CHAPTER 3

Nursing Process

This manual provides questions and answers, rationales for the correct and incorrect answers, and references to help you prepare for the CEN examination. As you study, remember that the entire nursing process is an integral part of emergency nursing and, therefore, of the examination.

The steps of the nursing process provide the framework for the essential components of emergency nursing practice. These steps are assessment and data gathering, analysis, planning, intervention, and evaluation. Reassessment has been suggested as another critical step in the nursing process.

Assessment

Assessment is defined as the “systematic collection of data about the patient’s actual or risk for health care problems and needs” (Jordan, 1999, p. 12). Two types of information are included in an assessment: subjective data and objective data.

Subjective data represent information offered by the patient or others. This information may include descriptions of the current health concern or concerns, the patient’s report of past medical history, and events and perceptions surrounding the precipitating event that brought the patient to seek treatment. Caregivers, friends, bystanders, and past medical records may provide subjective data, especially when patients cannot provide such information themselves.

Objective data include vital signs, other physical findings, and nursing observations. Emergency nursing assessment differs from usual nursing assessment in that it begins with a primary assessment. Included in the primary assessment is the determination of the patient’s airway, breathing, and circulatory status (ABCs). If the primary assessment identifies any area of concern, attention is given to correcting life-threatening conditions before the assessment is continued.

Once the primary assessment has been completed and emergent problems, if any, have been identified and addressed, a secondary assessment is performed. Secondary assessment is a systematic head-to-toe examination of the patient in search of signs of illness or injury. Particular attention is paid to areas of concern that the patient has identified.

Both subjective assessment and objective assessment are ongoing processes in emergency nursing throughout the patient’s stay in the emergency setting. Exam questions reflecting assessment may look for the candidate’s ability to ask the right questions, gather the right information, or perform the appropriate exam.
Analysis

When initial data collection has been completed, the next phase of the nursing process calls for the nurse to **analyze** all assessment data in order to identify and prioritize the patient’s actual or potential health problems. Utilizing critical thinking skills and assessment data, laboratory values, and alterations in pathophysiology, the nurse formulates a judgment or conclusion about the patient’s condition.

In essence, the nurse identifies a patient’s problem or problems for which the nurse is held responsible. Although the satisfactory resolution of many health problems requires a collaborative effort—and indeed, nurses are actively involved in the treatment of the patient’s medical diagnosis—medical and nursing diagnoses differ. A nursing diagnosis is based on the priorities of care delivered by the nurse. Multiple nursing diagnoses may be applicable to the patient, but the nurse and patient must prioritize the diagnoses in order to plan care that will be most effective. Possible analysis exam items may list assessment findings in the stem followed by statements such as “the nurse should suspect,” “the nurse’s conclusions are due to . . .”.

Intervention

Analysis leads to the development of a plan of care. In busy emergency settings, it is not unusual for this plan or components of it to be unwritten. It is clear, however, that the nurse must formulate a plan in order to proceed with the appropriate **interventions** for a particular patient. The plan includes the patient’s priorities as well as the nurse’s.

Implementation of the plan follows the priorities already established. The interventions should be patient oriented, goal directed, and based on established psychological and/or physiological principles. The nurse selects interventions based on the likelihood of success in achieving desired outcomes.

Interventions can be independent or collaborative. Independent interventions are those activities that the nurse is licensed to implement and is responsible for implementing, based on the nurse’s education and experience. Collaborative interventions are those activities performed by the nurse in conjunction with members of other health care disciplines. For example, if the patient is experiencing pain, independent nursing interventions might include positioning and anxiety reduction, whereas collaborative interventions might include administration of pain medications. Administration of pain medication is a collaborative intervention because the nurse may not administer the medication until a physician has written an order for it.

The stem of intervention questions may end with “the nurse prepares to,” “the nurse assists with,” “the nurse anticipates the administration of,” “the nurse should not,” or “the nurse should first” followed by a variety of intervention options.

Evaluation

As the plan is being developed and implemented, the nurse must be aware of the outcome that is desired as a result of the intervention(s) to be made. The **evaluation** component of the nursing process is the time when the nurse assesses the attainment of the desired outcome as a result of the intervention(s). The criteria by which the efficacy of the intervention will be measured
should be predetermined as part of the plan of care. Criteria should be outcome focused and based on patient response.

If the interventions suggested for pain relief are implemented, certain outcomes are expected to result; for example, “Patient will experience pain relief within 30 minutes.” Evaluation in this case would consist of the nurse’s reassessment of the patient’s pain status 30 to 40 minutes after the intervention had been made and comparing that to the level of pain experienced before the intervention took place. If satisfactory pain relief has not been accomplished, the steps of the nursing process should be repeated. In this way, additional assessment data, analysis, or interventions as a result of ongoing assessment may lead to a more satisfactory outcome. Both in practice and on the examination, outcomes are not always positive and may identify the need for additional interventions or modifications in the plan of care.

**Reassessment**

Emergency patients should be *reassessed* regularly while they are in the emergency setting. The analysis should be reviewed, and additional independent and collaborative interventions would be implemented if planned outcomes had been achieved or if changes were noted in reassessment. Following these steps, the patient’s response to the interventions would be evaluated once again. The steps of the nursing process should be repeated as frequently as needed to meet the goals established by the patient and nurse.

**Documentation**

All nursing assessments, interventions, and evaluations must be documented. This process allows the nurse to share these findings with other caregivers. It is important to consider all steps of the nursing process in preparing documentation, both for legal reasons and to ensure clear communication to other caregivers.

**Reference**