

TITLE: NURSING PROCESS**NUMBER: POL - 1.8****PAGE 1 OF 4**

PURPOSE: All patients will receive safe, effective and appropriate nursing care as evidenced by utilization and documentation of the nursing process. This standard applies to all patients within the hospital where nursing care is provided.

REFERENCE: JCAHO Standards, 2002
Nurse Practice Act, Annotated Code of Maryland, Health Occupation Article, Title 8,
Code of Maryland Regulations, Title 10, Subtitle 27, 2002.

RESPONSIBLE PERSONS: Nurse Manager
Registered Nurse

***NOTE:** Aspects of the process may be delegated, in accordance with the Maryland Nurse Practice Act and other regulatory standards.

POLICY:**I. DEFINITION**

The nursing process consists of four components:

A. ASSESSMENT

A systematic, continuous gathering of data relative to the patient's reason for admission. The data may be collected through patient interview, through physical examination, through family/significant other interview and the patient's record. The assessment includes collection and analysis of data. The analysis of data will assist the nurse, the patient and the patient's family/significant other to identify the patient's problems and needs. It includes but is not limited to:

1. **biophysical** review of the relevant major body systems and appropriate physiological parameters.
2. **psychosocial** relevant information about psychosocial support systems, cultural or religious influences, anxiety, fears that may affect care.
3. **environmental** individual considerations needed in planning the patient's care during hospitalization; and pertinent living conditions and environmental needs to promote patient safety post discharge.
4. **educational** patient's and family's/significant other's learning needs for care during hospitalization and post discharge.

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B. PLANNING

Identification and prioritization of problems based on the assessment data; determination of protocols and/or interventions to address problems for the purpose of achieving a desired measurable outcome.

C. IMPLEMENTING

Follow through on the interventions defined in the nursing plan of care.

D. EVALUATION

Review of the outcome and validation the effectiveness of the current plan of care. It would include evaluating the patient upon transfer to another level of care or discharge.

II. IMPLEMENTATION

A. ASSESSMENT

1. The patient's needs related to his/her admission will be comprehensively assessed upon admission. The admission assessment is to be completed within the established time frame specific to the needs and acuity of the patients on the patient care unit. The assessment time frame is determined by:

- a. the anticipated length of stay
- b. the complexity of the patient's problems and related care
- c. the dynamics of the patient's condition

2. The registered nurse is responsible for interpreting the data and determining the needs of the patient.

3. The assessment includes but is not limited to the biophysical, psychosocial, environmental, educational and post discharge needs.

4. The patient will be systematically and continuously reassessed throughout the hospital stay as indicated by the patient's condition and the outcome of the devised plan of care.

B. PLANNING

1. The plan of nursing care shall be derived from a systematic, continuous and complete analysis using the nursing process.

2. Based on the assessment and taking into consideration input from other disciplines in the health care team, patient care problems or needs will be identified.

3. The problems will be prioritized according to the immediate needs of the patient, the anticipated

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length of stay and the extent to which problems can be resolved.

4. Measurable patient outcomes specific to each problem/need will be determined.
5. The plan of care will include other discharge planning needs as necessary, i.e. referral to Home Care, assistance from Social Services, nursing home placement, out-patient follow-up arrangements, etc. in coordination with family/significant other.

C. EVALUATION

1. Evaluation is derived from the continuous, systematic and complete review of the assessment, plan of care and its implementation.
2. The patient's response to and the outcomes of the care provided will be systematically and continuously assessed to determine the effectiveness of the care provided.
3. Reassessments of patients are ongoing according to time frames specific to the patient population served and as indicated by a change in the patient's needs.
4. The abilities of the patient and family/significant other to manage continuing care needs post discharge will be evaluated.
5. The plan of care must be reviewed and revised as indicated by the patient's condition and as needs change.

III. DOCUMENTATION

- A. All aspects of the nursing process will be documented in the patient's permanent record in a systematic, ongoing manner according to established divisional and unit-specific standards.
- B. Unless otherwise specified in unit guidelines, documentation must be completed, using the appropriate forms (electronic or paper) as follows:
 1. data collection and assessment information: admission data base; assessment form.
 2. identification of problems, interventions and expected outcomes: the care plan.
 3. updates/revisions to the plan of care: the care plan
 4. reassessment data and care provided: the medication administration record, flow sheets and the nurses' notes.
 5. the patient's response to care given and/or the outcomes: flow sheets and the nurses's notes.
 6. patient teaching: education documentation form; nurses's notes.
- C. Whenever the patient is transferred from one level of care to another, documentation must include a current assessment and the status of the plan of care.
- D. When the patient is discharged to home or to another facility, the status of identified problems and the

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outcomes achieved will be documented. Any referrals to outside resources for continuing care needs will also be documented in the discharge summary.

REFER TO GUIDELINES FOR SPECIFIC INSTRUCTIONS IN COMPLETING ALL FORMS.

**APPROVED FOR
IMPLEMENTATION:**


Selling Vice President Patient Care Operations

5/11/02
DATE

ORIGINAL DATE(S): 7/92

REVISED DATE(S): 2/93, 2/96, 12/98, 4/02

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