Nursing Process

Objectives:

- Introduce the history of nursing process
- Discuss purpose of nursing process
  Including philosophy
- Discuss nursing models in relation to assessment
- Discuss defensible documentation
- Criticism of process
- Summary
Nursing Process

- Assessment
- Planning
- Implementation
- Evaluation
The Nursing Process

The term “Nursing Process” came to the UK in the 1970’s and came to be understood as:

- A form of documentation
- As a means of organising work, that is patient allocation or primary nursing
- As an educational tool to help achieve patient centred nursing
- As a philosophy to help nursing attain professional status by offering an alternative to the medical model.
The nursing process is “An organised, systematic and deliberate approach to nursing with the aim of improving standards in nursing care” Rush S, Fergy S & Weels D (1996)

It uses a systematic, holistic, problem solving approach in partnership with the patient and their family”
Nursing Models

All models have 4 core components,
- The person,
- Their environment,
- Health and
- Nursing

(but all have different emphasis)
The Person

- Body (physical/ biological)

- Activities of daily living

- Genetic make-up – gender

- Nature/ Nurture
Mind (psychological)

- Healthy, impaired or damaged
- Intellect
- Attitudes
- Effect of illness - stress, fears, memories
- Emotional support
Social

Family and friends
Work
Play

Effects of illness (e.g. financial)
Belief systems about the meaning of life, death, hope, suffering,
it may involve organised religion, other customs or "New age" spirituality.
Environment

Home, neighbours, neighbourhood, work, social activities, town, county, country and political factors
Health

“The complete state of physical, psychological and social well-being” World health organisation 1946

Health care continuum (liked to age)

Optimum health ↔ Ill health
Independence ↔ Dependence
Adaptation ↔ Maladaption
Self-care ↔ Reliance on others
Human Needs Model: Roper Logan & Tierney’s Model (1980) (activities of daily living)

This is the main one used in Britain and has 5 dimensions:

- Physiological,
- psychological,
- socio-cultural,
- politico-economical
- and environmental.
There are 12 activities, some of which are essential such as breathing and others that enhance the quality of life.
It should be carried out:

- By or under the supervision of the “Named Nurse”
- With the agreement and co-operation of the patient
- Be evidence based and follow National and Trust Policy and guidelines
- Must use the NMC’s “Standards for record keeping” and “Code of professional conduct”
The purpose of care planning

- It is a legal document
- Shows accountability “The care plan is a document that identifies the care to be given, and a record that shows who planned and gave that care
- It should guide the work of others and be a basis for continuity of care
- Should show a logical and systematic flow of ideas through from the initial assessment to the final evaluation
Assessment

What components are needed for a successful assessment

- Good communication
- A systematic approach to data collection
- Interpretation-based on nursing knowledge

Objective (scientific Quantitative)

- Empirics- measurement of knowledge with scientific fact

Subjective (Art, Qualitative)

- Aesthetics-gained through empathy and is how a nurse becomes sensitive to a patient’s pain, worry or joy
- Ethics- concerned with motivation, morality, human rights and law
- Personal knowledge- awareness that the nurse has an impact on patient care
Sources of Data

1. Non verbal observation
   - Sight - Physical, psychological (and social)
   - Touch - Skin temp, hydration, pulse/BP
   - Sound - Breath - wheeze, stridor
   - Smell - breath body fluids infections, gangrene

2. Verbal Communication
   - Patients/ clients
   - Family and friends (Meaningful others)
   - Nursing colleagues
   - Medical colleagues
   - Other members of multidisciplinary team

3. Written records
   - G.P Letter
   - Transfer letter
   - Old notes
Communication

Why are good communication skills required?

- To establish and maintain a relationship with patients and their families
- To encourage patients to describe all relevant aspects of their problems
- To get and give accurate information
- To use time and opportunity effectively
- To improve patient satisfaction with the care given
- To improve thrust and cooperation with the care
- To reduce negative emotions and fear
Guide to a successful assessment

- Prepare adequately
- Introduce yourself - prepare patient
- Use non-verbal communication
- Be courteous
- Use sensitivity, compassion and empathy
- Use focused questions (opened and closed)
- Listen
- Clarify
- Summarise what they describe
- Make notes
- reflect
Effective planning depends on the quality and comprehensiveness of the assessment

- Determine the problems
- Establish the risks and priorities - How ill are they?
- Can they breathe adequately (safe airway?)
- Are they in pain? (physical/ psychological)
- Can they maintain a safe environment? If not why not? (Drugs, drink, mental or psychological problem?)
- Non-compliance with medical advice
Writing a care plan (s)

Think about

- Who is it for? (The patient and other members of nursing team)
- What are the short-term and long term goals?
- How can you determine that you have reached the goals? (measurable)
- How will the patient know he/she has achieved the goals? (realistic)
- Who is involved in the delivery of the care? (The patient (and family), yourself, the nursing team, medical staff, multidisciplinary team, labs, investigations, procedures etc)
- How quickly is the problem likely to change- How soon will you need to re-evaluate the plan?
How many problems are there?
Which order of priority?

How can you prove that they are evidence based (what resources do you need?) (core care plans Vs individualised ones)
Implementing

a) At the start of the shift, during handover and when you first meet them, think about whether the oral report matches the patients actual condition

b) Compare this to what you already know of the patient and to the existing care plans

c) Has anything changed for better or worse

d) Decide:

What are the priorities for looking after this patient?

- Is their condition stable? What observations need doing- how often
- Are they going off the ward tests/investigations/operations
- Are they being discharged? When are they going? Is every thing ready?
Repeat this process for all the patients you are looking after.

f) What routine work must be done and when should this be done

g) Who is going to do this work— are you on your own or do you have a Clinical support worker with you? How will they give you feedback?

h) Who is available to give you help or advice if needed? (senior nurse-medical team)

i) How are you going to organise the work

TIME MANAGEMENT

j) What resources do you need?
Evaluation.

- MENTAL-On going throughout implementation

- WRITTEN (this should preferably be done with the patient present in order to get accurate feedback)
  - Must be carried out at least twice in 24 hours
  - And whenever any incident occurs. (date, time signature)
  - Write a general statement about patient’s condition (better, same, worse)
  - Evaluate each care plan in turn and by number
- Personalise- use patient’s own words appropriate
- State what care you have given “Care of planned” or any variation/ comment e.g. “pressure area care given skin slightly red on ...sacrum”
- Amend the care plan if circumstances have changed
- Discontinue care plans if the goal(s) have been reached
- Legally- *if the care given has not been recorded than it hasn’t occurred!*
Criticisms of the nursing process & Roper Logan & Tierney’s Model

Assessment

- It is only a “snap shot”- and is often not referred to after the initial assessment or updated
- There is the danger of a “reductionist” approach in which patients are made to “fit” into the boxes rather than allowing flexibility
- It is only one among several nursing assessment tools (waterlow, moving & handling, nutrition, pain etc) in addition to other medical. Paramedical records
- Patients may lie or conceal “incriminating” or embarrassing information
- Psychological, sexual, spiritual or issues surrounding death may not be mentioned
Planning and Giving Care

- The patient’s may not be consulted, empowered to cooperate, or compliant in their care.

- With increasing skill mix CSW’s now provide most of the physical care, but the often have not been taught (or expected) to read care plans, may not report back (or realise the significance of) changes to the RN who is writing the evaluation and may or may not document the care they have given.

- Patient care is fragmented “task nursing” rather than holistic nursing.
Evaluation

- There is not enough time
- It is just paper work that takes nurses away from hands-on-care
- We are bad at reading: so care plans are not consulted- nurses rely on verbal handovers and their notes. (But these are only as good as the individuals memory and continuity of care)
- Evaluation tends to concentrate on objective measurable activity- it may not be appropriate to describe “therapeutic” care interventions or set measurable goals
Other Models

These include

- Nightingale (1859)
- Medical model
- Henderson (1966)
- Systems model: used in USA
- Development models
- Burford Nursing Development Unit
Any Questions
Further Reading:


Cohen E, Gesta T (2001) Nursing case management from essential to advanced practice application 3rd edition Mosby USA


