

REPORT OF AN EXPERIMENT WHICH USED A CLINICAL CASE TO ENCOURAGE THE NURSE'S CLINICAL JUDGMENT AND CRITICAL THINKING FOR DECISION MAKING AND ACCURACY IN DIAGNOSES, INTERVENTIONS, AND OUTCOMES (NNN).

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Introduction: Both in practice and education there is an agreement among experts that the nursing process application allows for the foundation of critical thinking skills required for a safe and efficient professional life. Our world, with its previously established treatment plans, has not been a substitute for the need to know the nursing process. Instead, meeting patterns and showing independent and proactive thinking in order to ensure a competent and individualized care require thinking habits developed by the use of the nursing process's principles and rules. This process – a systemic and dynamic way to offer nursing healthcare - encompasses five interconnected steps: *investigation, diagnosis, planning, implementation, and evaluation*. Basic to all nursing approaches, the nursing process provides for a humane and outcome-focused care. It also encourages the nurses to continuously investigate and study their practice to make it better (LeFevre, 2005). Nurses are committed to the identification of accurate diagnoses as a basis for treatment planning. They work with the patient as a collaborator to promote healthy responses, and to identify and control problems and risk situations. Critical thinking is introduced as an element of the nursing intellectual mind, also working as a guide to diagnostic thinking. The associated analyses and comments provide for enriching resources to learn the complex diagnoses for human responses, and the thinking strategies to deal with these complexities, as well (Lunney, 2004). **Objectives:** To identify the main diagnoses and select the most relevant diagnosis, according to the study group, and also the nursing interventions and the nursing outcomes identified for an hypothetical clinical case, based on the North American Nursing Diagnosis Association (NANDA), the Nursing

interventions classification (NIC), and the Nursing outcomes classification (NOC) during teaching activities by a nursing Consultant in the *Great São Paulo*. **Methodology:** descriptive study, with a quantitative approach. Data were collected in April and May, 2007 when this investigation was carried out by study groups, with a 90-participant sample. The case study involved Mrs. M.P., 80 years old, after undergoing a traumatic brain injury (TBI), a fall consequence which evolved into somnolence, with response to pain stimuli, right hemiplegia and left hemiparesia. She had NEL (nasogastric tube) diet every 3 hours, and saline by central venous catheter, with good infusion. Maintenance of oxygen catheter at 3L/min. She had productive cough which needed aspiration of the upper airways. Diuresis noticed in diaper. Perceived soft bowel movement. Pressure ulcer, stage II in the sacrum. From data collection we tried to identify the nursing diagnoses, interventions, and outcomes, by interacting with the patient to achieve the same objectives. **Results:** The following nursing diagnoses were identified: Ineffective Tissue perfusion: Cerebral; Nutrition, deficient: Less than the corporal needs; Impaired Urinary Elimination; Diarrhea; Constipation; Impaired physical mobility; Ineffective respiratory pattern; Acute confusion; Risk of infection, and Ineffective protection. Impaired physical mobility was the selected diagnosis because it was the only nursing diagnosis described with the highest percentage in all performed activities. In this case, Impaired physical mobility was characterized by Limited capacity to perform gross or fine motor skills; Uncoordinated movements; Limited range of motion; Difficulty to turn herself; Decreased reaction time; Slow movements; Movement-induced shaking related to Medications.; Prescribed movement limitation; Uneasiness; Pain; Sensory-perceptive and cognitive impairment; Musculoskeletal impairment; Activity intolerance, and Decreased resistance and strength; Depressive mood or Anxiety; Decreased strength, control and/or muscle mass; Joint stiffness or contractures. The nursing interventions for these diagnoses were Exercise Therapy: Muscle Control; Exercise Therapy: Joint Mobility; but the nursing activities next described are related to Exercise Therapy: Muscle Control. They

include: To Determine the patient's readiness to engage in an activities or exercise protocol; to Consult with a physical therapist to determine an optimal patient position during exercise, and the number of repetitions for each movement pattern; to Assess sensory functions (e.g., vision, hearing, and proprioception); to Explain the justification for each and every exercise, and the protocol for the patient/family; to Begin pain control measures before the exercises/activity; to Help and maintain the stability of the proximal joints during motor activity; to Reassess the need for regulatory mechanisms, at regular intervals, with the physical therapist and the occupational therapist; to Help patient to sit/stand for exercise protocol; to Help patient develop an exercise protocol for strength, persistence, and flexibility; to Help patient to set realistic and measurable aims; to Use motor activities which require attention to both sides of the body and their use; to Encourage patient to practice exercises independently, as indicated; to Monitor the emotional, cardiovascular, and functional responses to exercises; to Evaluate patient's progress toward the increase/recovery of movements and body functions. Mobility level was identified as the nursing outcome, defined as the capacity to move purposefully, for the nursing diagnosis Impaired physical mobility, because it encompasses everything related to the previously mentioned nursing treatments. The identified indicators show that the patient is dependent/does not participate, a long-persisting condition due to her severe neuromuscular compromise. The identified indicators include: Balance performance, Body positioning performance; Muscle and joint movement; Transfer performance; Deambulation: walking and wheelchair. These indicators guide all nursing activities.

Conclusions: The critical thinking process can be continually improved along time. It is also required for an optimal effective and efficient nursing care, mainly for complex and very slow health scenarios. This study allowed us to improve the scientific body of knowledge, and played its part for an individualized nursing care, based on the NANDA, NIC and NOC theoretical framework. Its importance was also evident in the thinking process and the decision-making process to help people to achieve positive health outcomes and emphasize negative outcomes as

well. It is worth noticing here the different levels of nursing competence, from the novice, advanced novice, competent, proficient, and specialist (Benner, 1984), along with the different interpretations of the clinical situations and perceptions of the holistic dimensions.