Ego integrity
- < Elimination
- < Food/fluid
- < Hygiene
- < Neurosensory
- < Pain/discomfort
- < Respiration
- < Safety
- < Sexuality
- < Social interaction
- < Teaching/learning

Table 3-2 shows the nursing diagnoses developed by NANDA according to the respective domain.

How is a nursing diagnosis formulated? The diagnosis consists of a problem combined with a primary cause, also referred to as the etiology, if such information is known. Five types of problems may be experienced by the patient (Gardner, 2002) (**Table 3-3**):

1. Actual: This problem
 - < Is currently experienced by the patient
 - < Can be validated by specific symptoms the patient notices along with specific signs observed by the nurse

TABLE 3-2 2009–2011 Nursing Diagnoses**(organized according to nursing focus by Doenges/Moorhouse diagnostic divisions)**

ACTIVITY/REST—Ability to engage in necessary/desired activities of life (work and leisure) and to obtain adequate sleep/rest

Activity intolerance, risk for

Activity planning, ineffective disuse syndrome, risk for diversional activity, deficient fatigue

Insomnia, lifestyle, sedentary

Mobility, impaired bed mobility, impaired wheelchair sleep, readiness for enhanced sleep deprivation

Sleep pattern, disturbed transfer ability, impaired walking, impaired

CIRCULATION—Ability to transport oxygen and nutrients necessary to meet cellular needs

Autonomic dysreflexia, risk for

Bleeding, risk for cardiac output, decreased

Intracranial adaptive capacity, decreased

Perfusion, ineffective peripheral tissue

Perfusion, risk for decreased cardiac tissue

Perfusion, risk for ineffective cerebral tissue

Perfusion, risk for ineffective gastrointestinal

Perfusion, risk for ineffective renal

Shock, risk for

EGO INTEGRITY—Ability to develop and use skills and behaviors to integrate and manage life experiences

Anxiety [specify level], death

Behavior, risk-prone health body image, disturbed conflict, decisional (specify)

Coping, defensive

Coping, ineffective

Coping, readiness for enhanced

Decision making, readiness for enhanced denial, ineffective

Dignity, risk for compromised human distress, moral

Energy field, disturbed fear

Grieving

Grieving, complicated; grieving, risk for complicated; hope, readiness for enhanced

Hopelessness

Identity, disturbed personal post-trauma syndrome, post-trauma syndrome, risk for power

Readiness for enhanced powerlessness

Powerlessness, risk for rape-trauma syndrome

Relationships, readiness for enhanced

Religiosity, impaired religiosity, ready for enhanced religiosity, risk for impaired

Relocation stress syndrome

Risk for resilience

Impaired individual resilience

Readiness for enhanced resilience

Risk for compromised self-concept

Readiness for enhanced self-esteem

Chronic low self-esteem

Situational low self-esteem

Risk for situational low sorrow, chronic

Spiritual distress

Spiritual distress, risk for

Spiritual well-being, readiness for enhanced

ELIMINATION—Ability to excrete waste products

Bowel incontinence

Constipation

Constipation, perceived

Constipation, risk for

Diarrhea

Motility, dysfunctional gastrointestinal

Motility, risk for dysfunctional gastrointestinal urinary elimination, impaired

Urinary elimination, readiness for enhanced

Urinary incontinence, functional

Urinary incontinence, overflow

Urinary incontinence, reflex

Urinary incontinence, risk for urge

Urinary incontinence, stress

Urinary incontinence, urge

Urinary retention [acute/chronic]

FOOD/FLUID—Ability to maintain intake of and utilize nutrients and liquids to meet physiological needs

Breastfeeding

Effective breastfeeding

Ineffective breastfeeding, interrupted

Dentition, impaired

Electrolyte imbalance

Risk for failure to thrive, adult

Feeding pattern, ineffective infant

Fluid balance, readiness for enhanced

Fluid volume, deficient hyper/hypotonic

Fluid volume, deficient [isotonic]

Fluid volume, excess

Fluid volume, risk for deficient

Fluid volume, risk for imbalanced glucose

Risk for unstable blood +liver function

Risk for impaired Nausea

Nutrition: less than body requirements

Imbalanced nutrition: more than body requirements

Imbalanced nutrition: risk for more than body requirements

Imbalanced nutrition, readiness for enhanced

Oral mucous membrane, impaired swallowing, impaired

HYGIENE—Ability to perform activities of daily living self-care, readiness for enhanced

Self-care deficit

Bathing self-care deficit

Dressing self-care deficit

Feeding self-care deficit

Toileting neglect, self

NEUROSENSORY—Ability to perceive, integrate, and respond to internal and external cues

Confusion

Acute confusion

Risk for acute confusion, chronic

Infant behavior, disorganized

Infant behavior, readiness for enhanced organized infant behavior, risk for disorganized

Memory, impaired neglect, unilateral

Peripheral neurovascular dysfunction, risk for

Sensory perception, disturbed (specify: visual, auditory, kinesthetic, gustatory, tactile, olfactory)

Stress overload

PAIN/DISCOMFORT—Ability to control internal/external environment to maintain comfort

Comfort, impaired

Comfort, readiness for enhanced pain, acute

Pain, chronic

RESPIRATION—Ability to provide and use oxygen to meet physiological needs

Airway clearance, ineffective

Aspiration, risk for breathing pattern

Ineffective gas exchange, impaired

Ventilation, impaired spontaneous

Ventilatory weaning response, dysfunctional

SAFETY—Ability to provide safe, growth-promoting environment

Allergy response, latex

Allergy response, risk for latex

Body temperature, risk for imbalanced contamination

Contamination, risk for

Death syndrome, risk for sudden infant environmental interpretation syndrome

Impaired falls, risk for

Health maintenance

Ineffective home maintenance

Impaired hyperthermia

Hypothermia

Immunization status, readiness for enhanced infection, risk for

Injury, risk for

Injury, risk for perioperative positioning

Jaundice, neonatal

Maternal/fetal dyad

Risk for disturbed mobility, impaired physical

Poisoning, risk for Protection

Ineffective self-mutilation self-mutilation, risk for

Skin integrity, impaired

Skin integrity, risk for impaired

Suffocation, risk for

Suicide, risk for

Surgical recovery, delayed

Thermoregulation, ineffective

Tissue integrity, impaired

Trauma, risk for

Trauma, risk for vascular

Violence, [actual/] risk for other-directed

Violence, [actual/] risk for self-directed

Wandering [specify sporadic or continual]

SEXUALITY—Ability to meet requirements/characteristics of male/female role

Childbearing process, readiness for enhanced sexual dysfunction

Sexuality pattern, ineffective

SOCIAL INTERACTION—Ability to establish and maintain relationships

Attachment, risk for impaired

Caregiver role strain

Caregiver role strain, risk for

Communication, impaired verbal

Communication, readiness for enhanced

Conflict, parental role

Coping, ineffective community

Coping, readiness for enhanced community

Coping, compromised family

Coping, disabled family

Coping, readiness for enhanced family

Family processes, dysfunctional

Family processes, interrupted

Family processes, readiness for enhanced

Loneliness, risk for

Parenting, impaired

Parenting, readiness for enhanced

Parenting, risk for impaired

Role performance, ineffective

Social Interaction, impaired

Social Isolation

TEACHING/LEARNING—Ability to incorporate and use information to achieve healthy lifestyle/optimal wellness

Development, risk for delayed growth

Risk for disproportionate growth and development

Delayed +health behavior

Risk-prone +health management

Ineffective self knowledge, deficient (specify)

Knowledge (specify)

Readiness for enhanced noncompliance

Therapeutic regimen management, ineffective

Therapeutic regimen management, ineffective family

Therapeutic regimen management, readiness for enhanced

Source: NANDA, 2011.

- < When combined with a contributing cause, an example of a nursing diagnosis of this type is
 - < Self-care deficit related to bilateral forearm casts
- 2. Risk: This problem
 - < Could develop in the future because of the presence of specific risk factors
 - < Is almost inevitable unless nursing measures are implemented to stop the progression of the risk factors
 - < Is validated by the presence of the risk factors
 - < When combined with a contributing cause, an example of a nursing diagnosis of this type is
 - < Risk for impairment of skin integrity related to inability to get out of bed without assistance
- 3. Possible: This problem
 - < Could develop if additional risk factors develop
 - < But will not develop until enough risk factors are present to change this diagnosis to a “risk” problem

- < When combined with a contributing cause, an example of a nursing diagnosis of this type is
 - < Possible fluid volume deficit related to occasional nausea
- 4. Wellness:** This is a progression from one level of wellness to a higher level of wellness
 - < Cannot be used unless the patient has indicated a desire for a greater level of wellness and
 - < The level of functioning on the patient's part must be already effective
 - < Because the client is already healthy for this diagnosis to be used, no etiology is included because there is no problem
 - < An example of a nursing diagnosis of this type is
 - < Readiness for enhanced therapeutic regimen management
- 5. Syndrome:** This diagnosis
 - < Includes a group of nursing diagnoses that all relate to a specific situation
 - < Indicates that a serious clinical situation has developed
 - < Usually there is no etiology present because the use of a syndrome diagnosis
 - < indicates the contributing factors in the diagnosis
 - < An example of a nursing diagnosis of this type is
 - < Relocation stress syndrome

Wilkinson (2011) stressed the importance of using the process of formulating a nursing diagnosis to help the RN progress in thinking critically. This process of selecting appropriate nursing diagnoses can assist the RN in developing the skill of evaluating a patient's current situation and accurately judging the diagnoses applicable and the nursing interventions that will most effectively assist the patient. Wilkinson (2011) recommended the following questions for the nurse who is determining a nursing diagnosis:



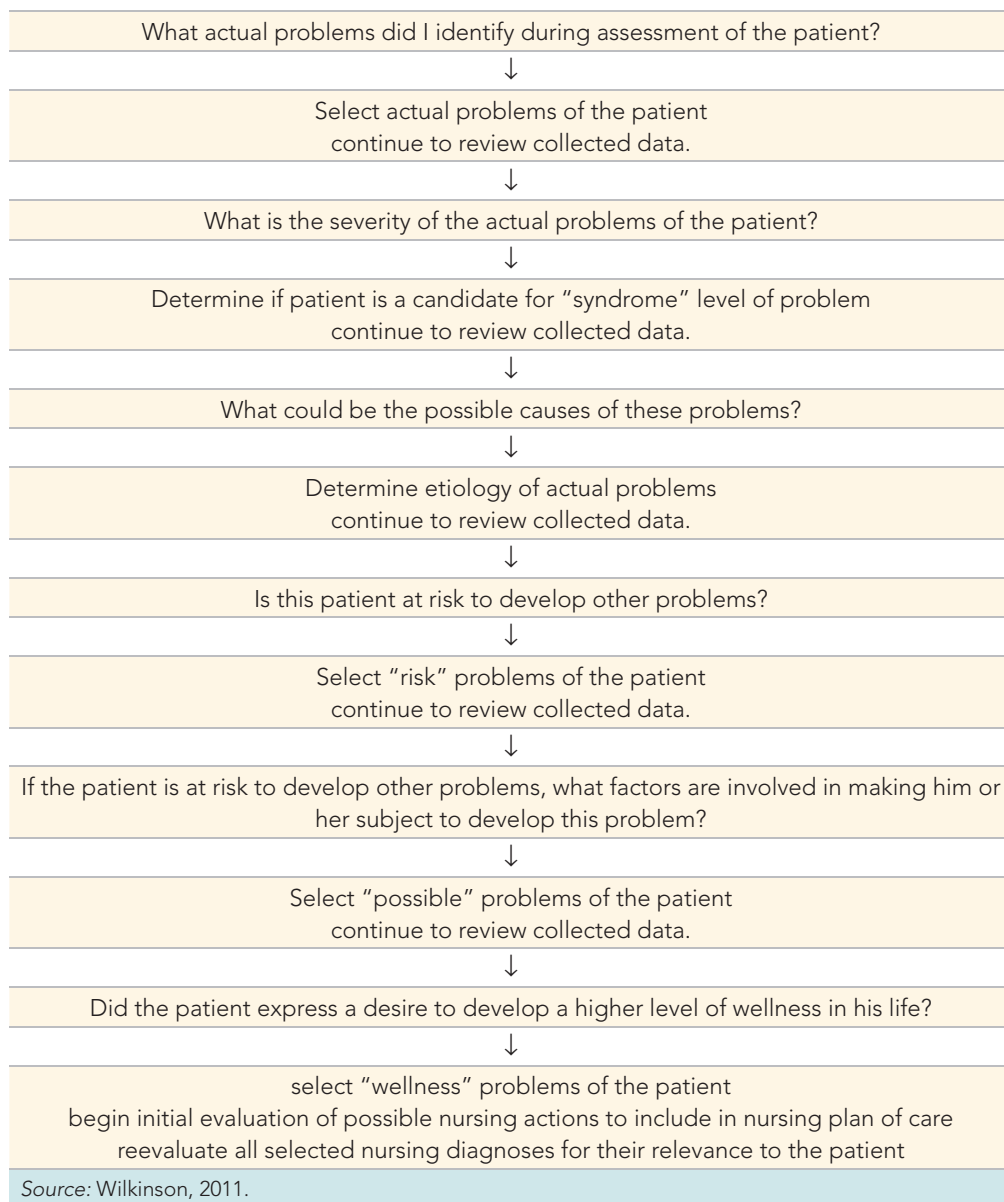
- < What actual problems did I identify during assessment of the patient?
- < What could be the possible causes of these problems?
- < Is this patient at risk to develop other problems?
- < If the patient is at risk to develop other problems, what factors are involved in making him or her subject to develop this problem?
- < Did the patient express a desire to develop a higher level of wellness in his or her life?

TABLE 3-3 Types of Nursing Problems

| Type of Problem | Description of Problem | Example of Nursing Diagnosis |
|-----------------|---|---|
| Actual | This is a problem that is being experienced by the patient currently and can be validated by specific symptoms that he or she notices, along with specific signs that can be observed by the nurse. | Self-care deficit related to bilateral forearm casts |
| Risk | This is a problem that could develop in the future because of the presence of specific risk factors. The problem is almost inevitable unless nursing measures are implemented to stop the progression of the risk factors. The presence of the risk factors validates the diagnosis. | Risk for impairment of skin integrity related to inability to get out of bed without assistance |
| Possible | This is a problem that could develop if additional risk factors develop. Currently, not enough risk factors are present to change this diagnosis to a "risk" problem. | Possible fluid volume deficit related to occasional nausea |
| Wellness | This is a progression from one level of wellness to a higher level of wellness. The patient must have indicated that there is a desire for a greater level of wellness, and the level of functioning on the patient's part must be already effective. Since the client is already healthy for this diagnosis to be utilized, no etiology is included because there is no problem. | Readiness for enhanced therapeutic regimen management |
| Syndrome | This diagnosis includes a group of nursing diagnoses that all relate to a specific situation. The purpose of the diagnosis is to indicate that there is a serious clinical situation that has developed. Usually there is no etiology present since the use of a syndrome diagnosis indicates the contributing factors in the diagnosis. | Relocation stress syndrome |

The relationship of these questions to the process of formulating nursing diagnoses is summarized in **Figure 3-1**.

A third element can be included in the nursing diagnosis to further individualize it to the characteristics of the patient, that is, the signs and symptoms the RN observes in the patient. NANDA refers to the inclusion of these factors

FIGURE 3-1 Critical Thinking Questions to Ask When Formulating Nursing Diagnoses

as the “defining characteristics” of the patient’s nursing diagnosis. The phrase “as evidenced by” can be included to make the diagnosis more specific to the patient’s situation.

Using the nursing diagnosis of “Self-care deficit related to bilateral forearm casts” shown in Table 3-2, an example of how this could be used follows. If signs and symptoms the nurse observed that clearly indicated a self-care deficit was present were included, the diagnosis could be changed to read “Self-care deficit related to bilateral forearm casts as evidenced inability to feed self or comb hair.” Such defining characteristics often are easier to add to an existing diagnosis after caring for a patient for at least an entire shift so that more lengthy observation is possible and a relationship can be established. Some experts advise using the phrase “secondary to” with a nursing diagnosis to specify the medical condition of the patient as part of the etiology (an example is “Self-care deficit related to bilateral forearm casts secondary to osteomyelitis”), but such phrasing should be used with caution, because it is all too easy to result in a medical diagnosis rather than a nursing diagnosis (Chitty & Black, 2007).

Planning

Once all applicable nursing diagnoses have been selected, the *planning* phase of the nursing process begins. In this phase the RN prioritizes the diagnoses based on the immediate needs of the patient, such as airway, breathing, and circulation. The RN collaborates with the patient to design goals to determine the choice of nursing interventions to assist the patient in resolution of the problem and also to indicate the amount of progress that is being made (Chitty & Black, 2007).

Goals are typically written to center around one of three *domains*, or categories, of learning as indicated in *Bloom’s taxonomy*. Bloom was an educator who determined that learning occurred according to three basic categories of activities: *psychomotor*, *cognitive*, and *affective*. The psychomotor domain involves physical movement, and thus learning in this category can be assessed according to distance, time, and speed. The following is an example of a *nursing goal* written using this domain: “Patient will ambulate 12 feet three times daily with assistance.” In comparison, the cognitive domain involves knowledge and intellectual skill. An example of a nursing goal written using this domain is “Patient will describe three signs of infection in her surgical incision by date of discharge.” Finally, the affective domain involves feelings, values, and attitudes, and therefore an example of a nursing goal written using this domain is “Patient will report feeling accepting of her mastectomy surgical site by date of discharge” (Chitty & Black, 2007).



Both short-term and long-term goals should be developed, with short-term goals being achieved within hours or days and long-term goals requiring a lengthier period of time to be achieved. It is not unheard of for a long-term goal to require months to be accomplished, because it frequently can pertain to rehabilitation (Chitty & Black, 2007).

Goals can be made measurable through the development of **outcome criteria**. Outcome criteria specify the terms under which the goal will be met. Each goal can have several outcome criteria. Outcome criteria describe the conditions under which the patient will act to accomplish the goal and ultimately solve the problem and therefore are indicated by the phrase “as evidenced by” written after the goal. For example, if the goal is “Patient will report feeling accepting of her mastectomy surgical site by date of discharge,” the accompanying outcome criteria would be incorporated into the goal as “Patient will report feeling accepting of her mastectomy surgical site by date of discharge as evidenced by (1) asking to view site by postoperative day 3 and (2) asking to perform dressing change without assistance by date of discharge” (Chitty & Black, 2007). If the goal and outcome criteria are written correctly, they should give a clear indication of the nursing interventions needed to assist in the accomplishment of the goals.

Intervention

Both short-term and long-term goals are written during the planning stage of the nursing process. These are particularly important because, along with the outcome criteria that make them measurable, they indicate the nursing orders that dictate the nursing interventions needed to fulfill the goals. Each goal will have its own set of nursing orders, such as “instruct on dressing change procedure prior to discharge” (Chitty & Black, 2007).

There are three basic types of nursing interventions: dependent, independent, and interdependent (**Table 3-4**). **Dependent nursing interventions** require supervision from another healthcare professional, such as a physician or a nurse practitioner. The supervision is necessary because the intervention requires an order for an action that is outside the scope of practice for the RN. For example, medication administration requires that an initial order is written by a physician or a nurse practitioner who has prescribing privileges that cover the substance being ordered.

In comparison, **independent nursing interventions** are those that require no supervision. The nurse will have all

TABLE 3-4 Types of Nursing Interventions

| Type of Intervention | Description | Example |
|----------------------|---|---|
| dependent | Requires supervision from another health-care professional, such as a physician or a nurse practitioner. The supervision is necessary because the intervention will require an order for an action that is outside the scope of practice for the registered nurse. | Administration of a medication will require an initial order to be written by a physician or nurse practitioner |
| independent | Requires no supervision from personnel other than the registered nurse. The nurse will have all necessary information and skill needed to implement them. | Observe the patient's urine hourly for color and clarity |
| interdependent | Requires collaboration and consultation with other healthcare professionals during the implementation of the action. Direct supervision from the other healthcare professional is not required because the intervention is not one that is necessarily outside of the RN's scope of practice, but consultation is required because the other professional has expertise that the RN usually does not possess. | Nursing order is written for an intervention involving a specific type of breathing exercise with which the RN is only vaguely familiar. The assistance of the facility's respiratory therapist will be required. |

necessary information and skill needed to implement them. An example of an intervention could be to observe the patient's urine hourly for color and clarity. Most types of nursing interventions that involve teaching are usually independent unless they involve instruction on specific areas of expertise that are unfamiliar to the RN or are outside of his or her scope of practice (Chitty & Black, 2007).

Finally, **interdependent nursing interventions** require collaboration and consultation with other healthcare professionals during the implementation of the action. Direct supervision from another healthcare professional is not required because the intervention is not one that is necessarily outside of the RN's scope of practice, but consultation is required because the other professional has expertise the RN usually does not possess. For example, this could be required if a nurse and a respiratory therapist are not familiar with a specific breathing exercise. © Jones and Bartlett Publishers, Inc. NOT FOR SALE OR DISTRIBUTION

type of breathing exercise with which the RN is only vaguely familiar. Thus, the RN would develop an interdependent nursing intervention requiring the assistance of the facility's respiratory therapist (Chitty & Black, 2007).

As nursing orders are written and nursing interventions are developed, it is very important to remember that the interventions must be both patient-centered and related to a specific goal. This means the intervention clearly provides for individualized care for the patient based on his or her current health status in its comprehensive state, both physical and psychosocial, and also considering his or her knowledge needs (Alfaro-Lefevre, 2009).

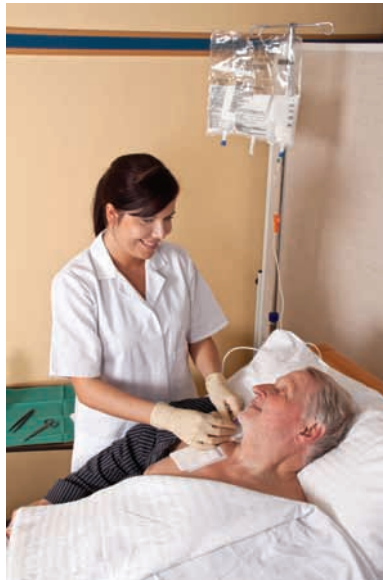
When considering the various needs of the patient in preparation for writing nursing interventions, it may be helpful to review Maslow's Hierarchy of Needs. Maslow was a psychologist who proposed that humans are motivated by basic needs, with some of the most basic needs requiring satisfaction before some of the higher level needs can be addressed and satisfied. This means a person who lacks adequate shelter and food must have these basic needs satisfied before he or she can address the need for a stable intimate relationship (Chitty & Black, 2007). Maslow's hierarchy is described in detail in **Figure 3-2**.

FIGURE 3-2 Maslow's Hierarchy of Needs



Evaluation

Once nursing orders have been written and nursing interventions developed and implemented, the RN can progress forward into the final stage of the nursing process. Gardner (2002) noted that it is during the *evaluation* stage when the RN decides if the goals he or she developed in collaboration with the patient were actually fulfilled. When the goals were either not fulfilled or were only partially fulfilled, the RN should gather additional data through reassessment, critically scrutinize the nursing diagnosis to determine if it is still valid, and possibly shelve it in favor of a diagnosis that is now more appropriate for the patient (Gardner, 2002). The RN can determine if goals were met by measuring the expected outcomes of the nursing interventions against the actual outcomes. Subsequently, the RN should record the outcomes as being met, unmet, or partially met (Harkreader et al., 2007). For example, if the patient goal is to experience a manageable level of discomfort as evidenced by the outcome criteria of reporting a pain level no greater than 5 on a 1- to 10-point scale and showing no signs or symptoms of discomfort such as grimacing, perspiring, and moaning, then the RN should determine if the goal was met by examining the outcome criteria. If the patient reports a level of discomfort of 4 on a 1- to 10-point scale but does demonstrate occasional grimacing, then the RN should record the goal in this case as being partially met.



When the RN determines the goal was either not met or was partially met, he or she must also determine possible reasons for the client's lack of progress toward fulfillment of the goal. Failure to achieve the goal can usually be traced to the following (Alfaro-Lefevre, 2009):

- < The nursing diagnosis used to develop the goal was not accurate.
- < The goal was not realistic for the patient based on his or her abilities.
- < The nursing interventions were inappropriate for achieving the outcome criteria.
- < The patient's medical orders changed and thus invalidated the goal.

Summary of Key Points in Chapter

The chapter described the RN's use of the nursing process in patient care. The various stages of the nursing process were reviewed: assessment, diagnosis, planning, implementation, and evaluation. The specific types of assessment were discussed, such as

- < Initial assessment
- < Emergency assessment
- < Focused assessment
- < Ongoing assessment

In addition, the mechanics of formulating nursing diagnoses as well as writing goals and outcome criteria were discussed, including

- < Using the domains of learning as described in Bloom's taxonomy: affective, cognitive, and psychomotor
- < Differentiating between subjective and objective data
- < Formulating outcome criteria so they are measurable and specific
- < Differentiating between dependent, independent, and interdependent nursing interventions
- < Clearly tying the outcome criteria back to the goal

Conclusion

A primary responsibility of the RN is to create an organized plan of nursing care for the patient. The plan can only be designed within the confines of the nursing process to ensure it leads to continuity of nursing care and other health care provided in the current healthcare delivery system.

The stages of the nursing process—assessment, diagnosis, planning, implementation, and evaluation—fit together like puzzle pieces to create a plan to make inpatient care of the highest quality as well as discharge and home care follow-up priorities for the nurse and patient.

Assessment and the data collection that comprise this stage of the process are the most important parts of the entire nursing process. Part of data collection is the research needed to achieve a sufficient understanding of the patient's current health condition. We continue our data collection in the next chapter by discussing the nursing theory.

Critical Thinking Questions



1. Discuss the four types of nursing assessment and describe when it is most appropriate in your nursing practice as an RN to use each type.
 - a. What type of information could you obtain using each type of nursing assessment?
 - b. You are caring for Mr. Smith, a patient who was just admitted to the medical-surgical floor complaining of persistent left upper quadrant abdominal pain. Describe how you might be required to use each of the four types of nursing assessment during your care of Mr. Smith during a 12-hour shift.
2. You are the nurse manager of a nursing unit that is attempting to be more thorough in its documentation of the daily use of the nursing process. One of the personnel that you recently hired is a new graduate licensed practical nurse who is uncertain as to how the nursing process should be used in his daily patient care. Explain in simplified terms how he should be expected to use the nursing process daily.
3. In your job as a nurse manager, you find the hospital education department has just purchased some computer software that will generate nursing diagnoses based on the input of some basic information. You overhear one of the new nurses express relief that “now we have premade diagnoses, and we don’t have to figure out how they can be individualized!” Explain how you would intervene to counsel this nurse on the importance of individualizing nursing diagnoses to the specific patient.

Scenarios



1. You are caring for Mr. Jones, a 52-year-old man who drove himself to the Emergency Department and presented complaining of persistent chest pain and pressure. He smokes one pack of cigarettes daily, is morbidly obese, and reports being severely stressed at his job as an accountant. His wife is a pharmaceutical representative who travels approximately 4 days per week. Together they have two teenage boys. Mr. Smith has a 28-year-old daughter from his first marriage who is married and expecting her first baby.

Assess this situation thoroughly and try to identify all possible nursing diagnoses. When you identify a nursing diagnosis, also identify an etiology for it as well as defining characteristics, if you believe this will strengthen the diagnosis.

2. Review scenario 1. Prioritize the nursing diagnoses, select the top three, and write a goal with outcome criteria for each diagnosis. Also write at least one long-term goal.
3. Review the domains of learning that are part of Bloom's taxonomy. Use the nursing diagnoses you wrote in scenario 2 and write a goal for each diagnosis that will pertain to each domain of learning. When you finish, each diagnosis should have a goal in the psychomotor domain, a goal in the cognitive domain, and a goal in the affective domain.
4. You are caring for Mrs. Smith, a 58-year-old woman who underwent a mastectomy 3 days ago. She is scheduled to begin chemotherapy treatments for stage III breast cancer in 4 weeks. She is divorced with one 21-year-old daughter who is in college in another state. You find Mrs. Smith crying one morning when you come in to assess her at the beginning of your shift. She tells you, "I am so afraid to look at my wound. I feel so ugly!"
 - a. Assess Mrs. Smith and write down all the pertinent pieces of information you identify from this scenario. Identify the information as either subjective or objective information.
 - b. Try to identify all the possible nursing diagnoses that are present in scenario 4. When you identify a nursing diagnosis, also identify an etiology (primary cause) for it as well as defining characteristics.
 - c. Use the nursing diagnoses that you wrote in part b and write a goal for each diagnosis that pertains to each domain of learning. When you finish, each diagnosis should have a goal in the psychomotor domain, a goal in the cognitive domain, and a goal in the affective domain.
 - d. Write nursing orders and nursing interventions for each goal written in part c. Identify each nursing intervention as dependent, independent, or interdependent.
 - e. Determine if the goals that you wrote in part c were met completely, partially, or not at all. If the goals were met partially or not at all, determine what could have caused this. (Because this is a fictionalized patient, be creative but realistic.)

NCLEX® Questions



Using the information you obtained from studying this chapter, go online to complete the following NCLEX®-format review questions. Visit <http://go.jblearning.com/terryLPN> using the access code in the front cover of your book. This interactive resource allows you to answer each question and in-

stantly review your results. Practice until you can answer at least 75% successfully, and then try to improve your score with each successive attempt.

1. The nursing process will help the RN (select all that apply)
 - a. document the ineffectiveness of care implemented
 - b. stay organized during data collection regarding the patient
 - c. develop a nursing diagnosis to describe the current situation of the patient
 - d. implement steps involved in the regimen of nursing care
2. When used appropriately, the nursing process will (select all that apply)
 - a. require the use of critical thinking, problem-solving, and use of nursing judgment
 - b. maximize errors that can occur during delivery of patient care
 - c. ensure the care that is planned and implemented is individualized for the patient
 - d. promote the patient's participation in his care by encouraging his autonomy
3. The type of assessment that should occur continuously throughout a patient's healthcare experience is
 - a. emergency
 - b. ongoing
 - c. focused
 - d. initial
4. The type of assessment that should include only essential data that are relevant to the patient's immediate issue is
 - a. emergency
 - b. ongoing
 - c. focused
 - d. initial
5. The type of assessment that is performed on each symptom as it is identified is
 - a. emergency
 - b. ongoing
 - c. focused
 - d. initial
6. An example of subjective data is
 - a. blood pressure
 - b. pulse

- c. nausea
 - d. respiration
- 7. An example of objective data is
 - a. temperature
 - b. pain
 - c. nausea
 - d. dizziness
- 8. Types of problems that can be experienced by a patient include (select all that apply)
 - a. actual
 - b. potential
 - c. wellness
 - d. risk
- 9. The domain of Bloom's taxonomy that involves feelings, values, and attitudes is
 - a. intellectual
 - b. psychomotor
 - c. cognitive
 - d. affective
- 10. The domain of Bloom's taxonomy that can be assessed according to distance, time, and speed is
 - a. intellectual
 - b. psychomotor
 - c. cognitive
 - d. affective
- 11. "The patient will ambulate 6 feet with minimal assistance three times daily." Which domain of Bloom's taxonomy does this nursing goal fit?
 - a. intellectual
 - b. psychomotor
 - c. cognitive
 - d. affective
- 12. "Patient will report feeling accepting of her surgical site within 2 weeks of discharge." Which domain of Bloom's taxonomy does this nursing goal fit?
 - a. intellectual
 - b. psychomotor
 - c. cognitive
 - d. affective

13. "Patient will verbalize methods of assessing feet daily for signs and symptoms of infection." Which domain of Bloom's taxonomy does this nursing goal fit?
- a. intellectual
 - b. psychomotor
 - c. cognitive
 - d. affective
14. The progression of Maslow's Hierarchy of Needs, from lesser to greater, is
- a. basic physiological needs, esteem needs safety needs, love and belonging needs, self-actualization
 - b. basic physiological needs, love and belonging needs, safety needs, esteem needs, self-actualization
 - c. basic physiological needs, self-actualization, safety needs, love and belonging needs, esteem needs
 - d. basic physiological needs, safety needs, love and belonging needs, esteem needs, self-actualization
15. The RN develops a nursing diagnosis after identifying the patient has a need for self-reliance. This need falls into which section of Maslow's Hierarchy of Needs?
- a. esteem needs
 - b. love and belonging needs
 - c. safety needs
 - d. basic physiological needs
16. The RN develops a nursing diagnosis after identifying the patient has a need for healthy intimacy. This need falls into which section of Maslow's Hierarchy of Needs?
- a. esteem needs
 - b. love and belonging needs
 - c. safety needs
 - d. basic physiological needs
17. The RN develops a nursing diagnosis after identifying the patient has a need for self-respect. This need falls into which section of Maslow's Hierarchy of Needs?
- a. esteem needs
 - b. love and belonging needs
 - c. safety needs
 - d. basic physiological needs

18. The RN develops a nursing diagnosis after identifying the patient has a need for adequate nutritional intake. This need falls into which section of Maslow's Hierarchy of Needs?
 - a. esteem needs
 - b. love and belonging needs
 - c. safety needs
 - d. basic physiological needs
19. The RN develops a nursing diagnosis after identifying the patient has a need for freedom from anxiety. This need falls into which section of Maslow's Hierarchy of Needs?
 - a. esteem needs
 - b. love and belonging needs
 - c. safety needs
 - d. basic physiological needs
20. The RN develops a nursing diagnosis after identifying the patient has a need for physical safety. This need falls into which section of Maslow's Hierarchy of Needs?
 - a. esteem needs
 - b. love and belonging needs
 - c. safety needs
 - d. basic physiological needs


For more information on the topics in this chapter and others, please see Appendix on p. 299 for a list of web links to additional resources.



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