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# The Nursing Process: A Comprehensive Guide

UPDATED ON JANUARY 28, 2022 BY GIL WAYNE, BSN, R.N.



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In 1958, Ida Jean Orlando began developing the nursing process still evident in nursing care today. According to Orlando's theory, the patient's behavior sets the nursing process in motion. Through the nurse's knowledge to analyze and diagnose the behavior to determine the patient's needs.

Application of the fundamental principles of critical thinking, client-centered approaches to treatment, goal-oriented tasks, evidence-based practice (EBP) recommendations, and nursing intuition, the nursing process functions as a systematic guide to client-centered care with five subsequent steps. These are assessment, diagnosis, planning, implementation, and evaluation (ADPIE).

# What is the Nursing Process?



The **nursing process** is defined as a systematic, rational method of planning that guides all nursing actions in delivering holistic and patient-focused care. The nursing process is a form of scientific reasoning and requires the nurse's critical thinking to provide the best care possible to the client.

# What is the purpose of the nursing process?

The following are the purposes of the nursing process:

- To identify the client's health status and actual or potential health care problems or needs (through assessment).
- To establish plans to meet the identified needs.
- To deliver specific nursing interventions to meet those needs.
- To apply the best available caregiving evidence and promote human functions and responses to health and illness (ANA, 2010).
- To protect nurses against legal problems related to nursing care when the standards of the nursing process are followed correctly.
- To help the nurse perform in a systematically organized way their practice.
- To establish a database about the client's health status, health concerns, response to illness, and the ability to manage health care needs.

# Characteristics of the nursing process

The following are the unique characteristics of the nursing process:

- **Patient-centered**. The unique approach of the nursing process requires care respectful of and responsive to the individual patient's needs, preferences, and values. The nurse functions as a patient advocate by keeping the patient's right to practice informed decision-making and maintaining patient-centered engagement in the health care setting.
- **Interpersonal**. The nursing process provides the basis for the therapeutic process in which the nurse and patient respect each other as individuals, both of them learning and growing due to the interaction. It involves the interaction between the nurse and the patient with a common goal.
- **Collaborative**. The nursing process functions effectively in nursing and inter-professional teams, promoting open communication, mutual respect, and shared decision-making to achieve quality patient care.
- **Dynamic and cyclical**.The nursing process is a dynamic, cyclical process in which each phase interacts with and is influenced by the other phases.
- **Requires critical thinking**. The use of the nursing process requires critical thinking which is a vital skill required for nurses in identifying client problems and implementing interventions to promote effective care outcomes.

# Nursing Process Steps

The nursing process consists of five steps: **assessment, diagnosis, planning, implementation, and evaluation.** The acronym **ADPIE** is an easy way to remember the components of the nursing process. Nurses need to learn how to apply the process step-by-step. However, as critical thinking develops through experience, they learn how to move back and forth among the steps of the nursing process.

The steps of the nursing process are not separate entities but overlapping, continuing subprocesses. Apart from understanding nursing diagnoses and their definitions, the nurse promotes awareness of defining characteristics and behaviors of the diagnoses, related factors to the selected nursing diagnoses, and the interventions suited for treating the diagnoses.

*The steps of the nursing process are detailed below:*

# 1. Assessment: *"What data is collected?"*

The first phase of the nursing process is **assessment**. It involves collecting, organizing, validating, and documenting the clients' health status. This data can be obtained in a variety of ways. Usually, when the nurse first encounters a patient, the nurse is expected to assess to identify the patient's health problems as well as the physiological, psychological, and emotional state and to establish a database about the client's response to health concerns or illness and the ability to manage health care needs. Critical thinking skills are essential to the assessment, thus requiring concept-based curriculum changes.

## Collecting Data

Data collection is the process of gathering information regarding a client's health status. The process must be systematic and continuous in collecting data to prevent the omission of important information concerning the client.

## Types of Data

Data collected about a client generally falls into objective or subjective categories, but data can also be verbal and nonverbal.

### Objective Data or Signs

Objective data are overt, measurable, tangible data collected via the senses, such as sight, touch, smell, or hearing, and compared to an accepted standard, such as vital signs, intake and output, height and weight, body temperature, pulse, and respiratory rates, blood pressure, vomiting,

distended abdomen, presence of edema, lung sounds, crying, skin color, and presence of diaphoresis.

## Subjective Data or Symptoms

Subjective data involve covert information, such as feelings, perceptions, thoughts, sensations, or concerns that are shared by the patient and can be verified only by the patient, such as nausea, pain, numbness, pruritus, attitudes, beliefs, values, and perceptions of the health concern and life events.

## Verbal Data

Verbal data are spoken or written data such as statements made by the client or by a secondary source. Verbal data requires the listening skills of the nurse to assess difficulties such as slurring, tone of voice, assertiveness, anxiety, difficulty in finding the desired word, and flight of ideas.

## Nonverbal Data

Nonverbal data are observable behavior transmitting a message without words, such as the patient's body language, general appearance, facial expressions, gestures, eye contact, proxemics (distance), body language, touch, posture, clothing. Nonverbal data obtained can sometimes be more powerful than verbal data, as the client's body language may not be congruent with what they really think or feel. Obtaining and analyzing nonverbal data can help reinforce other forms of data and understand what the patient really feels.

# Sources of Data

Sources of data can be **primary, secondary,** and **tertiary**. The client is the primary source of data, while family members, support persons, records and reports, other health professionals, laboratory and diagnostics fall under secondary sources.

## Primary Source

The **client** is the only **primary source** of data and the only one who can provide subjective data. Anything the client says or reports to the members of the healthcare team is considered primary.

## Secondary Source

A source is considered **secondary data** if it is provided from someone else other than the client but within the client's frame of reference. Information provided by the client's family or significant

others are considered secondary sources of data if the client cannot speak for themselves, is lacking facts and understanding, or is a child. Additionally, the client's records and assessment data from other nurses or other members of the healthcare team are considered secondary sources of data.

## Tertiary Source

Sources from outside the client's frame of reference are considered **tertiary sources of data**. Examples of tertiary data include information from textbooks, medical and nursing journals, drug handbooks, surveys, and policy and procedural manuals.

# Methods of Data Collection

The main methods used to collect data are health interviews, physical examination, and observation.

## Health Interview

The most common approach to gathering important information is through an interview. An interview is an intended communication or a conversation with a purpose, for example, to obtain or provide information, identify problems of mutual concern, evaluate change, teach, provide support, or provide counseling or therapy. One example of the interview is the nursing health history, which is a part of the nursing admission assessment. Patient interaction is generally the heaviest during the assessment phase of the nursing process so rapport must be established during this step.

## Physical Examination

Aside from conducting interviews, nurses will perform physical examinations, referencing a patient's health history, obtaining a patient's family history, and general observation can also be

used to gather assessment data. Establishing a good physical assessment would, later on, provide a more accurate diagnosis, planning, and better interventions and evaluation.

## Observation

Observation is an assessment tool that depends on the use of the five senses (sight, touch, hearing, smell, and taste) to learn information about the client. This information relates to characteristics of the client's appearance, functioning, primary relationships, and environment. Although nurses observe mainly through sight, most of the senses are engaged during careful observations such as smelling foul odors, hearing or auscultating lung and heart sounds and feeling the pulse rate and other palpable skin deformations.

# Validating Data

Validation is the process of verifying the data to ensure that it is accurate and factual. One way to validate observations is through "double-checking," and it allows the nurse to complete the following tasks:

1. **Ensures that assessment information is double-checked, verified, and complete.**
   For example, during routine assessment, the nurse obtains a reading of 210/96 mm Hg of a client with no history of hypertension. To validate the data, the nurse should retake the blood pressure and if necessary, use another equipment to confirm the measurement or ask someone else to perform the assessment.
2. **Ensure that objective and related subjective data are valid and accurate.**
   For example, the client's perceptions of "feeling hot" need to be compared with the measurement of the body temperature.
3. **Ensure that the nurse does not come to a conclusion without adequate data to support the conclusion.**
   A nurse assumes tiny purple or bluish-black swollen areas under the tongue of an older adult client to be abnormal until reading about physical changes of aging.
4. **Ensure that any ambiguous or vague statements are clarified.**
   For example, a 86-year-old female client who is not a native English speaker says that "I am in pain on and off for 4 weeks," would require verification for clarity from the nurse by asking "Can you describe what your pain is like? What do you mean by on and off?"
5. **Acquire additional details that may have been overlooked.**
   For example, the nurse is asking a 32-year-old client if he is allergic to any prescription or non-prescription medications. And what would happen if he takes these medications.
6. **Distinguish between cues and inferences.**
   **Cues** are subjective or objective data that can be directly observed by the nurse; that is, what the client says or what the nurse can see, hear, feel, smell, or measure. On the other hand, **inferences** are the nurse's interpretation or conclusions made based on the cues. For

example, the nurse observes the cues that the incision is red, hot, and swollen and makes an inference that the incision is infected.

## Documenting Data

Once all the information has been collected, data can be recorded and sorted. Excellent record-keeping is fundamental so that all the data gathered is documented and explained in a way that is accessible to the whole health care team and can be referenced during evaluation.

# 2. Diagnosis: *"What is the problem?"*

The second step of the nursing process is the **nursing diagnosis**. The nurse will analyze all the gathered information and diagnose the client's condition and needs. Diagnosing involves analyzing data, identifying health problems, risks, and strengths, and formulating diagnostic statements about a patient's potential or actual health problem. More than one diagnosis is sometimes made for a single patient. Formulating a nursing diagnosis by employing clinical judgment assists in the planning and implementation of patient care.

> The types, components, processes, examples, and writing nursing diagnosis are discussed more in detail here "**Nursing Diagnosis Guide: All You Need To Know To Master Diagnosing**"

# 3. Planning: *"How to manage the problem?"*

Planning is the third step of the nursing process. It provides direction for nursing interventions. When the nurse, any supervising medical staff, and the patient agree on the diagnosis, the nurse will plan a course of treatment that takes into account short and long-term goals. Each problem is committed to a clear, measurable goal for the expected beneficial outcome.

The **planning phase** is where goals and outcomes are formulated that directly impact patient care based on evidence-based practice (EBP) guidelines. These patient-specific goals and the attainment of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum.

## Types of Planning

Planning starts with the first client contact and resumes until the nurse-client relationship ends, preferably when the client is discharged from the health care facility.

## Initial Planning

Initial planning is done by the nurse who conducts the admission assessment. Usually, the same nurse would be the one to create the initial comprehensive plan of care.

## Ongoing Planning

Ongoing planning is done by all the nurses who work with the client. As a nurse obtain new information and evaluate the client's responses to care, they can individualize the initial care plan further. An ongoing care plan also occurs at the beginning of a shift. Ongoing planning allows the nurse to:

- determine if the client's health status has changed
- set priorities for the client during the shift
- decide which problem to focus on during the shift
- coordinate with nurses to ensure that more than one problem can be addressed at each client contact

## Discharge Planning

Discharge planning is the process of anticipating and planning for needs after discharge. To provide continuity of care, nurses need to accomplish the following:

- Start discharge planning for all clients when they are admitted to any health care setting.
- Involve the client and the client's family or support persons in the planning process.
- Collaborate with other health care professionals as needed to ensure that biopsychosocial, cultural, and spiritual needs are met.

# Developing a Nursing Care Plan

A **nursing care plan (NCP)** is a formal process that correctly identifies existing needs and recognizes potential needs or risks. Care plans provide communication among nurses, their patients, and other healthcare providers to achieve health care outcomes. Without the nursing care planning process, the quality and consistency of patient care would be lost.

The planning step of the nursing process is discussed in detail in **Nursing Care Plans (NCP): Ultimate Guide and Database**.

# 4. Implementation: *"Putting the plan into action!"*

The **implementation phase** of the nursing process is when the nurse puts the treatment plan into effect. It involves action or doing and the actual carrying out of nursing interventions outlined in the plan of care. This typically begins with the medical staff conducting any needed medical interventions.

Interventions should be specific to each patient and focus on achievable outcomes. Actions associated with a nursing care plan include monitoring the patient for signs of change or improvement, directly caring for the patient or conducting important medical tasks such as medication administration, educating and guiding the patient about further health management, and referring or contacting the patient for a follow-up.

A taxonomy of nursing interventions referred to as the **Nursing Interventions Classification (NIC)** taxonomy, was developed by the Iowa Intervention Project, in addition to the efforts of NANDA-I to standardize the language for describing problems. The nurse can look up a client's nursing diagnosis to see which nursing interventions are recommended.

# Nursing Interventions Classification (NIC) System

There are more than 550 nursing intervention labels that nurses can use to provide the proper care to their patients. These interventions are categorized into seven fields or classes of interventions according to the Nursing Interventions Classification system.

## Behavioral Nursing Interventions

These are interventions designed to help a patient change their behavior. With behavioral interventions, in contrast, patient behavior is the key and the goal is to modify it. The following measures are examples of behavioral nursing interventions:

- Encouraging stress and relaxation techniques
- Providing support to quit smoking
- Engaging the patient in some form of physical activity, like walking, to reduce the patient's anxiety, anger, and hostility

## Community Nursing Interventions

These are interventions that refer to the community-wide approach to health behavior change. Instead of focusing mainly on the individual as a change agent, community interventionists recognize a host of other factors that contribute to an individual's capacity to achieve optimal health, such as:

- Implementing an education program for first-time mothers

- Promoting diet and physical activities
- Initiating HIV awareness and violence-prevention programs
- Organizing a fun run to raise money for breast cancer research

## Family Nursing Interventions

These are interventions that influence a patient's entire family.

- Implementing a family-centered approach in reducing the threat of illness spreading when one family member is diagnosed with a communicable disease
- Providing a nursing woman support in breastfeeding her new baby
- Educating family members about caring for the patient

## Health System Nursing Interventions

These are interventions that designed to maintain a safe medical facility for all patients and staff, such as:

- Following procedures to reduce the risk of infection for patients during hospital stays.
- Ensuring that the patient's environment is safe and comfortable, such as repositioning them to avoid pressure ulcers in bed

## Physiological Nursing Interventions

These are interventions related to a patient's physical health to make sure that any physical needs are being met and that the patient is in a healthy condition. These nursing interventions are classified into two types: basic and complex.

- **Basic.** Basic interventions regarding the patient's physical health include hands-on procedures ranging from feeding to hygiene assistance.
- **Complex.** Some physiological nursing interventions are more complex, such as the insertion of an IV line to administer fluids to a dehydrated patient.

## Safety Nursing Interventions

These are interventions that maintain a patient's safety and prevent injuries, such as:

- Educating a patient about how to call for assistance if they are not able to safely move around on their own

- Providing instructions for using assistive devices such as walkers or canes, or how to take a shower safely.

# Skills Used in Implementing Nursing Care

When implementing care, nurses need cognitive, interpersonal, and technical skills to perform the care plan successfully.

- **Cognitive Skills** are also known as *Intellectual Skills* are skills involve learning and understanding fundamental knowledge including basic sciences, nursing procedures, and their underlying rationale before caring for clients. Cognitive skills also include problem-solving, decision-making, critical thinking, clinical reasoning, and creativity.
- **Interpersonal Skills** are skills that involve believing, behaving, and relating to others. The effectiveness of a nursing action usually leans mainly on the nurse's ability to communicate with the patient and the members of the health care team.
- **Technical Skills** are purposeful "hands-on" skills such as changing a sterile dressing, administering an injection, manipulating equipment, bandaging, moving, lifting, and repositioning clients. All of these activities require safe and competent performance.

# Process of Implementing

The process of implementing typically includes the following:

## 1. Reassessing the client

Prior to implementing an intervention, the nurse must reassess the client to make sure the intervention is still needed. Even if an order is written on the care plan, the client's condition may have changed.

## 2. Determining the nurse's need for assistance

Other nursing tasks or activities may also be performed by non-RN members of the healthcare team. Members of this team may include unlicensed assistive personnel (UAP) and caregivers, as well as other licensed healthcare workers, such as licensed practical nurses/licensed vocational nurses (LPNs/LVNs). The nurse may need assistance when implementing some nursing intervention, such as ambulating an unsteady obese client, repositioning a client, or when a nurse is not familiar with a particular model of traction equipment needs assistance the first time it is applied.

## 3. Implementing the nursing interventions

Nurses must not only have a substantial knowledge base of the sciences, nursing theory, nursing practice, and legal parameters of nursing interventions but also must have the psychomotor skills to implement procedures safely. It is necessary for nurses to describe, explain, and clarify to the client what interventions will be done, what sensations to anticipate, what the client is expected to do, and what the expected outcome is. When implementing care, nurses perform activities that may be independent, dependent, or interdependent.

## Nursing Intervention Categories

Nursing interventions are grouped into three categories according to the role of the healthcare professional involved in the patient's care:

### Independent Nursing Interventions

A registered nurse can perform independent interventions on their own without the help or assistance from other medical personnel, such as:

- routine nursing tasks such as checking vital signs
- educating a patient on the importance of their medication so they can administer it as prescribed

### Dependent Nursing Interventions

A nurse cannot initiate dependent interventions alone. Some actions require guidance or supervision from a physician or other medical professional, such as:

- prescribing new medication
- inserting and removing a urinary catheter
- providing diet
- Implementing wound or bladder irrigations

### Interdependent Nursing Interventions

A nurse performs as part of collaborative or interdependent interventions that involve team members across disciplines.

- In some cases, such as post-surgery, the patient's recovery plan may require prescription medication from a physician, feeding assistance from a nurse, and treatment by a physical therapist or occupational therapist.
- The physician may prescribe a specific diet to a patient. The nurse includes diet counseling in the patient care plan. To aid the patient, even more, the nurse enlists the help of the

dietician that is available in the facility.

## 4. Supervising the delegated care

Delegate specific nursing interventions to other members of the nursing team as appropriate. Consider the capabilities and limitations of the members of the nursing team and supervise the performance of the nursing interventions. Deciding whether delegation is indicated is another activity that arises during the nursing process.

The American Nurses Association and the National Council of State Boards of Nursing (2006) define delegation as **"the process for a nurse to direct another person to perform nursing tasks and activities."** It generally concerns the appointment of the performance of activities or tasks associated with patient care to unlicensed assistive personnel while retaining accountability for the outcome.

Nevertheless, registered nurses cannot delegate responsibilities related to making nursing judgments. Examples of nursing activities that cannot be delegated to unlicensed assistive personnel include assessment and evaluation of the impact of interventions on care provided to the patient.

## 5. Documenting nursing activities

Record what has been done as well as the patient's responses to nursing interventions precisely and concisely.

# 5. Evaluation: *"Did the plan work?"*

**Evaluating** is the fifth step of the nursing process. This final phase of the nursing process is vital to a positive patient outcome. Once all nursing intervention actions have taken place, the team now learns what works and what doesn't by evaluating what was done beforehand. Whenever a healthcare provider intervenes or implements care, they must reassess or evaluate to ensure the desired outcome has been met. The possible patient outcomes are generally explained under three terms: the patient's condition improved, the patient's condition stabilized, and the patient's condition worsened.

# Steps in Evaluation

Nursing evaluation includes (1) collecting data, (2) comparing collected data with desired outcomes, (3) analyzing client's response relating to nursing activities, (4) identifying factors that contributed to the success or failure of the care plan, (5) continuing, modifying, or terminating the nursing care plan, and (6) planning for future nursing care.

## 1. Collecting Data

The nurse recollects data so that conclusions can be drawn about whether goals have been fulfilled. It is usually vital to collect both objective and subjective data. Data must be documented concisely and accurately to facilitate the next part of the evaluating process.

## 2. Comparing Data with Desired Outcomes

The documented goals and objectives of the nursing care plan become the standards or criteria by which to measure the client's progress whether the desired outcome has been met, partially met, or not met.

- **The goal was met**, when the client response is the same as the desired outcome.
- **The goal was partially met**, when either a short-term outcome was achieved but the long-term goal was not, or the desired goal was incompletely attained.
- **The goal was not met.**

## 3. Analyzing Client's Response Relating to Nursing Activities

It is also very important to determine whether the nursing activities had any relation to the outcomes whether it was successfully accomplished or not.

## 4. Identifying Factors Contributing to Success or Failure

It is required to collect more data to confirm if the plan was successful or a failure. Different factors may contribute to the achievement of goals. For example, the client's family may or may not be supportive, or the client may be uncooperative to perform such activities.

# 5. Continuing, Modifying, or Terminating the Nursing Care Plan

The nursing process is dynamic and cyclical. If goals were not sufficed, the nursing process begins again from the first step. Reassessment and modification may continually be needed to keep them current and relevant depending upon general patient condition. The plan of care may be adjusted based on new assessment data. Problems may arise or change accordingly. As clients complete their goals, new goals are set. If goals remain unmet, nurses must evaluate the reasons these goals are not being achieved and recommend revisions to the nursing care plan.

# 6. Discharge Planning

Discharge planning is the process of transitioning a patient from one level of care to the next. Discharge plans are individualized instructions provided as the client is prepared for continued care outside the healthcare facility or for independent living at home. The main purpose of a discharge plan is to improve the client's quality of life by ensuring continuity of care together with the client's family or other healthcare workers providing continuing care.

**The following are the key elements of IDEAL discharge planning according to the Agency for Healthcare Research and Quality:**

- **I**nclude the patient and family as full partners in the discharge planning process.
- **D**iscuss with the patient and family five key areas to prevent problems at home:
  - Describe what life at home will be like
  - Review medications
  - Highlight warning signs and problems
  - Explain test results
  - Schedule follow-up appointments
- **E**ducate the patient and family in plain language about the patient's condition, the discharge process, and next steps throughout the hospital stay.
- **A**ssess how well doctors and nurses explain the diagnosis, condition, and next steps in the patient's care to the patient and family and use teach back.
- **L**isten to and honor the patient's and family's goals, preferences, observations, and concerns.

**A discharge plan includes specific components of client teaching with documentation such as:**

- **Equipment needed at home.** Coordinate home-based care and special equipment needed.
- **Dietary needs or special diet**. Discuss what the patient can or cannot eat at home.
- **Medications to be taken at home.** List the patient's medications and discuss the purpose of each medicine, how much to take, how to take it, and potential side effects.
- **Resources such as contact numbers and addresses of important people.** Write down the name and contact information of someone to call if there is a problem.
- **Emergency response: Danger signs.** Identify and educate patients and families about warning signs or potential problems.
- **Home care activities.** Educate patient on what activities to do or avoid at home.
- **Summary.** Discuss with the patient and family about the patient's condition, the discharge process, and follow-up checkups.

📁 Fundamentals of Nursing, Notes

🏷️ Nursing Diagnosis

‹  ICN Launches Revised Code of Ethics for Nurses

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Gil Wayne graduated in 2008 with a bachelor of science in nursing. He earned his license to practice as a registered nurse during the same year. His drive for educating people stemmed from working as a community health nurse. He conducted first aid training and health seminars and workshops for teachers, community members, and local groups. Wanting to reach a bigger audience in teaching, he is now a writer and contributor for Nurseslabs since 2012 while working part-time

as a nurse instructor. His goal is to expand his horizon in nursing-related topics. He wants to guide the next generation of nurses to achieve their goals and empower the nursing profession.

# 3 thoughts on "The Nursing Process: A Comprehensive Guide"

**Jeremy**

January 27, 2022 at 12:45 AM

This article is helpful

Reply

**Nourece**

February 11, 2022 at 3:41 AM

So helpful
And easy to understand
A very good guide for nurses

Reply

**Nadine O.**

February 5, 2022 at 9:38 AM

I'm a clinical instructor teaching Fundamentals this semester. The article will be very helpful to give an in-depth explanation of "The Nursing Process" to students. Thank you.

Reply

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