

Nursing Process Tool

A nursing process tool, called care plan by students, must be developed for each patient cared for in the clinical setting. Nursing process tools do take several hours to complete, so why are they required? Each time a tool is developed you will add to your nursing knowledge, your understanding of medications, your awareness of patients. They develop critical thinking through repeated use of the nursing process. They require decision making and problem recognition and solving. The tool provides structure and will develop your organization and manager of care role. But most important is the quality they produce – quality patient care and quality in your nursing career.

Before examining a Sinclair Nursing Process Tool for this section of your orientation, obtain a copy of both the standard tool and the change of patient tool. You need an actual paper copy. These can be purchased in the bookstore or printed from the nursing website. NSG 221, 223, and 225 will have a tool adapted to their content.

After reviewing the Nursing Process Tools using the following discussion, complete each tool using the patient scenario provided. Give your completed tools to the nursing office for feedback at least two weeks prior to entering your first course. You will be contacted by a faculty member from the course you are entering.

Standard Nursing Process Tool

The standard tool is divided into nine sections – patient care worksheet, assessment data base, diagnosis/stressor sheet, medication sheets, lab/diagnostic studies, assessment of response patterns, assessment summary, assessment analysis, and plan of care and evaluation. Note that the directions are included within the body of the tool so they are always available for review. Any blank pages are related to appropriate duplicating for the bookstore.

Section 1 – Patient care worksheet.

- Includes page 1, the actual worksheet, report sheets, narrative charting sheets, directions.
- Is a guide for implementation of patient care, applying your plan of care. Develops role of manager of care.
- Is truly a worksheet for med reminders, vitals, etc.
- Patient information obtained from chart, kardex/patient care summary.
- Time management grid to be developed before patient care. To include unit/agency routines, nurse routines like when to get report or check for new orders, etc., nursing actions for the patient – routine and from the plan of care interventions, doctor's orders, interdisciplinary orders.
- Meds column is a list of names with possible reminders for parameters, rates, etc. Does **NOT** replace agency MAR.
- Report sheet is for coming on and going off. Incorporates report from the nurse plus information that can be obtained from the kardex/patient care summary. Is to develop the skill of report.
- Narrative charting space to be used by courses where there is no opportunity for narrative charting and development of that skill.
- Directions for this section after narrative charting.
- 2 sets of report and charting forms – one for each patient care day.
- Used to document changes throughout the week. Changes crossed through once and new entered. This would be changes in meds, treatments, intervention, code status, etc.

Section 2 – Assessment data base.

- History – present and past. Complications section is related to a new problem with this admission (example pneumonia after surgery).
- Home medications (follows medication reconciliation form required by JACHO). No highlighting.

Section 3 – Medical diagnosis, physiological stressor.

- Purpose is to learn about the disease/stressor. Is to be used to guide assessment of patient and diagnostic studies, correlate medications and treatments expected and being done, and guide assessment for complications of the disease.
- No highlighting.
- Number is limited to 2.
- Note directions to bullet information, not write paragraphs.
- Note that this sheet is to be used, not a preprinted form or an internet copy.
- When possible the course text should be used. If no information found in the text, the internet can be used but go to a health care professional site (not Web MD).

Section 4 – Medications

- All meds to be given to a patient for all shifts are to be studied, reviewed.
- Med cards required for each med, med in IV's, meds given by RT.
- Medication sheet is necessary to organize the patient's meds and be a ready reference or - list during the clinical day. Medication sheet has four columns and is combined with the med card. You are responsible for knowing the class, action, side effects, nursing interventions, normal dose, reason patient receiving. and parameters for each medication. . The faculty will question you about meds to assure the med content has been learned.
- 3 of the 4 columns require decision making. The first column is the med order so it simply is copying from the MAR. The second asks if it is a normal dose, not just copying the normal dose. The third column is why the patient is receiving the med. The fourth is the parameter, if the med has one.
- Parameters are limits that define whether a medication should be given or held. Parameters come from the literature, Dr.'s orders, side effects, or you may have to use your knowledge base and critical thinking to determine if and what the parameter is. Not all meds have parameters. See example at the top of the first medication page.
- There are 3 IV sheets – continuous IV solutions, IVPB, and IVP. Each is very directive and guide preparation of the IV information and calculations.

Section 5 – Laboratory and Diagnostic Studies

- Requires assessment of both laboratory tests and diagnostic studies such as CT, X-ray.
- Commonly recurring labs/studies identified on form. Row for "other" in each section for additions that are essential for understanding the patient and condition.
- Agency norms are required so you compare your patient's result with the agency lab and not a textbook.
- The three columns for lab results guide trending of the studies. Initial is for the results from the first time the test was done, current is for the last time it was done, and the third is for results during patient care days.
- Diagnostic studies have space for one result since usually done once (like a bronchoscopy).
- Abnormal and normal results documented. Abnormals are highlighted.
- Interventions for abnormal results include 3 things – assessment that indicates the response to the abnormal result, nursing interventions based on the response, and doctor's orders specific to the patient (that is Levaquin, not an antibiotic) that treats the response to the

abnormal result. Interventions for most abnormalities are taught in the course with related content and carried throughout curriculum (example, abnormal K⁺, RBC, WBC, etc. in 122 with electrolytes and inflammation, amylase, etc. in 220 with nutrition, troponin, etc. in 222 with cardiac). Others are found in the required lab test text.

- The drug screen section is not therapeutic levels (digoxin level, peak/trough) which is under physical integrity, but is for opiates, cocaine, etc.

Section 6 – Response Pattern Assessment

- Vital signs are first documented at the beginning of the assessment.
- Assessment is arranged by response patterns. Assessment guided by bullets, boxes.
- All areas must be answered and documented, normal or abnormal.
- Day 2/3 columns are for assessment changes during the week. If there are no changes, nothing needs to be documented. The last two assessment pages do not have a Day 2/3 because the content does not change during the stay (smoking history, ethnic group, etc.).
- Initial assessment can be clarified by writing comments if desired.
- Abnormal data highlighted in any column.
- As much data as possible on the choosing/knowing and relating/perceiving pages should be obtained from chart, admission history, and nurse's history to avoid repetitive questions.

Section 7 – Summary of Assessment

- 2 pages – one with directions that requires no completion, and one with an open form for entering data.
- Is a spider map that organizes the previous assessment data into one visual aid.
- Data entered includes meds, abnormal assessment, abnormal diagnostics, health history IV's, and treatment. Data is taken from assessment, meds, history, labs and placed in appropriate response boxes. For example, cardiac meds in circulation, O₂ sat in oxygenation, weight loss under nutrition. Health history includes diseases, current and past, lifestyle risks such as smoking.
- Summary starts by identifying the major problem/medical diagnosis on admission. The data may be related to the central problem, or unrelated, but indicates nursing concerns.
- Prioritize the top 3 problem areas and place a 1, 2, and 3 in the right lower corner of the top 3 response boxes (those needing intervention now).

Section 8 – Analysis of Assessment

- Limits to 3 actual nursing diagnoses and one PC diagnosis.
- NSG 221, 223, 225 will add a wellness diagnosis.
- Nursing diagnoses are listed in priority. The diagnosis to be used for the plan of care does not need to be written on this page – just write “see plan of care”.
- Diagnoses are to be properly stated – 3 part actual, 2 part PC or risk. Remember that the RT of the nursing diagnosis is the pathophysiology of the disease causing the need for the diagnosis. As evidenced by (AEB) are the assessment findings that led to the decision about the diagnosis.
- Review pages included from NSG 120 LRP related to statement of a nursing diagnosis.

Section 9 – Plan of Care

- Starts with proper statement of the nursing diagnosis.
- Outcomes are a positive restatement of the nursing diagnosis (will have improved gas exchange). Expected patient responses are the improved assessment findings expected that will indicate the outcome is met.
- Interventions are Dr.'s orders, nursing interventions, medications, diet, etc.

- Interventions include teaching actions specific to patient's knowledge need. Teaching interventions must include medication teaching.
- Evaluation included side-by-side with outcomes and interventions. Decision as to whether outcome met, not or partially met must be validated with supporting data indicating change.
- Evaluation completed only at end of clinical week. Changes are summary statements as to what was or needs to be changed in the nursing diagnosis, outcomes, interventions.
- Read the Directions for Plan of Care, following POC form, for easy reference.

Change of Patient Nursing Process Tool

There will be clinical weeks when you complete your standard nursing process tool and your patient is discharged, transferred, dies, is off the unit all day, or no longer available to you. You will be reassigned to another patient. But what about the care plan for the new patient? You will use the change of patient tool.

If you are to have the patient only one day, you will complete the first two pages – patient information, medications to be given during your clinical time, report, and nursing diagnosis. If you will have your patient two days you will add the second report page and the plan of care map. For the map place the diagnosis from page 2 in the top box. Identify outcomes. List interventions. Labs and assessment boxes are what you will trend, not what you find. And evaluate after the second day.