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Nursing Process or Process of Care: Understanding the Nursing Process.

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Abstract.

Support workers work closely with their patients and members of the multidisciplinary team to deliver high quality care. Often this care will have been planned by a nurse using the nursing process. It is therefore important for the support worker to understand how the patient has been assessed and the care they are providing has been planned. Within this article the author will be discussing the nursing process, explaining the different stages and how these are utilised to deliver quality care. Relevant sections of The Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England (Skills for Care and Skills for Health, 2013) will be highlighted. Support worker have a clear and important role in making sure the nursing process is successful and patients receive the best quality care.

Key Words: Assessment, Evaluation, Implementation, Nursing Diagnosis, Nursing Process, Planning, Support Workers.

Introduction

Historically the medical model was used, whereby a diagnosis was made by a doctor and care was prescribed based on physical symptoms alone (Hamilton and Price, 2013). This ignored the holistic needs of the patient. To develop more of a problem solving focus to nursing care (Melin-Johansson et al, 2017) the nursing process was proposed by Yura and Walsh in 1967. It is seen as a “decision making approach that promotes critical thinking” (Yildirim and Ozkahraman, 2011:261). It comprises a cyclical process of four stages which are known as assessment, planning, implementation and evaluation. A fifth stage has subsequently been added coming immediately after assessment, namely nursing diagnosis (American Nurses Association, 2017).

Even though the initial assessment and planning will often be performed by a nurse, the support worker will be involved in all aspects. They will often be the person who then implements the planned care and evaluates its appropriateness and success as care is delivered. Ongoing assessment takes place and the support worker will be closely involved in this. A more accurate name for the nursing process today could

be the Caring Process which would incorporate all members of the multidisciplinary team involved in the care of the patient.

Code Words.

Within The Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England (Skills for Care and Skills for Health, 2013), section 3.2 states that you must “recognise and respect the roles and expertise of your colleagues both in the team and from other agencies and disciplines, and work in partnership with them.” By having an awareness and understanding of the nursing process allows you to recognise and respect the role that the nurse is playing in planning care for your patients. It also allows you to recognise the valuable contribution you make to the nursing process. Section 6.6 states you must “actively encourage the delivery of high quality healthcare, care and support.” Through the nursing process the patient’s needs can be assessed, care planned and delivered and then evaluated, thereby ensuring quality care is delivered. Section 4.2 states you must “communicate effectively and consult with your colleagues as appropriate.” Through having awareness of the nursing process enables you to discuss with your nursing colleagues which care has been planned and why and what outcomes are trying to be achieved.

Assessment

This is the first stage of the nursing process. It involves the collection of information from the patient and their family/carers concerning their condition and perceived problems. Hamilton and Price (2013) state that this is the cornerstone in establishing the needs of the patient and if done well, the nursing process will be a success. Information can be collected in a number of ways and the support worker will take an active part in this. Good communication, both verbal and non-verbal, together with observational skills are key.

Information gathered can be either subjective or objective, and primary or secondary (Kozier et al, 2008). Subjective is information that the patient tells you, how they are feeling, levels and sensation of pain. This is open to interpretation, however you must always accept what the patient is telling you. Objective information is that which can be measured such as blood pressure or weight. Primary information is that which is gained from the patient themselves whereas secondary data is information from other sources, such as family members.

Even before the nurse or support worker has seen the patient there will often be existing notes to read or a handover to receive. This initial information will help to guide the first stages and should give the nurse a starting point on how to approach the patient. Identifying any communication needs and recognising if any special adjustments need to be made. Of course in certain situations this is not always possible, where a patient is admitted urgently to the accident and emergency

department and care must commence immediately, an initial short term assessment will be made (Hamilton and Price, 2013).

The next part of the assessment takes place even before any words are spoken. As you approach the patient you will be observing them and looking for any outward signs, both positive and negative. This can be done very quickly on first seeing the patient. Do they look in pain, do they appear to be pale or clammy? Are they conscious and sitting up, or appear unconscious?

An assessment of the patient's airway, breathing and circulation needs to be performed immediately. Once these three areas have been assessed as being stable, then the more formal assessment can take place. Observations are taken to gain a baseline and again to identify anything abnormal which may need urgent intervention. Pulse, respirations, blood pressure, oxygen saturations, capillary refill time and anything else which is relevant to the patients presenting problems. These are all recorded to be repeated and compared.

General information is gathered together with a thorough health history (Kozier et al, 2008). This includes exactly how the patient is presenting at this moment in time. What symptoms are they describing to you? Other important questions are asked such as is the patient allergic to anything. Models of nursing care will be used as a tool to guide this process. These will already be established within the working environment and form a basis for the documentation used.

The focus of the assessment is the patient and how they are experiencing their illness and ill health. Once all the information has been collected it can be documented and sorted (Melin-Johansson et al, 2017). Excellent record keeping is key, so that all the information gathered is recorded and presented in a way that is accessible to the whole multidisciplinary team.

Nursing Diagnosis

This is an extra stage to the original four and is more wide spread and common in North America. Here the information gained from the assessment is used to identify actual and potential problems, as well as strengths (Yildirim and Ozkahraman, 2011). Strengths might be self-caring abilities or independence in certain areas. Or prior knowledge or experience of the illness. Actual problems are those that come directly out of the assessment, for example pain from a fracture. Potential problems are those that could arise from out of the problem, for example the risk of developing a pressure sore if confined to bed (Hogston, 2011). However Peate (2013) has a word of warning that the person making the diagnosis must have gained the sufficient expertise and experience to do so, otherwise this could be potentially dangerous.

Planning

The planning stage is where interventions are identified to reduce, resolve or prevent the patient's problems while supporting the patient's strengths in an organised goal directed way (Kozier et al, 2008). Care needs to be prioritised on the needs of the patient and the seriousness of the problems identified. Hogston (2011) identifies two steps in the planning stage, setting goals and identifying actions. Goals need to be set, both short term and long term. SMART goals should be identified which are **S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**imely (Hamilton and Price, 2013). These are all done in collaboration with the patient.

In action planning the actual care that is going to be implemented needs to be clearly stated. Hogston (2011) advises using the REEPiG criteria to ensure that care is of the highest standards. Firstly, that the care planned is **R**ealistic given available resources. Secondly, that the care planned is **E**xplicitly stated. Be clear in exactly what needs to be done so there is no room for misinterpretation of instructions. Thirdly, **E**vidence based. That there is research that supports what is being proposed. Fourthly, that the care being planned is **P**rioritised. The most urgent problems being dealt with first. Fifth, is to **I**nvolve both the patient and other members of the multidisciplinary team who are going to be involved in implementing the care. And lastly, **G**oal centred, that the care planned will meet and achieve the goal set.

Implementation

This is where the care is delivered and more than likely it will be the support worker who will be delivering the majority of the basic and increasingly, more advanced care. Especially when the patient is in their own home or a community setting. Implementation of the care occurs throughout the twenty four hour period. As each new member of the caring team comes on duty they need to re-assess if the care being delivered is still appropriate. Has anything new developed to change the plan of care. How is the patient responding to the care delivered? On-going assessment of the patient is vital and again this is where good record keeping is important (Alfaro-LeFevre, 2010).

Evaluation

The most important part of the nursing process after the assessment is done is evaluating has the care achieved the desired result. This should not just occur at the end of a course of treatment or care, but should occur constantly as care is being implemented. Evaluation at the end of a course of treatment involves reassessment of all the plan of care to determine if the expected outcomes have been achieved (Yildirim and Ozkahraman, 2011). Hogston (2011:16) also states that evaluation is an "opportunity to review the entire process and determine whether the assessment was accurate and complete, the diagnosis correct, the goals realistic and achievable, and the prescribed actions appropriate." With evaluation the whole process starts again.

Issues

To perform a good assessment of a patient takes time and time must be devoted to this crucial cornerstone. Otherwise the following stages will not have the information required to deliver quality care. In a study by Abdelkader and Othman (2017:81) it was found that “lack of knowledge, high patient nurse ratio/work load, and lack of educating, training and motivating factors affected the application of the nursing process.” These factors need to be recognised by managers and individual staff so that sufficient time is devoted to it and knowledge and awareness is raised to the important part this caring process plays in delivering high quality care.

Conclusion.

So to conclude, this article has highlighted the importance of planning and delivering care using the nursing process. Support workers need to be aware of the nursing process and more importantly involved in all stages of it. Having an awareness of how the assessment has been carried out and what nursing diagnosis has been reached will make the care more relevant and assist in an effective evaluation stage. This stage should be performed constantly as care is delivered, with the process being cyclical in nature, the patient being re-assessed and care improved and changed to meet the on-going needs of the patient. With care being predominantly delivered by members of a multidisciplinary team perhaps the new term of a caring process should be adopted rather than the term nursing process?

Key Points:

1. Support workers are key members of the team in ensuring the success of the nursing process.
2. Support workers should be involved in all aspects of the nursing process.
3. Care should be planned using SMART goals.
4. Evaluation of care should occur throughout the implementation stage.
5. The term nursing process could be seen as being misleading where Care Process would be a more accurate term today.

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