**NURSING PROCESS**

**Definition:**

Is a systematic and dynamic method of problem solving approach.

It is a systematic, problem solving approach toward giving individual nursing care that focuses on identifying and treating unique responses of individuals or groups to actual or potential alterations in health.

It involves the application of critical thinking to client care activities.

It allows nurses to communicate plans and activities to clients, other health care professionals and families

It encourages orderly thought, analysis, and planning.

It is specific to nursing.

**Process**

A series of steps or acts that lead to accomplishment of some goal or purpose

**Advantages of the Nursing Process**

1. Provides individualized care
2. Client is an active participant
3. Promotes continuity of care
4. Provide more effective communication among nurses and healthcare professionals
5. Develops a clear and efficient plan of care
6. Provides personal satisfaction as you can see client achieve goals
7. Professional growth as you evaluate effectiveness of your interventions

**Purpose**

Is to provide client care that is:

* Individualized
* Holistic
* Effective
* Efficient

Nursing process is central to nursing actions

It is an efficient method of organizing thought processes for clinical decision making and problem solving

Provides framework within which the individualized needs of the client, family and community can be met.

Ensures that care is planned, individualized and reviewed over period of time that patient and nurse have a professional relationship.

Why do we need to plan care?

Patient has a right to expect to receive complete and high quality care. Gaps will exist if care planning is not done.

Care planning and its documentation provide and promote means of professional communication.

Care planning provides a comfort level for providing ready reference to help ensure that care is complete.

Provide a guideline for documentation and promotes practice within legally defined standards.

Care planning provide legal protection of the nurse

The accreditation status of health care agency, can depend on consistent documentation that planning of care has been done.

**Characteristics/Properties of Nursing Process**

1. It is a framework for providing nursing care to individuals, families and communities.
2. It is orderly and systematic (assessment, diagnosis, outcome identification, planning, implementation, evaluation).
3. Dynamic (continuous change)
4. Interpersonal and collaborative (interactive and reciprocal relationship between nurse and patient)
5. Flexible (can be adapted to nursing practice, phrases may be used sequentially or concurrently)
6. Theoretically based (derived from a broad base knowledge….Science and Humanities)
7. Goal oriented
8. Universally applicable.
9. Interdependent.
10. Provides specific care for individuals, families and communities
11. It is client centered, using the client’s strength.
12. It is appropriate for use throughout the lifespan.
13. It can be used in all settings.

**Differences between Medical Process and Nursing Process**

|  |  |
| --- | --- |
| **Medical Process**  | **Nursing Process** |
| Identifies conditions the medical officer is licensed and qualified to treat | Identifies situations the nurse is licensed and qualified to treat. |
| Focuses on illness, injury or disease process | Focuses on the client’s responses to actual and potential health life problems. |
| Remains constant until a care is effective | Changes as the client respond to care. |
| Examples of Diagnoses:Chronic obstructive pulmonary diseaseCerebrovascular accidentAppendectomyAmputationStrep Throat | Examples of Diagnoses:Ineffective breathing patternActivity intolerancePainBody image disturbanceRisk for alteration of body temperature |

**Phases of the Nursing Process**

1. Assessment
2. Diagnosis
3. Planning
4. Implementation
5. Evaluation

Application of the nursing process in the provision of quality nursing care.

Nursing process is dynamic and requires creativity in its application.

Steps remain the same

Application and results are different.

Used throughout the lifespan in any care setting.

**Step #1 ASSESSMENT**

Is the systematic collection of data

It begins with the nurse’s first contact with the client and continues as long as a need for healthcare exists.

During assessment, the nurse collects information to determine areas of abnormal function, risk factors that contribute to health problems and client strengths.

It involves:

1. Collecting data (from variety of sources)
2. Validating data – act of “double checking or verifying data to confirm that it is accurate or factual.
3. Organizing the data
4. Interpreting the data: relevant versus irrelevant, bridging gaps that may arise, identifying patterns that have resemblance.
5. Documenting the data.

**Goal of Assessment**: establishing a data base about the client’s response to health concerns or illness.

The assessment techniques are basically 4:

1. Interviews
2. Physical examination
3. Observation
4. Laboratory investigations

**Types of assessment**

1. Comprehensive assessment
2. Focused assessment
3. Ongoing assessment
4. **Comprehensive assessment**

Provides the baseline data for continued evaluation.

Is physical and psychological

Is the initial information about the client’s physical, emotional, social and spiritual health. It is lengthy and comprehensive.

Nurse obtains data base information during the admission interview and physical examination.

Information obtained serves as a reference for comparing all future data and provides the evidence used to identify the client’s initial problems.

Comparing of ongoing assessments with baseline data helps determine whether the client’s health is improving deteriorating or remaining unchanged.

1. **Focused assessment**

Limited in scope

Involves screening for a specific problem.

It is short stay

It gives information that provides more details about specific problems and expands the original data base. e.g. During the initial interview the client tell the nurse that “constipation is the rule rather than the exception.” More questions follow. The nurse obtains data about:

* The client’s dietary habits
* Level of activity
* Fluid intake
* Current medications
* Frequency of bowel elimination
* Stool characteristics

The nurse may tell the client to save the stool specimen for inspection.

Focus assessments generally are repeated or done on a schedule basis to determine trends in a client’s condition and responses to therapeutic interventions e.g. conducting post-operative surgical assessments, monitoring the client’s level of pain before and after administering medications.

1. **Ongoing assessment**

Done during follow-up

Reason for monitoring and observation related to specific problems

**SOURCES OF DATA**

**Primary sources include:**

* Client
* Interview
* Physical examination

**Secondary sources**

* Family members
* Other healthcare providers-have discussions with them
* Medical records –gives information in current and past
* Reports
* Test results

**TYPES OF DATA**

Data are either:

1. Objective
2. Subjective
3. **Objective data**

Are observable and measurable facts and are referred to as a sign of a disorder e.g.

* a client’s BP measurement
* Main ways to collect objective data:
* Physical examination
* Lab and diagnostic testing
1. **Subjective data**

Consists of information that only the client feels and can describe.

They are called symptoms e.g. pain, feelings, perceptions, concerns.

The main way to collect subjective data:

Interview

**Examples of subjective and objective data.**

|  |  |
| --- | --- |
| **Objective data** | **Subjective data** |
| Weight | Pain  |
| Temperature | Nausea |
| Skin colour | Depression |
| Blood cell count | Fatigue |
| Vomiting | Anxiety |
| Bleeding | Loneliness |
| Diarrhea |  |
| Pulse rate |  |

**Organizing of data**

Interpretation of data is easier if information is organized.

Organization involves:

* Grouping related information.
* Using knowledge and past experiences, nurses can cluster related data.
* Data organized into small groups is easier to analyze and takes on more significance than when the nurse considers each fact separately or examines the entire group at once e.g.

On assessment findings you get:

1. Lassitude
2. Distended abdomen
3. Dry, hard stool passed with difficulty
4. Fever
5. Weak cough
6. Thick sputum

**Related clusters:**

1. Lassitude, fever
2. Weak cough, sputum
3. Distended abdomen. Dry, hard stool passed with difficulty

**Differentiate between Cues and Inferences**

**Cues**-objective and subjective data observed or given by the client or the client’s companion

**Inferences** –Nurses conclusion of the cues.

e.g.

the nurse observes that the patient has dry skin and mucous membranes **(cues)** but records that the patient is dehydrated **(Inference).**

**NURSING DIAGNOSIS**

**Content:**

1. Changes in nursing diagnosis
2. Components of the nursing diagnosis
3. Types of nursing diagnosis
4. Classification of nursing diagnosis
5. Review of formulation of nursing diagnosis
6. Exercise on formulation of nursing diagnosis.
7. **Changes in nursing diagnosis**

**What has changed?**

* **Definition:** includes the individual family and community.
* Now NANDA**-**1 (in response to the broadening scope of its membership)
* Cluster of cues
* 2-yearly reviews/updates
* New diagnostic labels
* Diagnoses grouped into 13 domains

**NANDA-1 (North American Nursing Diagnosis Association)**

Nursing knowledge has expressed through standardized nursing diagnosis language, is what makes NANDA-1 terminology a global standard.

NANDA international has approved more than 200 diagnoses for clinical use, testing and refinement.

**Definition of Nursing Diagnosis**

A clinical judgment concerning a human response to health conditions/life processes, or a vulnerability for that response, by an individual, family, group or community.

It provides a basis for selection of nursing interventions to achieve outcomes for which the nurse has accountability. (Approved at the 9th NANDA Conference; amended in 2009 and 2013)

**Steps in the Diagnostic process**

There are 4 steps involved in the diagnostic phase.:

1. Data analysis
2. Formulation of the nursing diagnosis
3. Verification
4. Documentation

**Analyzing data**

Compare data against standards. (e.g. patient’s BP within normal parameters)

Cluster cues and make inferences about data determining the relatedness of facts and their meaning. (e.g. cluster of Pulse-weak, increased rate 100/minute), rhythm change, failure to return to pre-activity level in 5 minutes)

**Problem**: Activity Intolerance

**Cues versus inferences**

**Cues**-objective and subjective data observed or given by the client/companion.

**Inference**-Nurse’s conclusion of the cues.

e.g. the nurse observes that patient has dry skin and mucous membranes but records patient is dehydrated.

* Dry skin and mucous membranes are **cues**
* Dehydrated is an **inference**

On examination of the eyes, patient has no discharge and no pain and is able to see.

Nurse reports: Eyes normal

20 year old female patient crying all the time.

Nurse reports: Patient depressed

Analyzing data identifies gaps and inconsistencies which could arise from: measurement errors; unreliable reports; expectations etc.

It determines problems-Actual, Risk, Possible.

Determines whether the problem is a nursing diagnosis.

Determine strengths and establish resources or ability to cope.

**The Nursing Diagnosis**

States a clear and concise health problem.

Derived from existing evidences about the client.

It is potentially amenable to nursing therapy.

It is the basis for planning and carrying out nursing care.

Confirms to NANDA-1 criteria

PES format (Problem, Etiology. Signs and Symptoms)

Cluster of cues

Accuracy etc

Upto date (review after 2 years)

Components of the Nursing Diagnosis

NANDA-1 Criteria

1. The problem (Diagnostic label) =P differentiates it from other diagnoses
2. Etiology –related factors and joined to the label by the phrase “related to” =E
3. Defining characteristics –signs and symptoms and joined to the etiology by the phrase “as evidenced by” =S

**Diagnostic Label**

Contains qualifier/adjective and the noun.

* **Deficient** –inadequate in amount, quality, degree, deficient, incomplete
* **Impaired** –made worse , weakened, damaged, reduced, deteriorated.
* **Ineffective** –not producing the desired effect

Its purpose is to direct the formation of client’s goals and desired outcomes e.g. Activity Intolerance

**N/B**

**Altered** and **Potential** for were removed and are no longer used

**Etiology** (the “related to” phrase)

* These are those factors that appear to show some type of patterned relationship with the diagnostic label.
* Ideally it should be something that can be treated by the nurse (independent nursing diagnosis)
* If medical intervention is also necessary(a collaborative diagnosis)
* Contains one or more causes of the health problem
* Contributing factors that have influenced the change in health status.
* Gives direction to the required nursing therapy and enables the nurse to individualize the client’s care

Related factors are divided into 4 categories

1. Pathophysiologic, Biologic or Psychological
2. Treatment related
3. Situational
4. Maturational.

**Pathophysiologic, Biologic or Psychological**

Cardiovascular factors e.g. CCF, MI, Angina, Arteriosclerosis-inadequate circulation

Hematological e.g. anemia- Compromised oxygen transport

Pulmonary e.g. COPD- deficient tissue oxygenation

**Treatment related**

Can be surgery, medication, diagnostic studies, therapies. (E.g. medications can cause nausea, radiation, fatigue; scheduled surgery can cause anxiety)

**Situational**

Environmental, home, institutional, roles, life experiences. (e.g a flood in a community can contribute to risk for infection; Divorce can cause grieving; Obesity contribute to Activity Intolerance).

**Maturational**

Old age and other age related influences (e.g. elderly-at risk for social isolation; infants at risk for injury; adolescents –risk for infection transmission.)

**Defining characteristics**

The cluster of signs and symptoms that indicate the presence of a diagnostic label.

In an actual nursing diagnosis defining characteristics are the signs and symptoms.

Risk diagnosis do NOT have signs and symptoms but there are factors/ conditions that cause the client to be at increased risk to the problem.

**Types of Defining Characteristics**

1. Major –must be present
2. Minor –may or may not be present

**Example:**

Defining characteristics for Activity Intolerance

**Major** –Ineffective physiologic response to activity e.g. Increased respiratory rate, shortness of breath.

**Minor** –Vertigo, Diaphoresis.

**Types of Nursing Diagnosis**

According to parts contained in the statement.

1st part = Readiness for enhanced nutrition

2nd part =Activity Intolerance related to deficient oxygen transport

3rd part =Activity Intolerance related to deficient oxygen transport as evidenced by weak, irregular and increase pulse rate of 115 per minute after 5-10 minutes.

NB: The course emphasizes the 3 part statement.

**Classification of Nursing Diagnosis**

1. Actual
2. Risk
3. Wellness
4. Syndrome
5. Possible

 **The course emphasizes Actual and Risk Diagnoses**

**Actual Nursing Diagnosis**

**Definition-** a clinical judgment that the problem exists at the time of assessment.

Represents a problem that has been validated by the presence of major defining characteristics e.g.

1. Imbalanced Nutrition less than body requirement R/T decreased appetite AEB weight loss of 4 kg.
2. Disturbed sleep pattern R/T cough AEB client verbalization of not feeling rested

**Risk Nursing Diagnosis**

**Definition**-a clinical judgment where an individual, family or community is more vulnerable to develop the problem than others in the same or similar problem.

The problem does not exist but presence of risk factors indicates that the problem will develop unless the nurse intervenes.

Examples:

1. Risk for impaired skin integrity (lateral aspect left ankle) R/T decrease in peripheral circulation
2. Risk for infection R/T compromised immune system.

**Wellness Nursing Diagnosis**

A clinical judgment about an individual, group, or community in transition from a specific level of wellness to a higher level of wellness.

There must be 2 cues:

1. A desire of increased wellness
2. Effective present status or function

Are 1 part: label begins with “Readiness for enhanced” e.g.

Readiness for enhanced family processes.

Readiness for enhanced communication

Readiness for enhances family processes

**Syndrome Nursing Diagnosis**

Comprise a cluster of actual or high risk nursing diagnosis. R/T a certain event or situation, and are best addressed together and through similar interventions.

Two or more nursing diagnoses must be used as defining characteristics.

Are 1 part statements:

e.g.

1. Disuse syndrome
2. Rape trauma syndrome
3. Relocation stress syndrome
4. Risk for relocation stress syndrome

**Possible Nursing Diagnosis**

Statements that describe a suspected problem requiring additional data. The statement indicates uncertainty.

The nurse has some, but insufficient data to support a confirmed diagnosis.

They are 2 part

e.g.

Possible disturbed self-concept R/T recent loss of role responsibility.

Possible sexual dysfunction R/T anxiety

**Types of Nursing Diagnosis (a different school of thought)**

1. Problem focused
2. Health promotion
3. Risk
4. Syndrome
5. Problem focused

Reflects clinical judgment concerning undesirable human response to health conditions or life processes that exists in a patient.

To make it certain elements must be present including defining characteristics (S/S)- that can be grouped to form recognizable patterns and related factors that are somehow related to , or lead up to the identified problem.

E.g.

Sleep deprivation R/T pain

Impaired bed mobility R/T left sided paralysis

Decreased cardiac output due to MI

1. **Health promotion**

Concerns the motivation and desire to increase well-being and move closer to a person’s own optimum health potential.

These diagnoses use terms related to a patient’s readiness for specific health behavior’s

To make a health promotion diagnosis, there must be:

Defining characteristics that begin with the phrase “express desire to enhance”

e.g.

Sedentary lifestyle

Risk prone behavior

Readiness for enhanced immunization status

1. **Risk nursing diagnoses**

This examines the patients’ vulnerability to a health condition or life process.

It requires identification of specific personalized risk factors, such as smoking, advanced age and obesity.

e.g.

Risk for infection

Risk for falls

1. **Syndrome**

This diagnosis identifies specific groups diagnoses that occur together in a pattern and are best addressed together through similar nursing interventions.

Making a syndrome diagnosis requires 2 or more nursing diagnoses that serve as defining characteristics and related factors, if they add clarity. However related factors are not required.

**Example:**

Risk for decreased cardiac tissue perfusion

Ineffective cerebral tissue perfusion

Ineffective peripheral tissue perfusion

Related to dysfunctional ventilator response.

A nursing diagnosis encompasses Maslow’s hierarchy of needs and helps to prioritize and plan care based on patient centered outcomes.

Basic physiological needs/goals must be met before higher needs/goals can be achieved such as self-esteem and self-actualization.

Physiological and safety needs provide the basis for the implementation of nursing care and nursing intervention.

Therefore they are at the base of Maslow’s pyramid laying the foundation for physical and emotional health.

1. **Basic Physiological Needs**: nutrition (water and food), elimination (toileting), airway (suction), breathing (oxygen), circulation (pulse, cardiac monitor, BP), (ABC).
2. **Safety and Security**: Injury prevention (side rails, call lights, hand hygiene, isolation, suicide precaution, fall precautions, car seats, helmets, seat belts), fostering a climate of trust and safety (therapeutic relationship relationship) patient education/modifiable risk factors for stroke, heart disease.
3. **Love and Belonging**: foster supportive relationships, methods to avoid social isolation/bullying employ active listening techniques, therapeutic communication, and sexual intimacy.
4. **Self-esteem**: acceptance: acceptance in the community workforce, personal achievement, sense of control or empowerment, accepting one’s physical appearance or body habits.
5. **Self-Actualization**: Empowering environment, spiritual growth, ability to recognize the point of view of others, reaching one’s maximum potential

**CASE STUDY 1**

A 65 year old man has been admitted to the medical ward with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). He states that “he has difficulty breathing, when walking short distances, his heart feels like it is racing” at the same time HR is 115 b/m, He is tired all the time and while talking to you, he is continually wringing his hands and looking out the window.

**THE SYMPTOMS LIST**

* Difficulty breathing when walking short distances
* Heart feels like it is racing
* Tired all the time
* Continually wringing his hands
* Looking out the window

**INTERPRETE THE SUBJECTIVE SYMPTOMS**

(Patient statement)

“Difficulty breathing when walking short distances” = Exertional discomfort

Defining characteristic for? Nursing diagnosis.

“Heart feels like it is racing” =heart rate response to activity

Defining characteristic for? Nursing diagnosis

“Tired all the time” =verbal report of weakness

Defining characteristic for? Nursing Diagnosis

Activity intolerance R/T deficient tissue oxygenation AEB

“Continually wringing his hands” = Extraneous movement of hands, arms

Defining characteristic for? Nursing Diagnosis

“Looking out of the window” = Poor eye contact, glancing about…..defining characteristic for?............Nursing diagnosis.

**NOTE:**

A carefully written individualized R/T statement enables the nurse to plan nursing interventions that will assist the client in accomplishing goals and return to a state of optimum health.

Etiology is not the medical diagnosis.

Should be appropriate for the individual client.

**GUIDELINES IN WRITING THE NURSING DIAGNOSIS**

1. Use R/T –identifies relationship between problem and etiology.
2. Write the nursing diagnosis in legally advisable terms –(e.g. “risk for impaired skin integrity R/T frequent turning.
3. Write the nursing diagnosis without value judgement (“poor” “good”)
4. Avoid reversing the clauses (e.g. disorientation R/T sleep pattern disturbance.
5. The first part of the nursing diagnosis should include problems not signs and symptoms
6. The etiology should be expressed in terms that can be changed by nursing intervention (e.g. impaired comfort R/T surgical incision ) is incorrect.
7. The medical diagnosis should not be included in the nursing diagnostic statement.

**EXERCISE**

1. Anxiety R/T the disease process
2. Chronic sorrow R/T crying and inability to sleep
3. Risk for injury R/T dizziness secondary to High BP
4. Impaired parenting R/T frequent screaming at child
5. Risk for constipation R/T reports of bowel movement once a week.

**ANSWERS**

1. Incorrect- disease process does not communicate what interventions are needed.
2. Incorrect –crying and inability to sleep. Signs and symptoms and not relating factors.
3. Correct
4. Incorrect –frequent screaming at child is a sign of a problem not a “related to” factor.
5. Incorrect –weekly bowel movement is a symptom of constipation, not related to a risk diagnosis.

**Assignment**

1. Formulate 2 actual diagnoses
2. Formulate 2 risk diagnoses.