Nursing Process and Critical Thinking

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centurion™

Clinical Operations

National Commission on Correctional Health Care

Disclosure and Disclaimer

"I do not have any relevant financial relationships with any commercial interests."

Educational Objectives

- Describe the Nursing Process
- Identify the concepts of critical thinking
- Understand nursing interventions and the goals of patient care

Lessons Learned

- The Nursing Process is easier to teach since it is a step by step methodology
- Critical Thinking is often difficult to teach due to multiple steps involved in the thought process
- Evidence based practices should NOT be the reason for nurses not to think!

Nursing Process

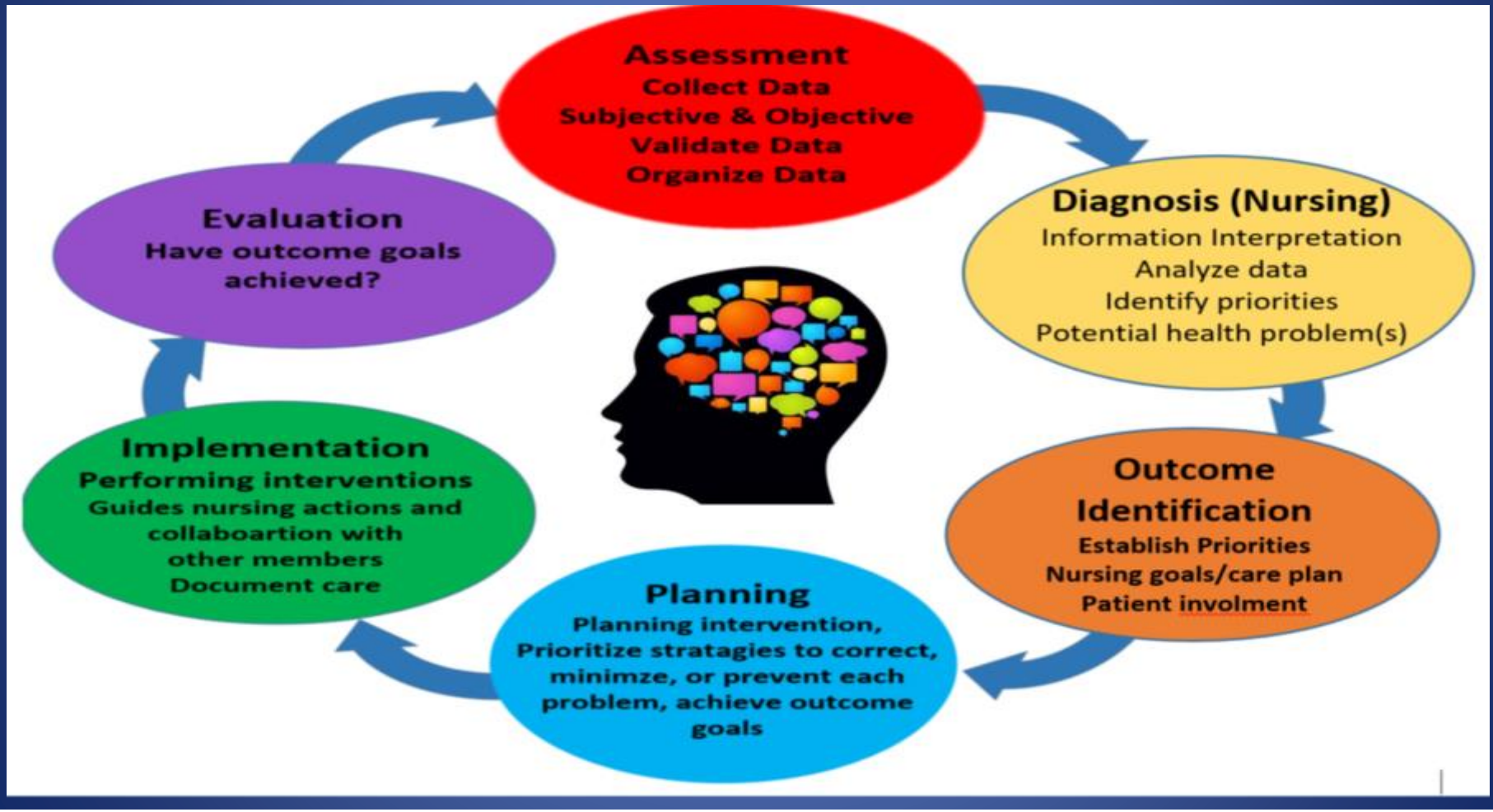
- Definition:
  - Systematic approach that is used by all nurses to gather data, critically examine and analyze the data, identify client responses, design outcomes, take appropriate action, then evaluate the effectiveness of the action.
  - Critical thinking is an important component of the nursing process

What Is the Nursing Process?

- A systematic problem-solving approach with the goal of providing individualized nursing care
- Initially introduced in 1960 - continues to evolve and modify
- One of our tools for identifying and treating human responses to potential or actual health problems
- Fosters continuity of care, which promotes quality of care
- Evidence based practices
  - Integration of clinical expertise, patient values and the best research evidence into the decision-making process for patient care

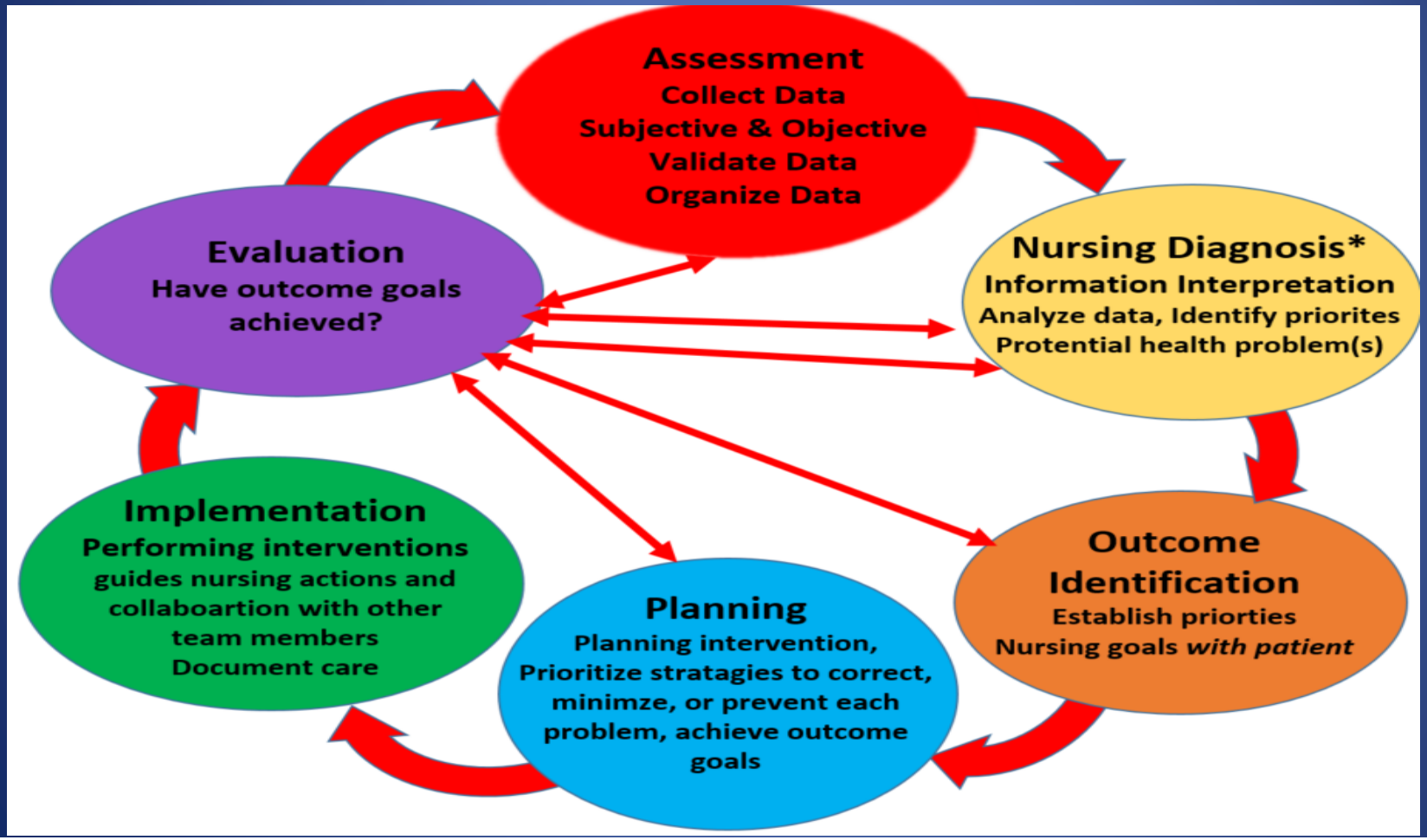
Nursing Process Phases/Steps

- 5 or 6 steps, as demonstrated in an organized pattern



Nursing Process Phases/Steps

- Thought process



Acronym: ADOPIE

- **A**ssessment
- **D**iagnosis (nursing)
- **O**utcome (identification)
- **P**lanning (plan of care/intervention/expected outcomes)
- **I**mplementation
- **E**valuation

Nursing Process: Assessment

- Systemically collects, verifies, analyzes and communicates data
- Most critical step in the Nursing Process
- Establishes a data base of the patient's needs, health problems, responses, related experiences, health practices, values, lifestyle, and expectations
- Answers the questions: "What is happening (actual problem) or "What could happen" (potential problem)

Assessment Data:

- Subjective data
  - What the patient tells you
- Objective data
  - Measurable data, observations by the nurse
- Source of data
  - Can come from patient, officers, other medical staff, and others (family, clergy, other incarcerated)
  - Review of patient health history
- Visual and auditory observation

Data - Next Steps

- Evaluate data
- Organize data
- Nursing Diagnosis
- Design a Plan (based on data)
- Implement the Plan
- Evaluate/re-evaluate the effectiveness of interventions provided, and decide if a new plan and/or interventions need to be completed

Nursing Process: Diagnosis

- Statement that describes the patient's actual or potential response to a health problem
- Focuses on patient-centered problems
- First introduced in the 1950's
- Allows nurse to individualize patient care
- Multiple publications

Nursing Process: Outcome Identification

- Establish the priorities
- Most immediate need
- Intervention meet need
- Patient should be involved if possible
- What is the goal of intervention
- What is expected outcome

NANDA International Nursing Diagnosis 2021-2023

Topics: over 200 list

- Health promotion
- Nutrition
- Elimination and Exchange
- Activity / Rest
- Perception/Cognition
- Self-Perception
- Role relationship
- Sexuality
- Coping/Stress Tolerance
- Life Principles
- Safety/Protection
- Comfort
- Growth /Development

Underlined indicates updated domains for 2021-2023

https://nanda.org/

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Nursing Process: Evaluation

- Measures the patient's response to nursing interventions/actions and the patient's progress toward achieving goals
- Data collected on on-going basis
- Supports the foundation for effectiveness of nursing interventions/actions

Nursing Process: Plan

- To provide consistent, continuous care that will meet the patient's unique needs.
- This includes patient goals and nursing orders
  - Patient goals = focused on patient, must be realistic and measurable
  - Nursing protocols and plans = describes what the nurse will do to help the patient achieve the goals

Nursing Process: Implementation

- Validate the plan is accurate/appropriate
- Ensure actions/interventions are initiated
- Ensure actions/interventions are accomplished

Nursing Process: Evaluation and Re-evaluation

- Measures if goals are achieved
- If goals not achieved:
  - Adjust plan and implement changes
  - Re-evaluate for effectiveness

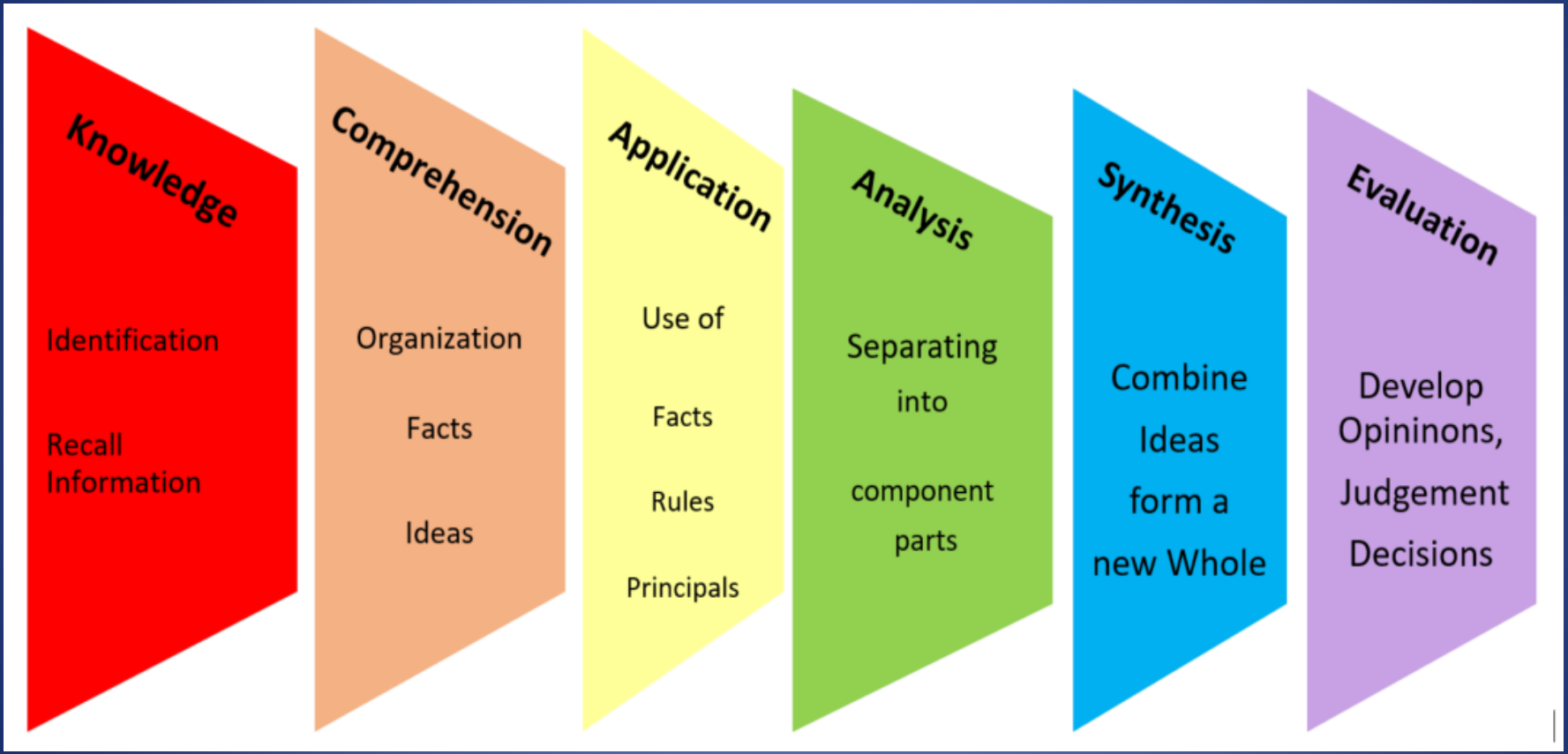
Critical Thinking:

- Definition
  - Cognitive process during which an individual reviews data and considers potential explanations and outcomes before forming an opinion or making a decision.
  - Critical thinking in nursing practice is a discipline specific, reflective reasoning process that guides the nurse in generating, implementing, and evaluating approaches for dealing with client care and professional concerns.

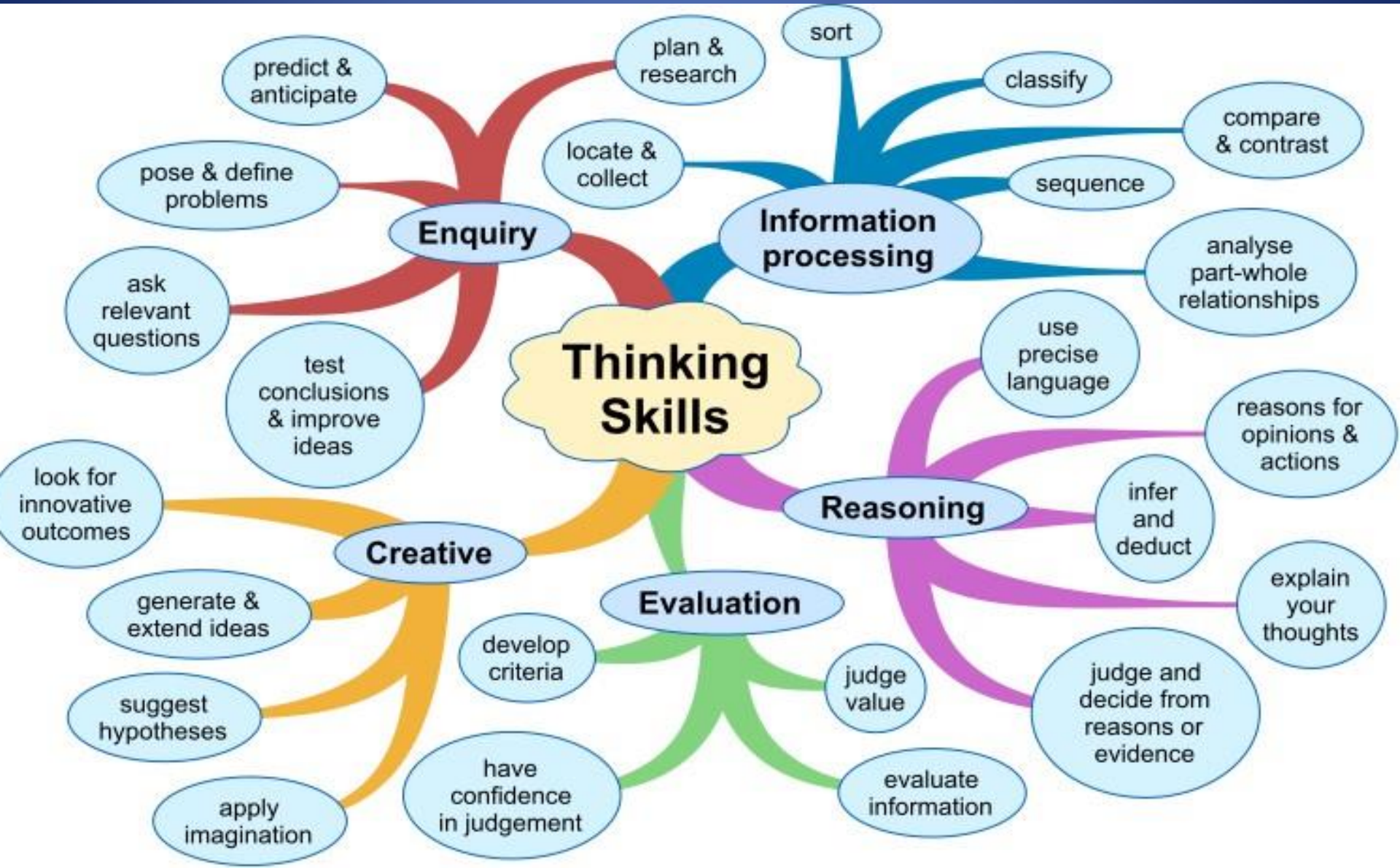
Components of Critical Thinking

- Scientific knowledge base
- Experience
- Competencies
- Attitudes
- Standards

Critical Thinking Process



Critical Thinking Skills



How Do We Develop Critical Thinking Skills

- Stay up to date with changes in the standards of care
- Complete basic nursing education
- Continue competency skills through career
- Continuous learning/education
- Mentor / share knowledge
- Florence Nightingale had a passion for excellence

The Road to Competence

- Formal education
- Nurses' expertise grows over the years
  - Is a product of experience
- Well thought out Orientation
  - Preceptors
  - Employee who can articulate learning needs
  - Mentors
  - Those who assist in professional development and clinical reasoning

The Road to Competence

- Novice
- Advanced Beginner
- Competent
- Proficient
- Expert

Novice

- Minimal experience
- Learn context-free rules that apply universally
  - Example: B/P q hour if diastolic is > 100 mmHg contact doctor
- Behavior in a clinical setting is limited
- Very limited ability to predict what will happen next in a patient situation
- Signs and symptoms can be recognized and assessed after a novice has had experience with patients with similar symptoms

Advanced Beginner

- Enough experience to note reoccurring, meaningful components of a situation
- Begins to formulate guidelines that dictate actions
- Have knowledge, skills and know-how but limited encounters with similar patients population

Competent

- Considers their actions in terms of long range goals and plans
- Have the feeling of mastery and can rely on advanced planning and organizational skills
- Begin to recognize patterns and the nature of clinical situations more quickly and accurately
- Need to examine fewer options to make decisions

Proficient

- Views situation as a whole rather than parts , and maxims, reflecting nuances of a situation to guide performance
- Learns from experience what events typically occur and how to modify plans in response to different events
- Sees goals and salient facts, but consciously makes decisions

Expert

- Knowledge of needs of patient and because of a well developed ability to recognize demands and recourses in situations and attain goals
- Have an intuitive grasp of a situation based on an in-depth knowledge and experience
- Focus on relevant problems
- Use analytical tools when they have no experience or the situation does not respond as expected
- Internal analysis
- Is prepared for what “may” happen

Novice to Expert

- Developing skills is a long and progressive process
- Experiential learning requires an engaged learner who is open to growth and development over time
- Professional with caring
- Nurses must know how to handle situations to meet the needs without losing themselves in the process

Novice to Expert

- Completing the rites of passage from Novice to Expert is not a forgone conclusion.
- Nurses can gain knowledge and skills (know how) without ever learning theory (know that), which brings expertise.
- As expertise develops, performance change:
  - Improvement in communication, organization, deal effectively with interruptions, anticipate patient needs and integrate varied nursing roles into work.

Responsibilities of the Manager

- Safety # 1 while promoting learning
- Integrate assessment of nurses' skills levels when determining staffing to allow for maximum care and development of expertise
- Select preceptors carefully and ensure the receive formal education for their role
  - Select preceptors that can solve tough problems
  - Like to teach and coach the new staff
- Support life long learning

Critical Thinking and Nursing Judgment

- Not a linear step by step process
- Process acquired through hard work, commitment, and an active curiosity toward learning
- Decision making is the skill that separates the professional nurse from technical or ancillary staff

Critical Thinking and Nursing Judgment

- Problem solving skills
- Reflect on past experiences and knowledge
- Listen to others point of view/ team approach
- Able to look at alternatives and “think outside the box”
- Select the best solution for improving the patient’s health
- Not always a clear textbook answer
- Medicine is not “on size fits all” science

Selection of Intervention

- Using clinical decision making, the nurse considers 6 factors in deciding the specific interventions that need to be included in the plan
  - Diagnosis
  - Expected outcomes
  - Research base
  - Feasibility
  - Acceptability to patient
  - Competency of nurse

Types of Interventions

- ***Anything*** you do to the patient is considered an intervention!
- Can be:
  - Nurse initiated
  - Provider initiated
  - Collaborative interventions

Goals of Patient Care

- Nurse is to address the patient's complaint, problem, or issue
- Provide quality medical care within the nurse's scope of practice
- Return the patient to their optimum health status

“DEAD ON!”
Promoting Critical Thinking

- **D**=Data
- **E**= Emotions
- **A**= Advantages
- **D**= Disadvantages

- **O**= Out of the Box
- **N**=Now What?

“DEAD ON”
D=Data

- What data (facts) do you have?
- What other data is needed ?
- What determinations have you made?
- what data might validate or negate them?

“DEAD ON”
E=Emotions

- What emotions (gut reactions) are there?
  - Yours
  - Others
- What is your intuition telling you, and what data might validate or negate it?
- How are values affecting thinking?
  - Yours
  - Others

“DEAD ON” A=Advantages

- What is the vision, benefit (s) and most important desired outcomes?
- What are the specific advantages to patient/<u>others?</u>
  - Benefits/outcomes
- What are the specific advantages to <u>you?</u>
  - Benefits/outcomes

“DEAD ON”
D=Disadvantages

- What could go wrong/what are the risks?
- What are the specific risks for others?
- What are the specific risks for you?
- What problems or issues must be addressed to get results?
- How much work will it take and do you have the necessary resources?

“DEAD ON” D=Disadvantages

- What could go wrong/what are the risks?
- What are the specific risks for others?
- What are the specific risks for you?
- What problems or issues must be addressed to get results?
- How much work will it take and do you have the necessary resources?

“DEAD ON”
N=Now What?

- What problems, risks, or issues MUST be addressed?
- Who will be most affected?
- What professional, community, and informal resources can help?
- Did you miss anything?
- What is the plan
  - What interventions do you need to get results and avoid risks?

Critical Care Development

Supportive practices to promote critical thinking for nurses

- Mentor not dictate
- Keep an open mind
- Work as team
- Problem = action = learning
- Ask questions, no one knows everything
- Thinking process
- Identify personal bias
- Multi-dimensional ways of thinking

Identifying Mind Sets

Fixed Mindset

- Belief that skills, intellect, and talents are set and unchangeable

Growth Mindset

- Belief that skills, intellect, and talents can be developed through practice and perseverance

Identifying Mind Sets

Fixed Mindset		Growth Mindset
I'll stick to what I know. Either I'm good at it or not	**DESIRES**	I want to learn new things. I am eager to take risks.
It's fine the way it is. There is nothing to change	**SKILLS**	Is this really my best work? What else can I improve?
This is a waste of time, there's a lot to figure out	**EFFORT**	I know this will help me even though it is difficult
It's easier to give up. I'm really not smart.	**SETBACKS**	I'll use another strategy; my mistakes help me learn.
This work is boring. No one likes to do it.	**FEEDBACK**	I recognize my weakness, and I know what to fix.
It's easy for others . They were born smart.	**TALENTED PEERS**	I wonder how they did it. Let me try to figure it out/ I will ask.

Case Scenarios

- We will look at how to apply the Critical Thinking and the Nursing Process to these case scenarios.
- By following the Nursing Process we will incorporate Critical Thinking skills.

Case # 1

- 32 yr. Female attempted hanging
  - Vitals: BP=142/88, P=108, R=22, Pulse ox=98% RA
  - Reddened areas to lateral aspects of neck seen
  - Patient is screaming “My neck hurts”

- What other info needed to:

  Assess

  Diagnose

  Evaluate (data)

  Plan

  Implement

  Re-assess

Case # 2

- 38 yr M c/o chest pain while playing basketball
  - Vitals: BP=156/90, P=114, R=22, Pulse ox=96%RA
  - Patient is diaphoretic

What other info needed to:

Assess

Diagnosis

Evaluate (data)

Plan

Implement

Re-assess

Case # 3

- 24 yr F who is 3 months pregnant c/o abdominal pain
  - Vitals: BP=106/66, P=108, R=22, Pulse ox= 97%RA
  - Patient says “I feel like I might pass out”

What other info needed to:

Assess

Diagnose

Evaluate (data)

Plan

Implement

Re-evaluate

Case # 4

27 yr M, 2 inch laceration to inner aspect left wrist

- Vitals: BP=110/72, P=92, R=18, Pulse ox=99% RA
- Patient not providing any other information

What other info needed to:

Assess

Diagnose

Evaluate (data)

Plan

Implement

Re-evaluate

Case # 5

54 yr M stating “I am shaky”

- Vitals: BP=176/102, P=122, R=22, Pulse ox= 97%RA
- Skin diaphoretic
- History of seizures secondary to a head injury
- Arrived to jail 2 ½ days ago

What other info needed to:

Assess

Diagnose

Evaluate (data)

Plan

Implement

Re-evaluate

Case # 6

- 29 yr old F c/o back pain
  - BP=148/90, P=112, R=22, Pulse ox= 97%RA
  - Patient holding right flank/back area

What other info is needed to:

Assess

Diagnose

Evaluate (data)

Plan

Implement

Re-evaluate

QUESTIONS?

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