The Nursing Process, a Tool to Enhance Clinical Care – a Theoretical Study

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Summary

Aim of this project is to gain deeper knowledge and understanding about the nursing process as a tool of ensuring safety and quality in delivering nursing care. The main questions considering this thesis were: can the nursing process be a tool for enhancing nursing care and can the nursing process function as a tool to insure safety in delivering care to the patient? The theory is based on Ida Jean Orlando's Nursing Process theory since Orlando as well as the Finnish Care Classification uses the term 'need' to describe patient problems. Qualitative content analysis was used to find out whether the nursing process has the probability to lead for a better nursing care. The data was consisted of selected articles. The respondent found out that the nursing process has positive effect on both safety and the quality of nursing care by increasing nurses' reflective thinking, promoting effective communication and better quality documentation.

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Sisällysluettelo

Introduction

Ida Jean Orlando describes in her nursing process theory principles of an effective interaction with the patient that lead to effective interventions and most likely to positive outcomes. (Parker & Smith, 2010, 79) According to Orlando it is not enough that the nurse does what she/he thinks is best for the patient's own good. Planning care and carrying out interventions without seeking mutual understanding with the patient is not professional. (Orlando, 1990, 6,8) Since every patient and every nurse is an individual it is understandable that persons taking part in interaction in nursing situations might perceive the situations and each other in a very varying way.

In this thesis I have tried to find out more about the nursing process, the six steps process, that assumable every nurse has heard of. This thesis tries to picture benefits of the nursing process implementation together with the factors affecting to the use of it. Currently in Finland classifications which have been designed for implementation of the nursing process are interesting topic, for example, due to their effect of changing documentation culture to more structured way of writing.

Interest to do this thesis with this kind of topic started when I attended Nordic Nursing Diagnostic course in Oslo year 2011. Nursing students and teachers from seven different Northern European countries were attending intensive course to learn about different nursing classifications used, practice using them and to discuss about the future of nursing diagnostics. After that course I was assured that nursing diagnostics and classification can offer multiple benefits for nursing care and they are something that we also are in need in Finland. Year 2011 I had not heard about FinCC, the classification system based in CCC and developed to Finnish surroundings. FinCC's function is to picture the nursing process and help implementing it in professional practice. (Liljamo, Kinnunen & Ensio, 2012,10). Now, in the year 2014 nursing students are learning how to use that classification system. Hopefully FinCC finds its' way also to practical environment, nursing homes, health care centers, and hospitals. In this thesis I have tried to find out if the nursing process itself can be a tool to ensure safety and quality of nursing care. This was done with help of literature review and qualitative content analysis.

2. Aim and Problem Definition

Aim of this project is to gain deeper knowledge and understanding about the nursing process as a tool ensuring safety and quality in delivering nursing care.

The research questions being:

1. Can the nursing process be a tool for enhancing nursing care?
2. Can the nursing process function as a tool to insure safety in delivering care to the patient?

3. Theoretical Background

The theoretical Framework of this thesis is going to be based on Ida Jean Orlando's (Pelletier) nursing process theory. Orlando's theory uses the term "need" while talking about individuals finding themselves in position of requiring nursing care. Orlando's theory has been tested in various health care settings and the results support its' implementation to practice in various nursing fields. (Schmieding, 2006, 443-444)

The term "need" is also used in structured data system designed by National Institute for health and Welfare (THL). "Need of care" – is one category in the Finnish "structured health and care plan" by THL. It describes problems linked to health that the patient himself can recognize with support from care professionals. These needs that are recognized by patient himself/herself or together with health care professionals are taken into consideration while writing the structured health and care plan. THL reminds that the care plans currently used are not planned to support patient self-activity in the care planning, which brings up the need for development of a national data structures and classifications that can support such an ideology. (THL, 2011, 6-7) The Finnish Care Classification (FinCC) is a classification for structured documentation. FinCC consists of three interrelated terminologies from which one terminology helps to describe patient's need of care. (Liljamo et al., 2012, 10)

The structured health and care plan strives for a patient-centered care, empowerment of the patient, continuity of care and using data systems in care delivery. In the structured health and care plan the needs that the patient himself finds, or can describe with help of healthcare professionals, are considered primary importance. National Institute for Health and Welfare notifies that issues that patient himself does not see as a problem should not usually be mentioned as a need. The structured

health and care plan should function as a tool to find mutual understanding between health care professionals and the patient. (THL, 2011, 12-13, 17)

3.1 The Nursing Process Theory by Ida Jean Orlando

Orlando's nursing process focuses on improvement in the patient's behavior by actions that are based on a patient's needs found through effective interaction with the patient. (Parker & Smith, 2010, 79) According to Orlando when a person is not able to meet the needs that he has, he becomes distressed and is in need of nursing care. Accordingly, the persons that are able to meet their own needs are not distressed, and do not need nursing care. If a patient has ineffective skills to express his/her needs and/or a nurse interprets the patient's behavior incorrectly it can cause distress to the patient. That is why nurse assesses the patient. (Schumacher et.al. 1998. 354, 359) Orlando highlights that it is crucial not only to meet the patient's needs but first of all find out what those needs are. If interventions are carried out before identifying if those interventions give benefits for the patient, nursing is not highly professional. Although all the nursing activities would be planned for the patient's own good, what the patient himself thinks that he needs can be entirely opposite from what a nurse assumes. (Orlando, 1990, 6,8)

When a nurse starts giving care for a patient, an action process begins. This process, where the nurse acts in a nurse-patient contact, is called the nursing process where both the nurse and the patient have their own thoughts, feelings, and opinions from the actual situation. (Schmieding, 2006, 436) Orlando explains that there are two variable types of action processes in the nursing process: automatic and deliberative ones. (Schmieding, 2006, 436)

Perceptions of both; nurse and the patient, need to be available in order for them to act as a reliable base for the nurse's actions. During the process of care the observations from patient behavior -both verbal and nonverbal- help the nurse to assess the level of the patient's distress and the need for help. After this assessment the nurse performs actions to relieve the patient from a distress. After those specific actions the nurse observes the patient behavior again to evaluate the outcomes. If distress is still evident, the process begins again. Orlando's nursing process is then describing a continuous reflective cycle were patient´s role in his own care is crucial. (Schmieding, 2006, 439) Orlando reminds that although how accurate or inaccurate the nurse's perceptions might be, once expressed to the patient, it opens a situation for communication were it is easier for the patient to express his own view. (Orlando, 1990, 45) According to Orlando Nursing process makes it easier

for nurses to see a patient from a nursing perspective. The nursing process helps nursing to function as an autonomic and distinct profession. (Schumacher et.al. 1998, 353, 359)

3.2 Research Supporting Implementation of Orlando´s Theory

Peterson & Bredow (2009, 243) emphasize that following the nursing process and becoming professional in it is not easy; it takes time, needs practice situations, critical thinking skills and often support from a supervisor. Schmieding (2006, 442) mentions several researchers that have used Orlando's Nursing process discipline as theoretical framework and found it useful. Anderson, Mertz & Leonard (1965) found that Orlando's theory promoted stress reduction during admission to surgery. Dumas & Johnson (1972) found correlance with reduced postoperative complications. Pienschke (1973) with suitability of care enhanced with emphatic approach. Wolfer & Visintainer (1975) found deliberative nursing actions being as stress reductive with children and their parents. Thibaudeau & Reidy (1977) found out that using deliberative nursing process affected positively on mothers' treatment commitment. According to Reid (1992) with use of the nursing process increased empathy occurred while taking care of cancer patients. (Schmieding, 2006, 442-443)

4. Literature Review

Terms and topics that are going to be discussed in the following chapter comprise the nursing process, including nursing diagnosis, where CCC, FinCC, and NANDA will be presented as examples of classifications that are based on the nursing process framework. Evidence Based Practice will be reviewed due to its' importance for the quality of nursing care. Orlando highlights the importance of patient participation and the respondent decided to view aspects affecting patient participation. Respondent looked also for more information about aspects that might hinder implementation of the nursing process. These topics were chosen to offer more wide perspective to the nursing process.

4.1 The Nursing Process

Deliberative nursing process is a term that Orlando uses for process where there is ongoing validation of nurse's actions together with the patient. Basically that process consists of four steps that are: patient action, nurse reaction, nurse-patient validation and nurse action. (Schmieding, 2006, 439) Automatic nursing process term describes a process where the nurse's response to the need of help is done according only to the perceptions of the nurse, leaving the role of the patient quite passive in his own care. Automatic nursing process actions are not necessarily wrong or inappropriate but a nurse using the deliberative nursing process in co-operation with a patient is more likely to reach positive outcomes, since the nurse is checking with the patient if the nurse's own views and feelings are correct ones when it comes to patient's behavior, and whether the nurse's actions where suitable and relieving in that certain situation. But while using the automatic nursing process such outcomes are not as likely. (Peterson & Bredow, 2009, 241-244)

One way to describe the nursing process is usually four to six steps linear model. Although steps of the nursing process are going to be viewed separately they are not independent in relation to one another, instead they are extremely interactive, and sometimes overlapping since connections between different steps is needed to answer the patient's needs. (Chabeli, 2007, 77-78) The relationship between different steps shortly explained: *"The assessment data have to be comprehensive, complete, accurate, valid and reliable...The diagnostic statements should be correct for the goals and nursing orders to flow logically for an individual, unique plan for the identified health problems. The goals and nursing orders serve to guide the nurse's actions during the implementation phase and also serve later as criteria for evaluating patient progress".* (Chabeli, 2007, 83)

4.1.1 Assessment

Assessment is a process where the nurse collects information in various ways, for example, by interviewing, observing and taking different measurements. Assessment step helps then discovering the needs of a patient which can then be addressed with proper nursing interventions. Interpretation and evaluation of the data collected is important before drawing any conclusions. Nurse needs to have enough evidence before stating an argument. Here nurse's skill to compare different factors and finding out those factors' value for patient, leading to finding out patient's actual or greatest

problem, demands critical thinking skills. If there is enough trust-worthy evidence nurse needs to be open-minded to adjust path of inquiry rather that following certain routines. (Chabeli, 2007, 77-80)

According to Baid (2006) physical assessment is important tool for nurses to use for collecting knowledge since it can help nurses to recognize any abnormalities. It begins with collecting the health history of the patient. Nurse can interview both the patient and the persons that can have important information, such as, people close to the patient, for example, the parents, a living partner, or people otherwise connected to the patient, for example, an ambulance driver. Information can be collected also from the patient's previous health records. (Baid, 2006, 710)

After coming in a contact with the patient, the nurse starts observing the patient and his/her behavior. Also vital signs should be taken. Information collected helps the nurse to determine how throughout the following assessment should be, meaning is the patient's main problem linked only to one, or couple of the body systems, for example, renal and/or musculoskeletal system, or is general approach, covering all the body systems needed. Methods used in complete physical assessment include inspection, palpation, percussion, and auscultation. (Baid, 2006 710, 712)

Chabeli (2007, 79) discusses that it is crucial that nurses notice special areas that are important, for example, by identifying certain behaviors, learning from even smallest cues, and predicting what will happen in the future. For example, Coombs, Curtis & Crookes (2011, 368) discuss in their article that psychiatric nurses should pay attention to, besides physical health, also to important factors like knowledge about person's social situation, behavior, mental status and situational context as important factors while making an assessment.

4.1.2 Nursing Diagnosis and Classification

Nursing diagnosis is the part of the nursing process were nurse draws conclusions from the assessment data collected before, compares different hypothesis and forms diagnostic statements that describe the patient's needs. Forming a correct nursing diagnosis demands critical thinking skills, scientific knowledge, social skills and multi-sided knowledge about the patient and his situation. (Gouveia Dias Bittencourt & da Graça Oliveira Crossetti, 2012) Important is to realize that only diagnostic title is not enough, Müller-Staub, Lavin, Needham & van Actenberg (2006) claim. Having diagnostic title alone cannot express the patient's problems, since only diagnoses that

are specific in their etiology are the base for choosing correct interventions. (Müller-Staub et al., 2006, 529)

The nursing process can be documented in a structured way with help of structured classifications, for example, with help of FinCC. (Liljamo et al., 2012, 10) Paans, Nieweg, van der Schans and Sermeus (2011) remind that nursing diagnosis itself is not limited to classifications but the conclusions in the diagnostic process made by the nurses need to be documented in a way that is understandable for the colleagues and other healthcare team members alike. With that duty classifications are helpful. (Paans et al., 2011, 2401)

NANDA (North American Nursing Diagnosis Association) is perhaps the most famous one of the standardized nursing classifications. First NANDA version was established in USA in the early 80s and nowadays term NANDA-I (Nanda International) is used to reflect expelling movement of nursing diagnosis and NANDA classification itself in countries worldwide. (NANDA, 2013)

FinCC is a classification for documenting nursing care. It has been available for all health care professionals since year 2008. FinCC has common structure at component level with Clinical Care Classification (CCC) but additional to only translating the classification, FinCC has gone through several pilot studies and user feedbacks which have been retrieved to form a classification that suites needs of patients in the Finnish culture, still keeping chance for an international comparison. (Liljamo et al. 2012, 9) In this thesis the respondent is going to refer to CCC for a closer look of a classification due to CCC's & FinCC's relationship.

CCC was previously named as Home Health Care Classification (HHCC). In the United States of America CCC was one of the first classifications to be noticed by American Nurses Association (ANA) as a supporting tool for clinical nursing. (McCormick, 2007) CCC structure consists of care components, nursing diagnoses, expected outcomes, nursing interventions, action types, and actual outcomes. Care components are factors describing different kinds of issues under several health patterns. Nursing diagnoses are diagnostic statements representing patient problems. Expected outcomes represent future goals of the care given with three concept choices: improve, stabilize or deteriorate. Nursing interventions are single actions that a nurse is responsible for, and that are planned to take care of different patient problems that need nursing care. Action types describe and specify nursing interventions. Actual outcomes are the evaluations of the effects of given care, with same concepts in present tense that were mentioned with expected outcomes: improved, stabilized or deteriorated. CCC follows nursing process and can be linked to its six steps: care components are linked to the assessment step, nursing diagnoses represent the diagnosis part, expected outcomes

represent the outcome identification, nursing interventions are tool for the planning, at the implementation step CCC represents 4 different kinds of action types and the evaluation step is described by actual outcome. (Saba, 2007, 152-155)

4.1.3 Planning

Leach (2008) describe planning as a *"phase of client care, which immediately follows client assessment and diagnosis, but precedes treatment and evaluation, is a projected course of action aimed at strategically addressing a client's presenting problem". (*Leach, 2008, 1729) Planning is important for nursing process, since it is the part where the goals of care (expected outcomes) are formed. Goals should be formulated with an idea that they are fully realistic while considering resources, health care team's skills and most of all, patient's capability and willingness to achieve those goals. (Leach, 2008, 1732)

The nursing process offers systematic framework that helps care planning. (Leach, 2008, 1731) Planning is also ongoing during the whole process. Every time when nurse collects new information and sees how patient responds to care given planning continues. Correctness of steps already implemented is crucial for conducting correct plans. Of course this is presumption also in the whole nursing process. (Chabeli, 2007, 83)

4.1.4 Intervention

"A nursing intervention is defined as a single nursing action…designed to achieve an outcome to a nursing diagnosis, or to a medical action, for which the nurse is accountable." (Saba, 2007) While a nurse chooses an intervention certain questions needs to be answered: does the intervention help the patient to reach the goals and what is the knowledge base for the intervention? In other words: evidence-based practice, experience or just a tradition and routine? The nurse who does the interventions needs also to evaluate the effects of the method chosen for the intervention. (Chabeli, 2007, 83-84)

Suhonen, Välimäki, and Leino-Kilpi (2006) discovered in their literature review concerning effects of personalized interventions that there seems to be a more positive correlation to patient outcomes if nurses make interventions suitable for their patients than if they do routine interventions.

(Suhonen et al. 2006, 856) This demand for individualized care continues the statement for taking patient actively in the consideration in the whole nursing process. Chabeli (2007, 84) also points out that whether or not a nurse has good communication with the patient is connected to the successfulness of the interventions.

4.1.5 Evaluation

Evaluation in the nursing process can be described as an ongoing process within the nursing process. In the whole nursing process during the assessment a nurse evaluates whether or not enough information has been collected to form nursing diagnosis, the nursing diagnoses are evaluated for their correctness, and then goals and interventions are evaluated for their chance to be realistic and reachable. If they are not, plan should be developed or changed. While doing interventions, evaluation is needed to consider if those interventions lead to achieving goals. Evaluation is important since in the absence of evaluation it is almost impossible to know if the care actually helps to meet the needs of the patient. Although intervention would not help patient, the knowledge from evaluating the intervention helps the nurses to develop care. (Chabeli, 2007, 85-86)

If all the steps of the nursing process are not systematically implemented it is a risk for the care continuity. (Baena de Moraes Lopes, Higa, José dos Reis, De Oliveira & Mafra Christóforo 2010, 121) Also according to Finnish law (§12, 2000/653) healthcare professionals must document any information needed for organizing, planning, implementing and following patient's care.

4.2 Evidence Based Practice (EBP)

While nurses make decisions considering patient care they should base their decisions on an evidence. Finnish law on Health Care Act (§8, 2010/1326) states that healthcare acts must be evidence based and also in other ways follow a good care practice. By following an evidence based practice guidelines nurses can find methods to deliver care that are more likely to be linked to a positive patient outcomes. It is crucial that nurses' decisions are based on a research, but nurses must also apply critical thinking skills to see if that evidence suites patient situation in that certain context. While making decisions nurse should use knowledge based on her expertise, patient's individual view, and the research based evidence. (Thompson, Cullum, McCaughan, Sheldon & Raynor, 2004)

Evidence Based Practice has its roots in the Cochrane collaboration, a foundation deeply influenced by British medical researcher Archie Cochrane. He strived for having research result summaries available for doctors and other health care team members. What once started as Evidence Based Medicine has become a movement that considers various parts of health care field in their individual practice. All separate guideline ideologies gather under one "umbrella term" that is Evidence Based Practice. (Polit & Beck, 2008, 30)

Polit & Beck (2008, 28, 30) refine as one of the cornerstones of EBP to be critical thinking. All decisions made that are based on "custom, authority, opinion, or ritual" should be questioned. Decisions should be based on research findings that are integrated into specific individual situation. Evidence to create guidelines of care about a specific situation should be trustworthy, and preferably had gone through confirmation in several studies. After collecting the research results, the results should be evaluated, compared and finally conclusion from them can drawn. Whereas many may think that EBP does not value clinical expertise the situation is quite contrary: EBP strives for applying the best research knowledge together with having individualized care, where clinical expertise ofnurses is helpful. (Polit & Beck, 2008, 28,30) EBP is term for a clinical judgment and decision making according to recommendations found in scientific research. Evidence based practice implemented into nursing can also be called Evidence based nursing (EBN). Scott & McSherry (2008) after doing a literature review using scientific articles about EBN and different ways of defining it come into a conclusion about contents of EBN and gave it a definition as "*an ongoing process by which evidence, nursing theory and the practitioners' clinical expertise are critically evaluated and considered, in conjunction with patient involvement, to provide delivery of optimum nursing care for the individual.*" Scott & McSherry (2008, 1088)

Documentation is a tool for the nursing research to bring new evidence showing the best ways of providing care. At its best it is a base for new knowledge, for development of a nursing practice that provides material to evaluate quality of care given. (Thoroddsen & Ehnfors, 2007, 1826) One way to gain this new knowledge is with help of documentation through a structured classification model. For example, CCC, is a system in which different terminologies interact together making it possible to review, revise and update them. Using standardized system makes it possible to study relationships between nursing interventions and patient outcomes. (Clinical Care Classification System^{TM}, 2012)

4.3 Patient Participation in The Nursing Process

According to the act on the status and rights of the patients (1992/785), patients have the right for a good health care and their individual needs need to be taken into consideration while caring and medically treating the patient. (§3, cl.2) The Finnish legislation also informs that patient's treatment should be done in mutual understanding with the patient. (§6 cl.2)

Patient participation means active involvement of the patient in his own care at every aspect. This process is highly dependent on the nurse, if the nurse takes the patient as an active partner to decision making and planning of the care. (Larsson, Sahlsten, Segesten & Plos, 2011, 575). Eldh, Ekman & Ehnfors (2006) write that to provide situations for the patient to truly participate in the decision making in his own care professionals must value the knowledge that the patient has about his/her unique situation, since only inviting patient to participate in decision making does not guarantee successful care planning where also the patient is active. Larsson et al. (2011,580) continue by saying that nurses' should distribute power that they have on patients by enhancing communication with the patient and by setting goals together with the patient. In this way participation can be achieved.

Respect is important factor for successful communication that is base for trust between patient and the nurse. (Eldh et al. 2006, 511) Communication in caring relationship is important aspect for providing environment where patient can truly participate in his own care. Through effective communication the goal is to get patients more involved in their own care to meet their needs. One must notify that sometimes needs of the patient might differ from the expectations of the nurse or the organization. (Sahlsten et al. 2005, 40)

Larsson et al. (2011) refer to Joffe, Manocchia, Weeks & Cleary (2003) who found out in their research that having patients to actively participate in the own care led to: more motivated patients, better results from the care and better patient satisfaction. Larsson et.al (2011) mention also research by Sainio, Lauri & Eriksson (2001) were patient participation were found to be connected with decreased fear, insecurity and anxiety levels.

Patient participation in his the care can be enhanced in many ways, for example, Sahlsten et al. (2005), write about 4 aspects needed for successful patient participation: interpersonal procedure, therapeutic approach, focus on resources and opportunities to influence. In interpersonal procedure where through dialogue between nurse and the patient mutual interaction can be achieved when opinions and thoughts of both participants can be discussed. Therapeutic approach describes

methods that the nurse uses to form a professional caring relationship with help of reassurance, empathy, keeping the professional distance and acknowledging nurse's own attitudes. With focus on resources the nurse tries her/his best to get to know patient's individual resources and comparing them to caring needs that patient has. This should be done carefully together with the patient and possible significant others, and in the end ensuring that all persons taking part have understood each other correctly. The last aspect is opportunities to influence through the information exchanged. (Sahlsten, Larsson, Lindencrona, Plos, 2005, 37-39) According to Eldh et al. (2006) two factors influencing patient participation where knowledge and respect. Knowledge included that patient felt that information was given in a way that it was easily to understand and relevant for his situation. With respect aspect nurses needed to be willing to listen to the patient and reflect to that information, see patient as an individual rather than an anonymous object with a disease. (Eldh et al. 2006, 511-512)

According to Eldh et al. (2006) factors that inhibit patient participation include lack of knowledge and lack of respect. Lack of knowledge was experienced as information giving where patients' individual situation where not taken into consideration while giving information. In that situation patients did not fully understand relevance of the information given. Non-participation easily occurred also in situations where patients felt that their individual knowledge and view about their condition where not paid attention. This included also the patient feeling i.e., they were treated more as an object rather than a subject. (Eldh et al. 2006, 509-510) According to Larsson et al. (2011, 575) main factors to contributing to nonparticipation in nursing care from the point of patients where facing own inability, meeting lack of empathy, meeting a paternalistic attitude towards the patient and/or sensing structural barriers

Structural barriers are *"barriers patient perceive in the design of the care which undermine their opportunities to exert control and influence"*(Larsson et al., 2011, 578-579) More specifically patients described these barriers as a problems like insufficient documentation, feeling that there is no specific nurse to turn to, and situations where their wishes were not heard. With the term facing own inability is described situations where patients are not in control of the situation and do not want to participate. If nurse had lack of empathy it will not encourage patient to participate and the patient may feel that he or she has been left unnoticed. Nurses that had paternalistic attitude view that they knew what is beneficial for the patient. This makes them insensitive for patient's own view about their situation, which instead does not encourage patients to participate. (Larsson et al. 2011, 578-579)

4.4 Challenges While Implementing The Nursing Process

 Peterson & Bredow (2009, 243) highlight that the nursing process discipline demands critical thinking skills from nurses; the same opinion is shared by many other researchers. Huckabay (2009, 72) informs that every part of the nursing process demands a nurse to think critically and derive conclusions correctly. Without thinking critically inaccurate or inefficient information can cause inaccurate nursing diagnosis. Huckabay (2009) continues by saying that gathering *"the information, facts, observations, data and experiences to make a nursing diagnosis requires that the person engage in inductive thinking [one aspect of critical thinking]"*. Huckabay (2009, 76) This idea is also found in Orlando's theory since, for example, Orlando states that every patient is a unique oneand different patients can signal with same kind of behavior totally different needs. Orlando's theory highlights that it is professional nurse's responsibility to recognize the patient's actual need. (Schmieding, 2006, 435)

Baena de Moraes Lopes et.al. (2010, 118) bring up that the nursing diagnoses step is most often the biggest barrier to successfully implement the nursing process in the practice. Implementing the nursing process and specially forming correct nursing diagnoses is challenging. Normally nursing diagnosis should consist of four parts: label, definition, signs and symptoms, and related factors. (Lee, 2005, 641) Many nurses can identify patient problems but the process where problem is made clearer and the ideas are being formed and finally the practice change needed is done can be difficult to achieve. (Lusardi, 2012, 55). In the study by Paganin, Moraes, Pokorski & Rabelo (2008) conducted in a university hospital in Brazil, they tried to find the main reasons affecting the implementation of specifically nursing diagnosis. The result was that 48% of the nurses that took part to the research thought that there was lack of practice in implementation of nursing diagnosis. (Paganin et al., 2008, 154)

Paganin et al. (2008, 155) consider that using a standardized model for the nursing process that could be implemented in practice would make it easier for implementing also the nursing diagnoses part. Baena de Moraes Lopes et.al. (2010, 121) found out that sometimes nurses view the nursing process only as a documentation activity. Researchers mention that sometimes there is tendency from nurses to document only nursing interventions not mentioning nursing diagnoses. This can lead to inaccuracy in care given since if the nursing process is not followed in a proper manner, the nursing diagnoses are not guiding the interventions. (Baena de Moraes Lopes et.al. 2010, 121)

Situational factors can also inhibit the implementation of the nursing process-and as a consequence also implementing nursing diagnosis. These include, for example, lack of time, and lack of support

from colleagues (Lee, 2005,644). Personal abilities hindering the correct implementation of the nursing process include: lack of preparedness or knowledge about the nursing process or some parts of it, as mentioned before. (Baena de Moraes Lopes et.al 2010, 118, Lee 2005, 645)

Scherb et al (2011) and Müller-Staub, Needham, Odenbreit, Lavin & van Achterberg (2008) claim that only implementation of certain classification is not enough, also special education is needed. Müller-Staub et.al (2008) state that nurses do not need only skills of practical work but also skills to critically evaluate patient needs, interventions and their effects. Orlando states that it is not only nurse's own observations and actions that nurse needs to evaluate; instead nurse needs to be aware of, other nurses' and actions that are also seen in documentation. (Orlando, 1990, 31)

It is presumable that good documentation quality, especially in cases where the nurses use structured language that has been agreed on make the reports clearer and patient care more efficient and effective according to Jones, Lunney, Keenan and Moorhead (2011, 255). Opinions from usability of not standardized way of documentation, compared to standardized classification cause discussion. For example, Müller-Staub (2009, 12) arise question about correctness of documentation without standardized classification, after research and implementation program of NANDA system in her study she concludes that from study material that she retrieved pre-implementation and which had been written in freestyle without standardized classification the correct symptoms were not often found, nor where the interventions and outcomes correctly documented. Müller-Staub (2009) claims that without standardized structure in documentation (classifications) it is challenging to discuss about clinical problems: nursing phenomena with a good quality. She also adds that results that she has analyzed show that *"the use of nursing diagnoses improved the quality of the documentation of patient assessment and the identification of commonly occurring diagnoses within similar settings"*, referring to NANDA. Müller-Staub (2009, 11) According to Müller-Staub et.al (2006,527), who after completing a systemic review about effects of nursing diagnostics want to point out that compared to a freestyle documenting nursing classification offer language that is based on a theory and that it is already professionally accepted.

5. Methodology

This section is a review of the data collection and method of data analysis as well as the ethical aspects. Data material will be collected through a literature review. After the data collection, material is going to be analyzed with the help of qualitative content analysis. This method was

chosen due to its' flexibility considering this use: various sizes and types of data, also including articles, can be handled for bringing up new evidence or information. (Elo & Kyngäs, 2007) In this thesis data to be analyzed is retrieved from scientific articles related to nursing science.

5.1 Data Collection

Data search was done with help of CINAHL with Full Text. CINAHL is a database consisting of numerous nursing journals. (EBSCO Industries Inc., 2012) Keywords used to search for articles for literature review included: *"nursing process approach"*, *"nursing process application"*, *"effect of nursing process"*, *"implementation of nursing process"*, *"applying nursing process"*, *"use of nursing process"*, and *"nursing process"*.

Those search words were combined separately with variety of other words, for example: *"enhancing"*, *"care situation"*, *"better care"*, *"practice"*, *"developing care"*, *"evaluation of intervention"*, *"the impact of"*, *"quality improvement"*, *"clinical decision making"*, *"results"*, etc.

Search criteria for articles chosen were that they were newer than 10 years, written in English and had Full text available. Some articles mentioned were older than 10 years but still considered to be relevant for today and giving enhanced background. One of the articles chosen for the review was 11 years old, but it was seen as information rich and up-to-date.

5.2 Qualitative Content Analysis

Polit & Beck (2012, 564) describes qualitative content analysis as a method which *"involves breaking down data into smaller units, coding and naming the units according to the content they represent and grouping coded material based on shared concepts"*. Qualitative content analysis a tool to describe phenomena, learn to understand and identify different processes and build new knowledge bases. (Elo & Kyngäs, 2007)

Qualitative content analysis can be conducted inductively or deductively. This thesis will be carried out inductively: units of information-categories- will be formed from specific smaller notifications that have something in common. The inductive process consists of three parts that are: preparing, organizing and reporting. The preparation consists of choosing the material for analysis. Then

analysis consist of trying to find meaningful units of information in the material, and marking them. Organizing data is done by dividing those smaller units of information into groups that have something in common, also called forming subcategories. After dividing the information into subcategories, it is the time to form larger categories, which will include all the subcategories that have something in common. The analysis process will, finally, be follow by the results. (Elo & Kyngäs, 2007)

In the preparation part, the respondent first chose material to be analyzed, in this case, articles. Articles were read through several times to find out the most meaningful units of information, distract those from the original text, and analyze them to find central meanings. All those units of information were, consequently, combined together to find out similarities. Similar units of information formed the first subthemes and then emerged as themes.

5.3 Ethics

While writing the thesis the respondent needs to be committed to absolute honesty and carefulness when it comes to selecting and presenting another author's work or the respondent's own plans, methods and final results. Forms of dishonesty include fabrication, falsification, plagiarism, and misappropriation. Fabrication means that the presented results are not real, or that the results have not been accomplished in the described manner. Falsification means that the data material is misinterpreted, so that results do not correspond with original reference. Leaving out crucial data material that would affect the results is considered falsification. Plagiarism refers to the process of using material produced by some other party and presenting it without correct references. There is no difference between direct citations or paraphrasing- it still constitutes plagiarism. Misappropriation entails that the author claims to be the legal author of someone else's creation. (Finnish Advisory Board on Research Integrity, 2012, 32-33)

For this thesis process to be ethically acceptable and valid, the respondent needs to be committed to guidelines for responsible writing in order to reach research integrity. In practice this means that the respondent needs to respect other authors' works that the respondent decides to use, handles their results correctly, gives appropriate value to those results and gives correct references while citing their work. The respondent is also committed to honesty and transparency at every step of the process, whether it comes to prescribing used methods, or to collecting and handling the data, or to

finally presenting and evaluating the results. (Finnish Advisory Board on Research Integrity, 2012, 30)

Important factor also to consider before starting and conducting any study, including also thesis writing is that it brings no harm and gives benefits. While talking about benefits the target population can be participants themselves, certain category of people and/or society as a whole. (Polit & Beck, 2008, 170) While conducting this specific study that is connected to nursing and documentation what the respondent hopes is that information collected would be useful for the respondent herself as a future graduated nurse, but even more for the nursing field.

6. Presenting the Results

The chosen articles were analyzed with the help of qualitative content analyzes. The fourth article chosen were read through several times to get an idea of the articles' nature. Next time the articles were read through more carefully while thinking of the research questions of the thesis to find out the most meaningful sentences. These sentences were then marked, written again on a separate sheet of paper. These statements were then read again compared to each other. As result of comparison groups with similar content were then formed. Every group needed to have citations at least from two different articles. These groups formed then subthemes that later on were gathered under larger themes based on similarities in the content. In the following when presenting the themes and subthemes quotations are used for visualizing the content. Themes that emerged were "Individual care", "Increased effectiveness" and "Safety" which were all considered to be part of the quality of nursing care. The themes, "Safety" and "Individual care" also included subthemes

6.1 Descriptions of The Articles Used for The Data Analysis

Figure 1

Author(s)	Year	Article	Description of the articles aim and methods
Björvell, Wredling & Thorell-Ekstrand	2003	Improving documentation using a nursing model	This article aims at discovering nurses' opinions about documentation intervention program in Sweden. Focus group interviews and qualitative content analyses were used to process the data.
Hansebo & Kihlgren	2004	Nursing home care: changes after supervision	Researchers aim is to investigate nurses' approach to their patients after supervision based on the nursing process and implementation of assessment instrument. Several different data collection methods were used to collect data, for example, video recorded care situations, and questionnaires. The data was analyzed with help of qualitative and quantitative methods.
Florin, Ehrenberg & Ehnfors	2005	Quality of Nursing Diagnoses: Evaluation of Educational Intervention	Researchers purpose is to investigate effects of the nursing process education and new forms for recording to quality of nursing diagnoses statements. The method was quasi-experimental pre- and posttest design.

Axelsson, Björvell, Mattiasson & Randers	2006	Swedish Registered Nurses' incentives to use nursing diagnoses in clinical practice.	Aim was to find out opinions of nursing diagnoses from nurses who used it on daily basis. Researchers used semi-structured interviews to collect qualitative data that was then analyzed with help of qualitative content analysis.

Figure 2.

Author(s)	Year	Article	The main results
Björvell, Wredling & Thorell-Ekstrand	2003	Improving documentation using a nursing model	A structured model for documentation may increase nurses' reflective thinking and lead to a better focus in nursing.
Hansebo & Kihlgren	2004	Nursing home care: changes after supervision	The nursing process lead to seeing patient as an individual. Assessment step was seen as valuable in improving quality of care.
Florin, Ehrenberg & Ehnfors	2005	Quality of Nursing Diagnoses: Evaluation of Educational Intervention	Quality of nursing diagnoses improved after the intervention.
Axelsson, Björvell, Mattiasson & Randers	2006	Swedish Registered Nurses' incentives to use nursing diagnoses in clinical practice.	Multiple possible aspects from using nursing diagnoses were named.

6.2 Individual Care

The respondent finds it evident that without care that is planned for each individual according to his/her needs, it is impossible to reach nursing care of good quality. The theme "Individual care" was further divided into four subthemes: "Involving patients", "Patient as a individual", "Specific interventions", and "Approach to patients".

6.2.1 Patient as an individual

The nursing process helps nurses to visualize the individual needs of the patients. Evidence was found that shows that the nursing process, or in some cases certain parts of the nursing process, was useful for nurses to see patients differently, as unique individuals, with different capabilities and needs.

"Nursing diagnosis was thus regarded as a tool, beneficial for planning individual care." (Axelsson, Björvell and Mattiasson, 2006, 942)

"The nurses in the present study emphasized that recorded nursing diagnoses was a tool to visualize and communicate the patient's individual needs." (Axelsson et al., 2006, 942)

"Carers sought information which they had not paid attention to or bothered about before the intervention, and more of patients' capacity and interests were considered." (Hansebo & Kihlgren, 2004, 275)

"The family situation and relatives were more in focus and after the intervention carers stressed more explicitly the importance of facilitating patients' capabilities." (Hansebo & Kihlgren, 2004, 273)

The nurses did not only consider patients, their capabilities and problems, but the nursing process led to a deepened understanding of the patient's specific situation.

"Furthermore they claimed that another aspect of patients was seen, and a better understanding gained gained of different behaviours." (Hansebo & Kihlgren, 2004, 275)

*"A deepened understanding of the patient's specific situation…was described." (*Björvell, Wredling & Thorell-Ekstrand, 2003, 405)

6.2.2 Approach to patients

Two articles described how the following nursing process demanded a more meaningful interaction with patients. The nursing process also seemed to help nurses notice the meaningfulness of collecting information, and helping them in the data collection.

"The interviewed nurses reported an increased interaction with the patient, as they required more thorough knowledge of the patient's situation to identify and formulate nursing diagnoses." (Axelsson et al., 2006, 942)

*"The participants described that they listened carefully to the patients in order to understand their needs, accordingly the nurses asked the patients more questions and made sure that they had understood the patient's view of his situation and needs." (*Axelsson et al., 2006, 939)

"They used a more structured and thorough approach when assessing or communicating with patients." (Björvell et al., 2003, 405)

6.2.3 Involving the patient

The nursing process motivated nurses, not only to collect more information through interaction, but also to encourage more active patient participation that may lead to more safety in the process of delivering the care.

"Their approach was to involve patients more in activities of daily living, but also in decision-making in contrast to previously, thus illustrating efforts to interpret verbal – as well as non-verbal communication." (Hansebo & Kihlgren, 2004, 274)

"The participants indicated that using nursing diagnoses increased patient participation, and contributed to a holistic view of the patient's situation" (Axelsson et al., 2006, 942)

6.2.4 Specific interventions

Care that strives to notice a unique individual, entails the consideration of actions that better suit for that his/her needs and capabilities.

"The participants stated that when identifying nursing diagnoses they decided on more specific nursing actions than would otherwise have been considered." (Axelsson et al., 2006, 942)

"Patient's needs were reported as being more precisely described, and hence more visible and leading to more specific nursing interventions." (Björvell et al., 2003, 405)

6.3 Increased Effectiveness

The nursing process seems to have a positive effect on other aspects than just direct patient care. These can all be described as factors that increase the quality of nursing care.

"Recorded nursing diagnoses were perceived as timesaving." (Axelsson et al., 2006, 940)

"...nursing diagnoses were reported to be a useful instrument for the head nurse to estimate nursing workload." (Axelsson et al., 2006, 941)

"Increased effectiveness in organizing their jobs was described by some of the participants" (Björvell et al., 2003, 405)

6.4 Safety

The theme included two subthemes that emerged from the material: "Documentation quality" and "Increased reflective thinking". Both of these aspects can be considered as factors that have a direct effect on safety and the quality of care. The lack of good quality documentation obstructs continuity of care which endangers safety. But only thoroughness and good structure in documentation are not enough when considering safety of patient care. Reflective thinking is an evident part of this, as evaluation is done to ensure correct decision making.

6.4.1 Documentation quality

All four articles analyzed reported increased documentation quality. This was considered to happen due to nurses' need to consider patient situations according to nursing process.

"The quality of nursing diagnoses improved in the experimental unit." (Florin et al., 2005, 39)

"The diagnostic level was found to increase and more specific diagnoses were stated after the intervention... The frequencies of specific diagnostic statements doubled, whereas the frequency of simple problem statements decreased 50%." (Florin et al., 2005, 38)

"Following the intervention… the main finding was that carers gave fuller, more detailed accounts of their patients after the intervention." (Hansebo & Kihlgren, 2004, 273)

"The main change after the interventions a nursing care plan was written for all patients based on a complete assessment." (Hansebo & Kihlgren, 2004, 273)

Carers also stressed that good documentation is needed to continue the given care, so that one runs a smaller risk of forgetting important data.

"Increased safety as a consequence of the documentation was mentioned in all three groups… not having to rely on another person's memory to tell you all you need to know." (Björvell et al., 2003, 406)

"Identification of nursing diagnoses was perceived to increase quality of nursing care by decreasing the risk of missing any of the patient's needs and hence missing adequate interventions." (Axelsson et al., 2006, 940)

"They stressed that this made it easier for colleagues to promote continuity of care, by discovering the motivation behind the reason for the prescribed interventions." (Axelsson et al., 2006, 942)

6.4.2 Increased reflective thinking

Nurses in two of the studies stressed the importance of reflective thinking for quality of care; without that kind of evaluative behavior nurses could not be sure if the care answers to the patient's needs. Reflective thinking is also linked to correct and good-quality documentation.

*"The increased reflective thinking was described as vital to ensure quality nursing car*e." (Axelsson et al., 2006, 941)

"If a nursing diagnosis was present in the record, the nurse was reminded that she at all times, had to evaluate its presence. By doing so, she automatically evaluated the effects of given nursing care." (Axelsson et al., 2006, 940)

"The participants stressed that using nursing diagnoses increased their reflective behavior when analyzing causes and consequences of the patient's problems and needs." (Axelsson et al., 2006, 941)

"They described how they were forced to think more about the specifics and how to name them correctly." (Björvell et al., 2003, 405)
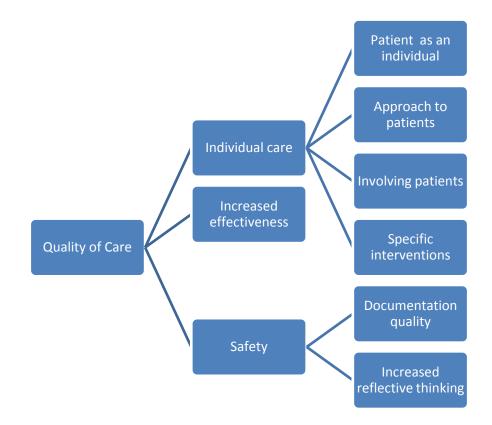

Figure 3. This table illustrates the relationships between the themes and the subthemes.

7. Critical Review

The respondent needs to be honest while considering the literature review material and say that more articles would have added trustworthiness to her work. One should also acknowledge that the choice of an 11-year-old study breaks the criteria of material selection applied to study. The respondent still thinks that that article is relevant since it more focused on nurses' attitudes and thoughts about usefulness of nursing diagnosis, instead of very specific part of care, for example, documentation models, that are always evolving. Unfortunately articles rich in data for this project considering FinCC, CCC, or nurses' attitudes towards nursing process here in Finland could not be found.

Carrying out the project alone has caused problems of its own. The literature review in particular forced the respondent to carefully consider whether her own impressions were justified. The respondent still trusts that her major conclusions can be agreed upon also by third parties. The supervisor's external view and comments has been valuable, to support the respondent's input on data and arguments.

8. Discussion

The content analysis showed that the nursing process can be linked to various positive aspects of the way nurses deliver nursing care. Finding that the nursing process deepens the nurses' understanding about patients' specific circumstances and helps them to more throughout data collection are supported also in systematic review of articles by Müller-Staub et al. They found out that nurses who used nursing diagnostics began to understand and appreciate their patients more, this leading to better assessment skills while communicating with the patient. (Müller-Staub et al., 2006) According to Orlando, it is crucial to not trust only your own prejudices and first impressions. (Schumacher et.al. 1998. 359)

The respondent linked quality of documentation and reflective thinking as subthemes under theme "Safety" due to their relevance for continuity of care. Both are needed together to evaluate if care given reaches its' goals. Continuous evaluation process instead can be seen as a way to support continuity of care which is one important aspect in safe delivery of care. This idea is also found from Orlando's nursing process theory were she stresses how important is to have continuous evaluation and interaction process together with patient so that nurses can decide upon correct nursing interventions. (Schmieding, 2006, 439)

This paper outlines how more effective interaction, and improved documentation of the nursing process, caused reflective behavior among the nurses and helped them to choose more suitable nursing interventions. Orlando has described that effective interaction is crucial for finding out patient's needs and a key for an improvement in the patient's behavior. (Parker & Smith, 2010, 79) It can help to choose more suitable interventions, and to involve patients in their own care. When considering the aim of this study and the research questions, the respondent concludes that it seems that the nursing process can be a tool to enhance nursing care, since each of the aspects like, safety, how effective is care giving or how well each individual is taken into consideration affect the quality of care and its continuity. The respondent's conclusion is that it is highly likely that nurses

with help of nursing process are supported in their decision making process and interactions with the patient in a way that it enhances the quality of care.

The respondent claims that the person-centered nursing process model would be a good tool for nurses to get to know their patients and the patients' needs. At the same time the respondent notices a demand for more studies about this area of nursing care: the nursing process and its application to practice. We are familiar with this fact already that the nursing process seems to be beneficial for practice, yet more research about the nursing process and its classification could potentially work as guideline to enhance patient care.

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