NURSING PROCESS
What is it ?

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NURSING PROCESS
— What is it?
— A PRACTICAL INTRODUCTION

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Gladys Law was appointed from 1979-1984, by the Department of Health and Social Security, to act as advisor/co-ordinator for activities relating to implementation of the Nursing Process in England and Wales.

"I do not pretend to teach her how, I ask her to teach herself, and for this purpose I venture to give her some hints".

"Notes on Nursing"
F. Nightingale (1859)
(in 1970 edition published by Duckworth)

Contents

We acknowledge the help of our many friends and colleagues who have supported the development of this booklet. We would especially mention those who have committed themselves to using the Nursing Process, without whom this booklet would never have materialised.

Foreword

This publication has been produced in response to numerous requests for information, at an introductory level, which is concise and understandable. Many of those who are attempting to use the Nursing Process, or teach others about it, have identified a need for such a publication. This booklet perhaps, could form a bridge to the more advanced literature which is already available.

Our aim is, therefore, to provide a simple, practical guide to the Nursing Process for anyone new to the topic. It is directed *primarily* to nurses in clinical areas who are introducing Nursing Process but who may be unclear or unconvinced of the advantages of adopting this approach.

We hope to reduce some of the anxiety which can occur when approaching change, but we are also aware of the danger of trivializing some of the concepts presented when attempting to simplify. Readers are therefore, encouraged to go on to further reading, thinking and action.

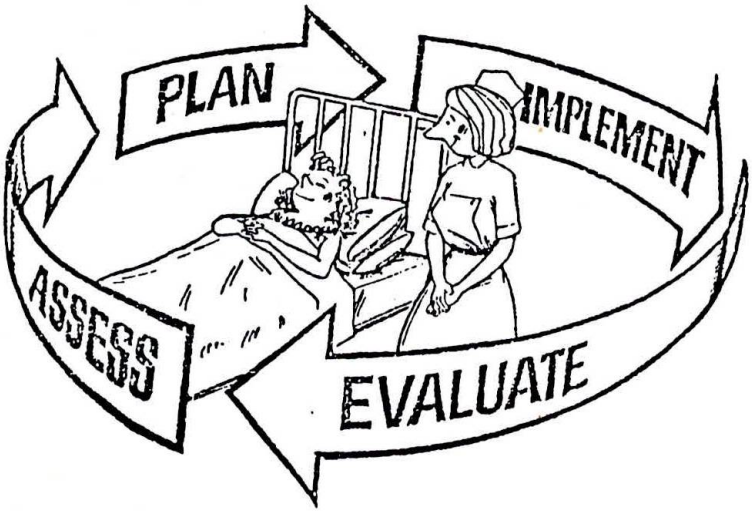
This second edition takes into account more recent thinking and writing about the nursing process. Some of the terminology has also been changed.

As you read through this booklet, you will find that we have suggested some activities for you. If you are a nurse learner, do make sure you have the approval of the person in charge first—you may need supervision in practice.

The Cartoons have been drawn by

STEVE GLEADALL

Introduction



The Nursing Process is a logical, systematic approach to the total care of a patient.

It involves the following steps:

1. Assessing
2. Planning
3. Implementing
4. Evaluating

Each of these steps will be considered separately in this booklet, but this approach to nursing care must be seen as a whole—each step is dependent on the others.

The word "Process" just means a course of action—a way of working which has some order to it.

The Nursing Process means a series of related actions involved when nursing—it is an orderly way of going about your business of caring for each patient, as an individual.

* It is a way of ensuring that the nursing you give is tailor-made for each individual patient.

* It is a way of ensuring that you plan your nursing around the identified needs of the person for whom you are caring.

* It is a way of ensuring that all the details you need to give individualised care, are available and documented for:—

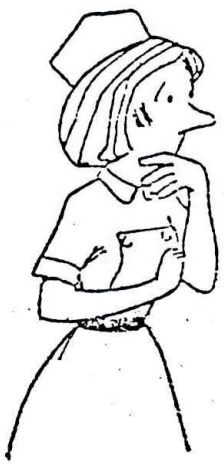
— other nurses to use when you are off duty

— an up-to-date record of progress

— future reference if necessary.

* It offers a framework for evaluating each patient's progress and for further assessment and planning.

THE NURSING PROCESS IS A LOGICAL, SYSTEMATIC APPROACH TO THE TOTAL CARE OF A PATIENT

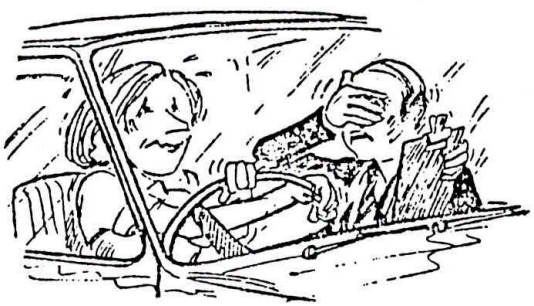


After reading this you may want to say "What's wrong with what I am doing now?" or "How can I give individualised care when we are short of staff and very busy?" etc., etc. We have attempted to answer some of the questions people have asked towards the end of this booklet, but please read the bit in between first.

Although each phase or step of the Nursing Process is presented separately, each depends on the other and all steps can occur simultaneously for different aspects of a patient's nursing care. You might also feel that in a busy ward or day hospital it is not always possible to follow through each step fully before proceeding to the next. Obviously you will not insist on asking your patient about his hobbies if he is vomiting or haemorrhaging!

The framework is intended to help you nurse more efficiently and effectively. When doing anything new or different, however, it can sometimes take a little longer initially.

For example— you may remember your feelings and difficulties when learning to drive?



The Nursing Process is a series of related actions which take place when providing individualised nursing. It provides a framework for making decisions, setting goals, taking action and measuring patient progress and the effectiveness of nursing.

The Nursing Process is not carried out in isolation. The work of other professionals for example—doctors, physiotherapists, social workers, district nurses—is taken into account as necessary. These people may be using a similar framework for their care. Nurses continue to work in collaboration to take into account the patient's medical diagnosis if known, and carry out medically prescribed treatment as appropriate.

Frequently nurses are required to co-ordinate the activities of other health care workers and organise appropriate and continuous care for

each patient. The nurse could well be the only member of this team who is in continuous day-to-day contact with the patient.

In order to understand the practical implication of these four important steps it is necessary to look at each of them in more detail.

REMEMBER:

The Nursing Process provides a framework for the total nursing care of a patient.

THE NURSING PROCESS

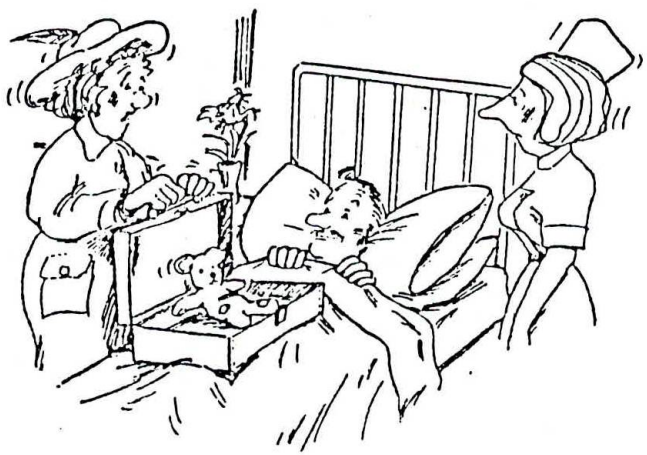
This sequence of steps gives us a framework for nursing which is based on the individual needs of the person for whom we are caring, and involving him/her whenever possible.

Step 1.

ASSESSMENT

* Collecting the information we need.

* Identifying the patient's actual and potential problems.



Step 2.

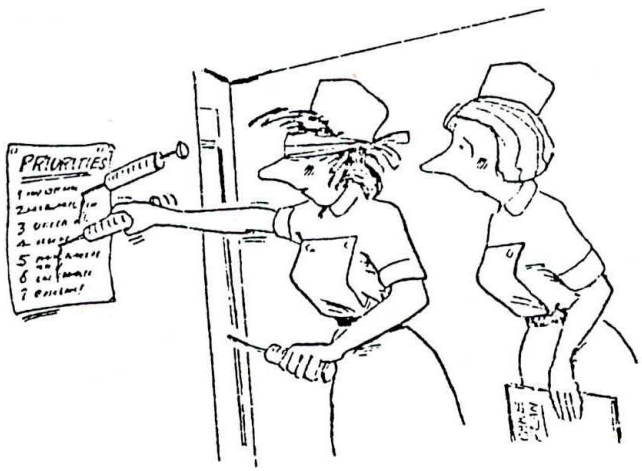
PLANNING

* Determining priorities.

* Setting goals.

* Choosing appropriate measures.

* Writing care plans.



Step 3.

IMPLEMENTATION

* Carrying out the care plan as agreed at the planning stage.

Step 4.

EVALUATION

* Has the patient reached his goal?

* Measuring our success.

* Further assessment and planning if goal has not been reached.

* Analysing the steps of the process and making necessary adjustments.

Let us now look at each step in more detail.

Step 1.

Assessment

An initial assessment is carried out and recorded as soon as possible. We can add to this as further relevant information is obtained.

Relevant information can be gathered in
various ways and from many sources, for example:—

1. *your own observations*

2. *the patient*

3. *friends and*
   Relatives

4. *other information and prescriptions*
   relating to Patient Care
   from other members of the care team
   e.g. doctors, social workers and
   physiotherapists.

Why do we need all this information?

The reasons are:—

* to try to establish what is *normal* for that person, his/her likes and dislikes, and perhaps strengths and weaknesses.

* To identify his/her specific problems and nursing needs.

* To establish a good working relationship between you and your patient.

* To give opportunity for the patient to ask questions.

* to give information to the patient.

* To provide an assessment which can be shared with other staff caring for the patient. This should prevent omissions or duplications.

Gathering information about a patient is very important. It sets the scene for any further action, wrong information leads to wrong actions. Lack of information leads to inadequate action. Make sure, however, that there is good reason for collecting this information.

For example, we may know that Mr. Brown is 65, is in hospital for a prostatectomy and he is on Dr. Smith's list for Tuesday, but we may not necessarily know that his dentures are broken, he hates all forms of fruit juice and he has never been able to sleep on his back since "that accident at work in 1950". All these are vital details for successful post-operative nursing care.

Information about a patient has often been collected in a rather haphazard way, usually by the person who stays to listen just that little bit longer. It may not be reported or recorded anywhere but in one person's head. And yet it is this type of information which makes all the difference to Mr. Brown. It might be important to sort out his denture problem *before* he has his prostatectomy.

So—what then are the advantages of this detailed assessment?

For the Patient

* The patient's normal pattern of life can be taken into account when nursing care is planned.

* He is more likely to be seen as a whole person with social and psychological aspects being taken into account as well as the physical.

* The patient can be encouraged to be actively involved in his own care.

* This approach enables the person for whom we are caring to retain some degree of independence and control of his/her life.

* A better relationship can be built between patient and nurse.

* The patient's family can be included if and when necessary.

For the Nurse

* It focuses on the unique role of the nurse. It focuses on nursing and enhances the nursing contribution to the multi-disciplinary team.

* An increased understanding of the patient as a person helps us focus on the individual as a whole rather responding *only* to the medical diagnosis.

* A written assessment provides security. We can look more objectively at the information we have gained and consider what is to be achieved. It aids decision making.

* The assessment is the foundation on which nursing care is planned, carried out and evaluated.

For Teaching and Learning

It provides a structure for both teaching and assessing learners.

* It provides an opportunity for ongoing learning by presenting a total view of a patient's care.

* It is ideal for the nurse learner who is helped to appreciate the reasons for nursing actions.

And, last but not least

* A systematic approach should increase professional competence and credibility.

Of course, the information we need to collect varies according to the patient for whom we are caring, but will include:—

— the patient's own perceptions of his situation, his needs and his problems. Parents, relatives or friends may also provide information.

— our observations and recording of the patient's current physical, psychological and social state.

— how the present illness or disability, and the fact of becoming a patient, has affected the individual's normal pattern of life.

— medical history, investigations and instructions.

> You may need practice to become skilled in collecting information from your patient. You should learn to look at, and listen to, him or her. Gathering information is not an end in itself.
>
> Inappropriately lengthy questioning must not become more important than your patient. An understanding of the *reasoning* behind the questions you ask is necessary.

Virginia Henderson (1969), in her small booklet 'Basic Principles of Nursing Care' lists 12 components of nursing care (page 19).

These are:—

- Respiration
- Nutrition
- Elimination
- Sleep
- Maintenance of temperature
- Mobility
- Ability to communicate
- Hygiene
- Safety
- Spiritual needs
- Educational needs
- Social needs

This list offers a good guide when taking a nursing assessment. An example of how this may be used is found on the next page with the first suggested activity for you to try.

One of the aims of these activities is to encourage you to be constructively critical of what you are doing and more important. . . of why you are doing it.

ACTIVITY 1.

You may like to use this structured assessment sheet to collect information about one of your patients. Is there anything you would like to add or change?

NURSING ASSESSMENT

Patient's Name
and other admission details:

Physical

Hygiene
Rest/Sleep
Elimination
Nutrition
Mobility/Safety

Present complaint
Allergies
Respiratory state
Skin
Pain/Comfort
Medications

Social

Family/Friends
Occupation/Recreation
Visitors
Language
Housing
Interests

Psychological

Mental State
Reaction to illness/hospital
Means of coping with stress/pain
Spiritual needs

After you have completed this assessment you may wish to reflect on how you used it e.g. at what point did you feel you needed more than a heading to prompt your question? Were there some questions or headings you felt were irrelevant? Did you formulate open-ended questions in order to get more than YES/NO replies from your patient? For example, "Do you have false teeth?" may just give you a yes/no answer whereas, "Have you any difficulties with your teeth?" may encourages the patient to enlarge on any difficulties he/she may have e.g.

a. with dentures needing repair/lost/ ill fitting

b. decayed, broken teeth.

Once information is obtained it has to be interpreted in order to identify the individual patient's nursing problems. These should be recorded on the care plan as clear, concise statements. Here are two simple examples:

Assessment Information (recorded on assessment form)	Patient's Problems (recorded on care plan)
— Patient confined to bed on leg traction, has difficulty moving in bed	This information would lead us to identify a potential problem of the patient in the future developing pressure sores and could be written as:— Potential problem —the development of pressure sores.
— History of having fallen repeatedly at home — Reluctant to walk unaided to toilet — Says he is frightened of falling again.	This information could lead us to identifying an actual problem of fear of falling.

You may like to think of other examples.

Some problems may be ongoing and realistically cannot be resolved by the nurse e.g. poor housing. This problem may have to be referred

to another professional, in this case the social worker. However, the nurse's awareness of the problem will enable her to have more understanding of the patient's situation especially when planning discharge.

The whole of the Nursing Process relies on skillful and sensitive assessment of the patient's nursing requirements. The next three steps depend on this.

You can now move on to the planning step—

Step 2.

Planning

When you are planning nursing care you *should be guided by the information you have collected and the patient's problems which have been indentified.* You may feel that the last statement is unnecessary, but if you stop for a few moments and think of how we often operate in this situation . . .

For example:

We sometimes carry out nursing with minimum information about a patient. We have preconceived ideas ("backed by experience and routine") about what we should do. We have general plans which fit all "Gastrectomy patients". We have ***general*** *guidelines of care in our heads and it is often considered easier to operate with these guidelines than to listen to the individual patient and adapt and modify in response to his or her needs.*

When planning nursing care:—

* Decide on priorities. Using the information gathered and the problems identified, what do you need to pay attention to first? What needs doing **now** and what can be left until later? (When appropriate, discuss this with your patient).

* Write down the patient's goals. This means that you write down what you, as a nurse working with the patient, hope to achieve.

In doing this you may find you have both long and short term goals.

Goals

We feel a word of clarification is needed here as to what **we** mean by goals in this context.

A *GOAL* is a statement about what you and the patient or perhaps his family aim to achieve. This should form a basis for evaluation later.

You may already use words and phrases like:

— expected outcome of care

— aims of care

— expected patient outcomes.

— patient goals.

Do use whichever terms you are familiar with but be clear about the meanings.

For example—on the next page are two problems.

PATIENT'S PROBLEMS	PATIENT GOALS	
	long term	short term
1. 14 kgs overweight	lose 14 kgs	In 7 days Mr. B. will lose 1.5 kgs
2. Unable to give own insulin	Will be able to administer own insulin injection	After demonstration and discussion, Mr. B. will be able to:— — discuss with understanding, alternative strengths and dilutions of insulin (by Jan. 1) — accurately draw up his prescribed dose of insulin (by Jan. 2) — administer this safely (by Jan. 3)

ACTIVITY 2.

Look again at the example given above—will it be easier to measure success if you write the more general long term goal or if you try to be more specific and write short term goals?

We hope you answer short term goals. You will most likely think, initially, in terms of long term goals but those are usually stated in general terms and are difficult to evaluate. By being specific and putting a time limit for yourself and your patient it is easier to say "Yes, that was achieved" or "That goal was unrealistic, perhaps my initial assessment was inaccurate" or "The approach was not particularly helpful".

Patient goals or 'expected outcome of care' are the forecast of what is thought possible for an individual patient within a given length of time. It will not always be a solution to the whole problem. For example, the patient may be 32 kgs overweight; the long term goal may be to lose that weight, but 1.5 kgs per week is a realistic, achievable goal for that particular patient in that particular time.

It is important to be able to measure or evaluate achievement in real terms.

Patient goals should indicate:—

***WHAT* change is to take place, *WHAT* the patient will be able to do or what his condition should be,**

***WHEN* the patient is expected to achieve this and,**

***HOW* the change will be observed.**

If you would like more practice on this, perhaps you would like to do the next activity.

ACTIVITY 3.

For extra practice in writing patient goals try the following exercise using the information you have already gathered in Activity 1.

REMEMBER— You will want to know if each of the patient's problems have been met.

We realize that this exercise is difficult to do without knowing more about the patient. However, do try and suggest what the expected outcome of care *might be* for these problems for a patient you have known.

PATIENT	INFORMATION	PATIENT GOALS
A	12.5 kgs. overweight	1 2
B	Has marked stiffness and weakness in both legs	1 2
C	Skin red over sacral area	1 2
D	Very frightened of walking to bathroom	1 2
E	A diabetic child does not know how to give his/her insulin	1 2
F	Your patient is very worried about having anaesthetic	1 2

— Discuss the goals with a colleague

— Ask yourself—"Can I really know if these goals have been achieved for each patient?"

Now decide what you need to do,

— can you do this yourself?

— do you need to check with colleague/ qualified staff/sister/doctor?

and if necessary,

— have you got the people to help or refer to?

— have you got the equipment you need?

THEN WRITE THE CARE PLAN

The way you structure your care plan may look something like this:—

NURSING CARE PLAN

Name of Patient:

Patient's Problem	Expected Outcome	Nursing Action	Date	Nurse's Signature
1 2 3 etc.				

or this:—

Patient's Identified problems	Patient Goal	Action to be taken	Date	Nurse's Signature
1 2 3 etc.				

ACTIVITY 4.

Activity 1 suggested you take a nursing assessment. Look again at your information and fill in either of the above care plan sheets. They are, of course, similar— it's just a matter of which words you prefer to use.

Step 3.

Implementation

CARRYING OUT YOUR PLAN

The action planned may take many different forms but:—

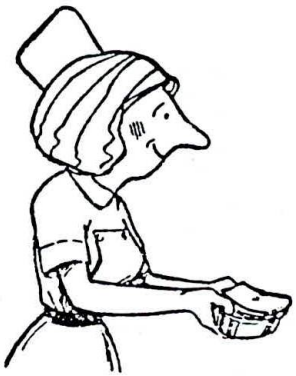
— It will be based on a careful assessment of the patient's problems and needs.

— The possible outcomes of the action will have been considered

— Your available resources, in terms of time, other staff, necessary equipment, etc., will have been assessed.

— The patient, when at all possible, will be working with you to achieve the set goals agreed upon.

In some circumstances, as changes occur, you may need to adapt or modify nursing care plans.



The care plans must be easily accessible to the nursing staff caring for a particular patient.

ACTIVITY

Think about wards you have worked on and consider where nursing care plans were kept—were they easily accessible—can you think of an alternative or better storage place?

Remember, these are confidential documents.

Step 4.

Evaluation

It is important for patients, and for nurses to be able to measure the effectiveness of nursing. This step will be made easier if achievable patient goals and review dates have previously been written.

Evaluating care should show the patient's response to nursing care and indicate progress. Evaluating what we do in this way should improve performance and increase a patient's well-being and the quality of care we give.

This approach should make it easier to find out what is successful, where things went wrong or what part of a patient's care needs improving. You may wish to look back over the steps you have taken and ask yourself . . .

When Assessing

— did you have sufficient information about the patient on which to base your decisions?

— did you miss some vital clues in your observations?

— were your communication skills effective in relation to the:—

  — patient/relatives

  — other nurses and

  — other professionals?

— was your nursing knowledge adequate to deal with the situation?

When Planning

— should you have referred this to . . . ?

— was the patient as informed as he or she would wish?

— were patient/relatives/friends working with or against the goals set?

— did you have the resources you needed?

— did you set goals which you could really evaluate?

In Implementing and Evaluating

— had you the skill/knowledge to act in this or that situation?

— can you evaluate the patient's progress?

— is further assessment required?

— were the care plans followed—or were a number of nursing approaches used which were not recorded? If that was the case it may be impossible to decide which of your actions were beneficial.

— is the patient and his/her family satisfied with their nursing care?

(How did you ascertain this?)

It is necessary to record the evaluation of the original care plan. Where you make this recording will depend on forms designed locally.

Doubts and Dilemmas

Many nurses question the value of attempting to use the Nursing Process. This is a common response to anything new or different. A healthy critical attitude should be encouraged *but* your criticism should be based on adequate knowledge.

The following represents the more common questions asked and comments made about Nursing Process. We have attempted to respond to these although we are aware that there are no 'right' answers. These responses are offered from our experiences over the last few years of talking and working with those who are exploring, in practice, the challenge of using the Nursing Process.

Why do we need to make changes in Nursing?

We should always be striving to make improvements in the quality of care we give.

Providing continuity and consistency in patient care is an increasing problem. Verbal and written communication can become more concise and relevant using the Nursing Process

Some of the routines in nursing are not always as 'good' as we may think—nursing research supports this, e.g.

Hamilton Smith, S. (1972)	Nil by mouth? R.C.N. Research Project Series 1 No. 1
Lelean, S. R. (1973)	Ready for Report Nurse? R.C.N. Research Project Series 2 No. 2

There is other research which suggests that improving communication with our patients can have very real benefits.

Boore, J. R. P. (1978)	Prescription for Recovery R.C.N. Research Series
Hayward, J. (1975)	Information—a Prescription against pain R.C.N. Research Project Series 2 No. 5

We don't have enough nurses to use the Nursing Process

The Nursing Process will not provide more nurses where there is a genuine shortage. It can, however, aid you in selecting the priorities of care needed for individual patients and enable nurses to use their time more effectively. By identifying each patient's problems and nursing requirements it is easier to demonstrate your 'real' nursing workload. Ritual, non beneficial and ineffective actions can be reduced. It may be possible to use the Nursing Process on one or two patients at first, to enable the nurses to get used to this approach and become skilled in its use.

ACTIVITY

If you claim you are presently short of staff in the area in which you work, make a list of the care you have been ***unable*** *to give to your patients in the past few days. Could you accurately identify this?*

Was this recorded in your patient's records?

Will the Nursing Process take more time?

Initially, it may do. Formulating individual care plans may take more mental effort. Nurses usually find, however, that it takes less time as their skills develop.

Some nurses presently spend a great deal of time in writing. They often duplicate records by keeping bathing and bowel books, and work lists etc., as well as ongoing patient records. Putting all the information about

a patient in one place can save time and produce a comprehensive permanent record.

Sometimes the contents of nursing records are not of great value, cliches such as "All nursing care given" and "Slept well" recur over and over again. These statements may mean something different to each nurse involved with a patient and be far removed from how the patient sees his/her own situation. Using the Nursing Process can make sure we make the best use of the documentary time we have.

How will Doctors and other Groups of Staff react?

Nurses usually find that they are supportive, or at least let nursing staff get on with nursing in their own way. Some professionals in the field of social work, psychology, physiotherapy and medicine are already using a systematic problem solving approach to their own work.

Where problems have arisen it has sometimes been either because the nurses themselves did not know enough about nursing process to describe it to others *or* nursing staff have felt pressured into using it by nurse managers, teachers, etc.

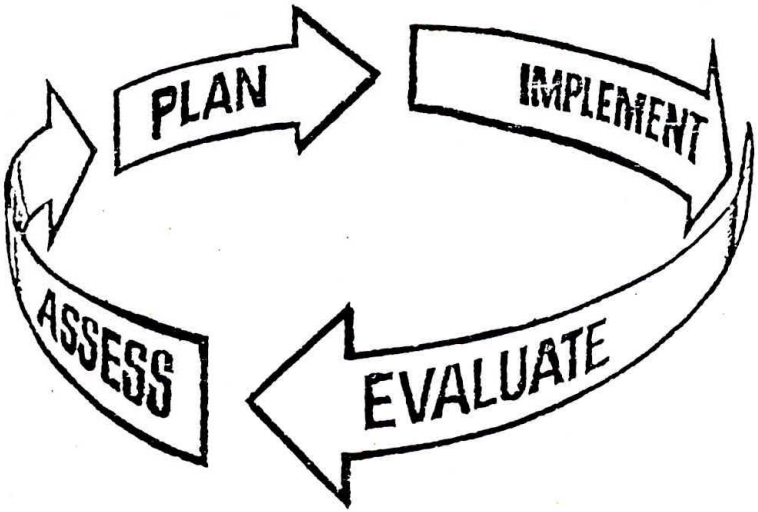
Who should do the Nursing Assessment and write the care plans?

It will depend to some extent on the grades of staff employed. Ideally it should be trained staff (SRNs and SENs) or nurse learners who are supervised by a trained nurse. Other staff such as nursing auxiliaries can contribute information, follow written care plans and take part in discussions held about a patient's progress. Situations are not always ideal, however. Where there are *only* auxiliary staff in attendance it will have to be decided locally to what extent they will contribute.

See King's Fund Project Paper No. 21

'A Handbook for Nurse to Nurse Reporting' 2nd Edition, March, 1983

Conclusion



There is a great danger of using the nursing process in a mechanical way without appreciating its real essence which is, *to try to improve standards of nursing care for patients*—to improve the way we communicate and work together with patients and with all those who are working to that end.

We have presented the nursing process as a series of steps and have attempted to show how they interrelate to form a framework which can be used for the patient's benefit. It will only be of value if nurses use nursing process with understanding and flexibility. We have presented the basic principles, which by necessity you will need to expand and develop in nursing practice. To do this you need commitment—change is not always easy.

Your commitment can then be channelled by understanding and your routines supported by reason.

We hope you enjoy using the Nursing Process and that this booklet will stimulate you to continue to explore ways of improving patient care.

Suggestions for Further Reading from British Literature

Books and Booklets

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The C. V. Mosby Company

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