Student Resource 9.3

Predictions: The Nursing Process

Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_

Directions: In the first column of the chart below are the five steps in the nursing process. Before you read Student Resource 9.4, Reading: The Nursing Process, fill out the second column of the chart by predicting what happens during each step of the process. Then, as you read Student Resource 9.4, fill out the I Learned column.

When you have completed the reading, your teacher will instruct you to complete the second page of the worksheet.

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| --- | --- | --- |
| Nursing Process | I Predict This Means | I Learned |
| Assessment |  |  |
| Diagnosis |  |  |
| Outcome / Planning |  |  |
| Implementation |  |  |
| Evaluation |  |  |

Directions: Draw a line from each step of the nursing process in the left column to the appropriate example of that step in the right column.

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| --- | --- |
| **Assessment** | The certified nursing assistants (CNAs) at the nursing home offered Matilda three hearty meals and three snacks a day. They sat with Matilda while she ate. They offered her seconds. |
| **Diagnosis** | The RN reviewed Matilda’s assessment and made a diagnosis: “Imbalanced nutrition: less than body requirements.” She wrote the diagnosis in Matilda’s file. |
| **Outcome / Planning** | The RN evaluated Matilda’s condition a week after implementing the plan. Matilda’s weight was stable, and she said that she felt more energetic. The nurse decided to continue with Matilda’s care plan without making any modifications. She noted this information in Matilda’s file. |
| **Implementation** | Matilda is a relatively healthy 86-year-old who lives in a nursing home. Because she is fairly independent, she eats her meals unsupervised. During a visit, Matilda’s son told the nurse that Matilda seemed weak. The RN visited Matilda, who told her that she felt lethargic. The nurse asked Matilda about her eating habits, and Matilda said sometimes she skipped meals or ate only crackers or fruit. The nurse took Matilda’s weight; she had lost several pounds. |
| **Evaluation** | The RN put together a care plan for Matilda. One of the goals of the plan was to increase both Matilda’s food intake and body weight. The care plan involved offering Matilda high-caloric food and supervising her meals more closely. The RN reviewed the plan with the CNAs. |

Student Resource 9.4

Reading: The Nursing Process

There are many different types of registered nurses. They have different responsibilities and work in different settings. One thing they have in common is that they all follow a standardized practice to deliver nursing care. This practice is called the nursing process.

There are five steps in the process that nurses follow, but the nursing process is not linear. At any step in the process, a nurse may return to a previous step, start the process over, or stop the process. The nursing process is cyclical.

This nursing process focuses on the whole patient, including the patient’s physical body, spiritual beliefs, and emotional state.

Step 1: Assessment

The first step in the nursing process is called assessment. During this step, the nurse collects and analyzes information about the patient. The information is not just about the patient’s physical body. The information may be psychological, sociocultural, spiritual, or economic. The nurse uses this information to identify the patient’s problems that require nursing care. These problems may be actual or potential problems. During this step, the nurse takes the patient’s medical history and does a psychological and social examination. The nurse also does a physical examination, which may include taking vital signs and also looking for signs and symptoms of other physical problems. The nurse reviews the patient’s diagnosis and medications and becomes familiar with the patient in general. The nurse carefully records information during the assessment. This information is critical to creating an effective and accurate care plan.

Here’s an example of how assessment works. Let’s say a patient in a nursing home is in pain. The nurse looks for the physical causes of the pain. But she will also examine the patient’s response to pain. Is the patient scared? Is the patient refusing to take pain medication? Is the patient expressing anger or frustration with the nursing home staff? The nurse records the information she takes during the assessment.

Step 2: Diagnosis

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| --- | --- |
| The second step is called diagnosis. The nurse uses the information gathered during the assessment to make a diagnosis. The diagnosis may be about a patient’s actual problems. The diagnosis may also be about problems that the nurse thinks the patient is at risk for developing. The nurse must use certain terms to describe and name the diagnosis.  For example, let’s say that in her assessment a nurse learns that a patient who has been admitted to the hospital for pneumonia has been treated for anxiety in the past. The patient also tells the nurse that he’s very worried that his time in the hospital will impact his new job. The nurse may diagnose him for being at risk for anxiety. | **Examples of Nursing Diagnoses**   * Risk for sleep deprivation * Risk for infection * Risk for delayed surgical recovery * Risk for situational low self-esteem * Hypothermia * Anxiety * Impaired swallowing * Ineffective breathing pattern * Fatigue |

A nursing diagnosis is different from a doctor’s diagnosis or the diagnosis obtained through diagnostic imaging. In the example given above, the nurse diagnosed the patient as being at risk for anxiety based on her assessment. However, the patient’s medical diagnosis, pneumonia, was obtained by means of a chest X-ray. The doctor and the radiologist reviewed the results of the X-ray and determined that the patient had pneumonia.

Step 3: Outcomes / Planning

The third step in the nursing process is establishing outcomes and planning. During this step, the nurse puts together a care plan, using the assessment and diagnosis to set short- or long-term goals for the patient. The nurse makes sure that the goals are achievable, or realistic. For example, a nurse’s care plan may involve helping a patient in a nursing home take one walk a day.

If there is more than one diagnosis, the nurse is responsible for prioritizing the patient’s problems. The nurse figures out which problems are most severe and should get attention first.

The nurse records the care plan in the patient’s file so that other health care workers who are caring for the patient will have access to it.

Step 4: Implementation

The fourth step in the nursing process is called implementation. During this step, the nurse implements, or performs, the care plan to provide care for the patient. The nurse may assign parts of the care plan to other workers and monitor their work. All parts of the plan that are implemented are carefully documented in the patient’s record. For example, if the care plan involves helping the patient take a walk every day, the nurses will coordinate when the activity will occur. They will record how long the patient walked for and any observations they had about the patient.

Step 5: Evaluation

The fifth step of the nursing process is called evaluation. In this step, the nurse evaluates the patient’s progress toward meeting the goals. Based on the patient’s progress, the care plan can be modified and the goals can be adjusted. If the patient’s progress is slow or if there are new problems, the nurse may decide to return to a prior step in the process, or decide to create a new care plan. For example, if the diet that was developed to help a patient with nausea is making him feel sicker, the nurse will likely return to the outcomes/planning step.

However, if the goal has been achieved, the nurse may decide to stop the care plan. As in every stage in the nursing process, the work that happens during the evaluation step is closely recorded in the patient’s records.