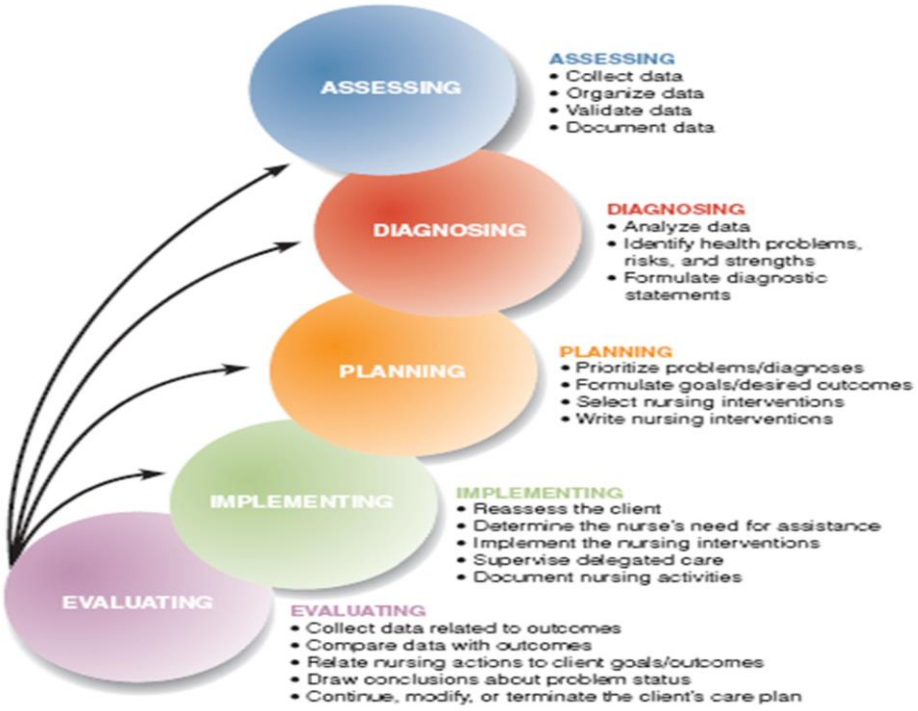
THE NURSING PROCESS

DNS 114: FUNDAMENTALS OF NURSING

DEFINITION

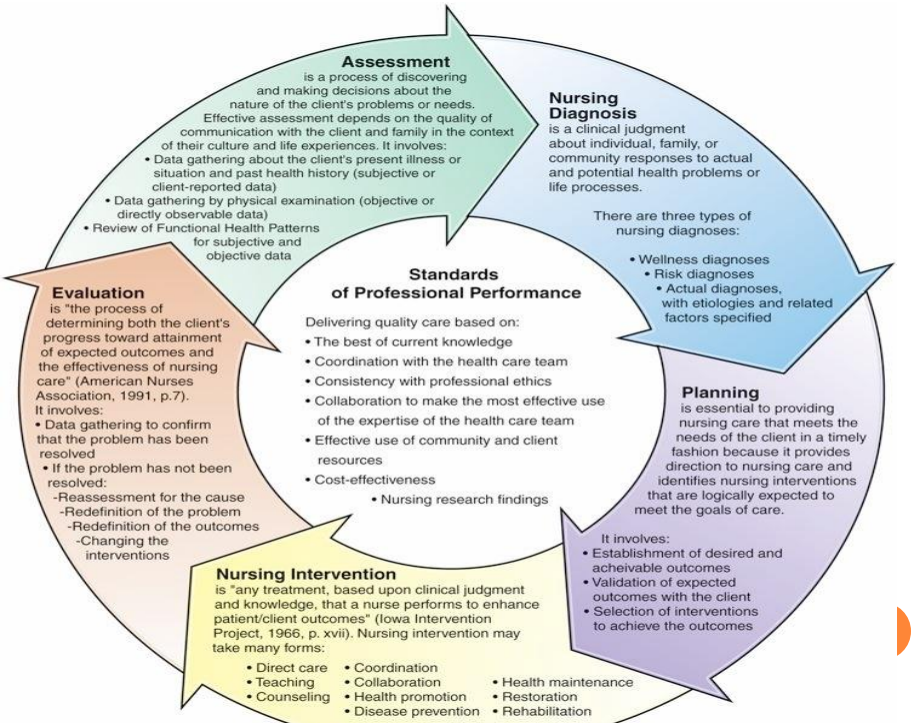
- The nursing process is a **deliberate, problem-solving approach used in nursing to** meet the health care and nursing needs of patients.
- It is framework for critical thinking specific to the nursing profession
  - It involves
    - Assessment (data collection),
    - Nursing diagnosis,
    - Planning and Outcome Identification,
    - Implementation,
    - Evaluation,
  - The process as a whole is **cyclical,** the steps being **interrelated, interdependent, and recurrent.**

- It incorporates subsequent modifications used as feedback mechanisms that promote the resolution of the nursing diagnoses
- It's purpose is to:
  - "Diagnose and treat human responses to actual or potential health problems"



Characteristics of the Nursing Process

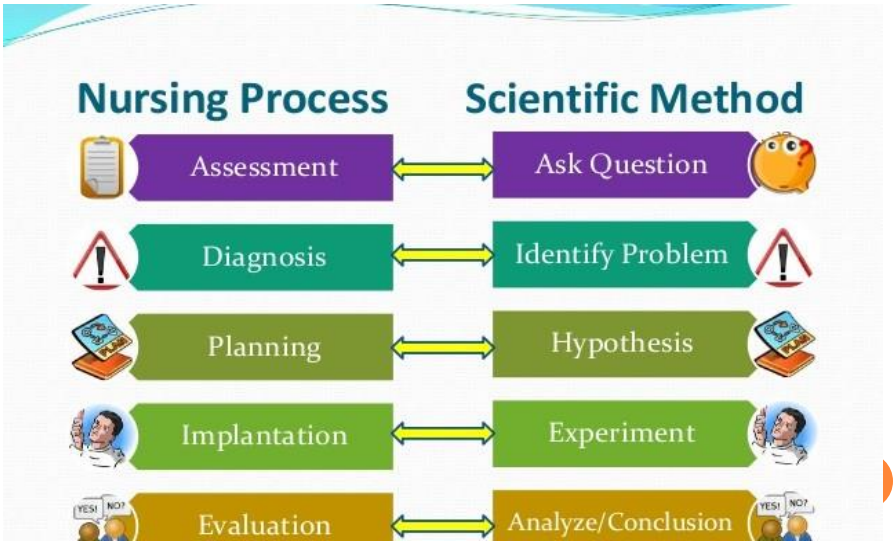
- Cyclic and dynamic nature
- Client centered
- Focus on problem-solving and decision-making
- Interpersonal and collaborative style
- Universal applicability
- Use of critical thinking



THE NURSING PROCESS AND SCIENTIFIC PROBLEM SOLVING

- Nursing process is very much like the scientific method of problem solving (research) .
  - The Nursing process however is UNIQUE to the nursing profession
- The scientific method of problem solving constitutes
  - Problem Identification and Data collection
  - Hypothesis Formulation
  - Developing a Plan of action
  - Study design and implementation (Hypothesis testing)
  - Results interpretation
  - Evaluation of findings

SCIENTIFIC METHOD OF PROBLEM SOLVING



ADVANTAGES OF NURSING PROCESS

- Provides individualized care
- Client is an active participant
- Promotes continuity of care
- Provides more effective communication among nurses and healthcare professionals
- Develops a clear and efficient plan of care
- Provides personal satisfaction as you see client achieve goals
- Professional growth as it facilitates evaluation of effectiveness of interventions

ASSESSMENT

- **First** step of the Nursing Process
  - Involves
    - Data collection
      - Collecting data is the process of gathering information about a client's health status.
    - Organizing data
      - Organizing data is categorizing data systematically using a specified format.
    - Validating data
      - Validating data is the act of "double-checking" or verifying data to confirm that it is accurate and factual.
    - Documenting data
      - Documenting is accurately and factually recording data

SOURCES AND TYPES OF DATA

- Sources of data
  - Primary Source – Client, physical assessment
  - Secondary Source - nursing history, team members, lab reports, diagnostic tests…..
- Types of data
  - Subjective / covert –experienced only by the client (symptom)
    - Sensations,
    - Feelings,
    - Values,
    - Beliefs,
    - Attitudes,
    - Perception of personal health status and life situations

- Objective / overt- observable data (sign)
  - Detectable by an observer
  - Can be measured or tested against an accepted standard
  - Can be seen, heard, felt, or smelled
  - Obtained through observation or physical examination
    - Example : Blood Pressure 130/80

METHODS OF DATA COLLECTION

- Observing
  - Gathering data using the senses
  - Used to obtain following types of data:
    - Skin color (vision)
    - Body or breath odors (smell)
    - Lung or heart sounds (hearing)
    - Skin temperature (touch)
- Interviewing (Health History)
  - Planned communication or a conversation with a purpose
    - Used to:
      - Identify problems of mutual concern
      - Evaluate change
      - Teach , Provide support, Provide counseling or therapy

- Examining (physical examination)
  - Systematic data-collection method
    - Uses observation and inspection, auscultation, palpation, and percussion
      - Assesses:
        - Vital Signs : Blood pressure, Pulses, Temperature , Respiration Rate
        - Heart and lungs sounds
        - Muscle strength
        - Neurological status etc

TYPES OF ASSESSMENTS

- Initial
  - Performed within a specified time after admission to a health care agency
    - Purpose : establishes a complete database for problem identification, reference, and future
- Problem-Focused
  - Ongoing process integrated with care
    - Determines status of a specific problem identified in an earlier assesment

- Emergency
  - Performed during physiologic or psychologic crises
    - Identifies life-threatening problems
    - Identifies new or overlooked problems
- Time-lapsed
  - A reassessment occuring several months after the initial assessment
  - Purpose: compare the client's current status to baseline data previously obtained.

NURSING DIAGNOSIS

- **Second** step of the Nursing Process
  - A Nursing Diagnosis is a problem statement of how the client is RESPONDING to a problem…that requires nursing intervention
    - May be an **actual** or **potential problem**
  - Interpreted data is clustered according to
    - Body systems,
    - Risk factors,
    - Family factors,
    - Emotional factors etc.
- This stage involves:
  - Interpretation and analysis of clustered data
  - Identification of client's problems and strengths
  - Formulation of the Nursing Diagnosis

NURSING VS. MEDICAL DIAGNOSIS

- Nursing Diagnosis
  - Within the scope of nursing practice
  - Focuses on Identifying **responses** to health and illness
  - Can **change** from day to day
    - Ineffective airway clearance **r/t** accumulation of copius secretions secondary to weak cough reflex and pain **aeb** rales, SPO_2 of < 90%
- Medical Diagnosis
  - Within the scope of medical practice
  - Focuses on **curing** pathology
  - Stays the **same** as long as the disease is present
    - Eg Malaria, Hypertension

TYPES OF NURSING DIAGNOSIS

- Actual
  - Problem **present** at the time of the assessment
  - Presence of associated signs and symptoms that are evidence of the problem
- Risk
  - Problem does not exist
  - Presence of **risk factors that would predispose** the patient **to the problem**
- Health promotion
  - Focuses on client's motivation and behaviour in response to current health situation/ status
- Wellness
  - Describes human responses to levels of wellness in an individual, family, or community that have a readiness enhancement
- Syndrome
  - Used when a cluster of actual or risk diagnoses predicted to be present in certain health states

Types of Nursing Diagnoses

Nursing Diagnosis	Example
Actual diagnosis	*Deficient Fluid Volume* related to nausea and vomiting as manifested by dry skin and mucous membranes and decreased oral intake of fluids
Risk diagnosis	*Risk for Infection* related to presence of invasive lines (intravenous line and indwelling bladder catheter)
Possible diagnosis	*Possible Imbalanced Nutrition: Less Than Body Requirements* related to insufficient oral intake
Wellness diagnosis	*Readiness for Enhanced Spiritual Well-Being*
Collaborative problem	*Potential Complication* (PC): *Increased Intracranial Pressure*

FORMULATING A NURSING DIAGNOSIS

- Actual Nursing diagnosis
  - Composed of 3 parts:
    - **Problem**
      - **Described as the Problem statement**- the client's response to a problem
      - Prescribed **DIAGNOSTIC LABELS** as outlined by the NANDA
    - **Etiology**
      - Identifies one or more probable causes of the health problem
        - What's causing/contributing to the client's problem
      - Denoted by the term RELATED TO
    - **Defining Characteristics (Signs and Symptoms)**-
      - Reffers to the evidence of the problem (identified during assessment)
      - Cluster of signs and symptoms Indicating the presence of a particular diagnostic label (actual diagnoses)
      - Factors that cause the client to be more vulnerable to the problem (risk diagnoses)
      - Denoted by the term AS EVIDENCED BY

NANDA DIAGNOSTIC LABELS

- Form the first part of the nursing diagnosis
  - Also referred to as the problem or problem statement
  - Are fixed universal labels as outlined by the NANDA association

NANDA Nursing Diagnosis List 2012 – 2014

Domain 1 – Health Promotion

Deficient diversional activity
Sedentary lifestyle
Deficient community health
Risk-prone health behavior
Ineffective health maintenance
Readiness for enhanced immunization status
Ineffective protection
Ineffective self-health management
Readiness for enhanced self-health management
Ineffective family therapeutic regimen management

Domain 2 – Nutrition

Insufficient breast milk
Ineffective infant feeding pattern
Imbalanced nutrition: less than body requirements
Imbalanced nutrition: more than body requirements
Risk for imbalanced nutrition: more than body requirements
Readiness for enhanced nutrition
Impaired swallowing
Risk for unstable blood glucose level
Neonatal jaundice
Risk for neonatal jaundice
Risk for impaired liver function
Risk for electrolyte imbalance
Readiness for enhanced fluid balance
Deficient fluid volume
Excess fluid volume
Risk for deficient fluid volume
Risk for imbalanced fluid volume

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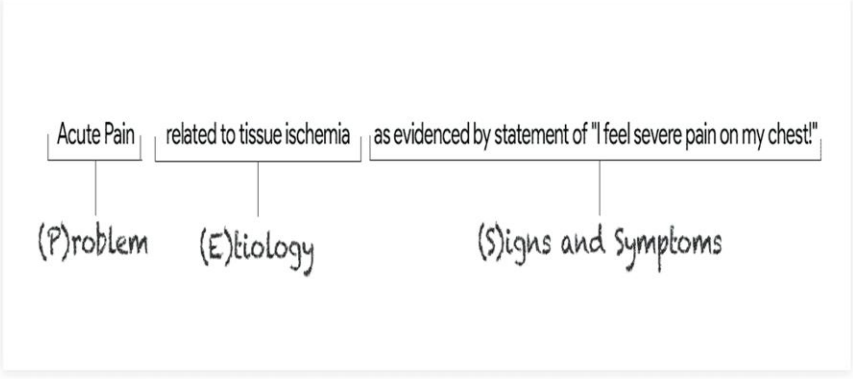
Components of a NANDA-I Nursing Diagnosis



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STEPS IN FORMULATION OF NURSING DIAGNOSIS

- Analyzing data
  - Compare data against standards
  - Cluster cues
  - Identify gaps and inconsistencies
- Identifying health problems, risks, and strengths
- Select approprate **diagnostic label**
- Formulate nursing diagnosis

FORMATS FOR WRITING NURSING DIAGNOSIS

- Basic two-part statement
  - Problem (P)- NANDA Nursing diagnostic label
  - Etiology (E) – existing factors that cause / contribute to the problem
    - Example:
      - Risk for infection related to invasive procedures/ prolonged hospitalisation/ depressed immunity

BOX 12–1 Basic Two-Part Diagnostic Statement

Problem	*Related to*	*Etiology*
Constipation	related to	prolonged laxative use
Severe Anxiety	related to	threat to physiologic integrity: possible cancer diagnosis

- Basic three-part statement
  - Problem (P)
  - Etiology (E)
  - Signs and symptoms (S)

BOX 12–2 Basic Three-Part Diagnostic Statement

Problem	*Related to*	*Etiology*	*As Manifested by*	*Signs and Symptoms*
Situational Low Self-Esteem	related to (r/t)	feelings of rejection by husband	as manifested by (a.m.b.)	hypersensitivity to criticism; states "I don't know if I can manage by myself" and rejects positive feedback

THERE ARE FIVE VARIATIONS OF THE BASIC FORMATS:

- Writing ***unknown etiology*** when the defining characteristics are present but the nurse does not know the cause or contributing factors
- Using the phrase ***complex factors*** when there are too many etiologic factors or when they are too complex to state in a brief phrase

- Using the word ***possible*** to describe either the problem or the etiology when the nurse believes more data are needed about the client's problem or the etiology
- Using the term ***secondary*** to divide the **etiology into two parts**, thereby making the statement more descriptive and useful
  - The part following secondary to is often a pathophysiologic or disease process or a medical diagnosis
    - Adding a second part to the general response or NANDA label to make it more precise

Collaborative Problems

- Reffers to problems that Require both nursing interventions and medical interventions

  EXAMPLE: Client admitted with medical dx of pneumonia

Collaborative problem = respiratory insufficiency

Nursing sg interventions: Raise HOB, Encourage C&DB

Medical interventions: Prescription of Antibiotics IV, O2 therapy

Guidelines for writing Nursing Dianoses

- Write statements in terms of a problem instead of a need.
- Word the statement so that it is legally advisable.
- Use nonjudgmental statements.
- Be sure both elements of the statement do not say the say thing.

- Be sure cause and effect are stated correctly.
- Word diagnosis specifically and precisely.
- Use nursing terminology rather than medical terminology to describe the client's response.
- Use nursing terminology rather than medical terminology to describe the probable cause of the client's response.

TABLE 12–6 Guidelines for Writing a Nursing Diagnostic Statement

GUIDELINE	CORRECT STATEMENT	INCORRECT OR AMBIGUOUS STATEMENT
1. State in terms of a problem, not a need.	*Deficient Fluid Volume* (problem) related to fever	*Fluid Replacement* (need) related to fever
2. Word the statement so that it is legally advisable.	*Impaired Skin Integrity* related to immobility (legally acceptable)	*Impaired Skin Integrity* related to improper positioning (implies legal liability)
3. Use nonjudgmental statements.	*Spiritual Distress* related to inability to attend church services secondary to immobility (nonjudgmental)	*Spiritual Distress* related to strict rules necessitating church attendance (judgmental)
4. Make sure that both elements of the statement do not say the same thing.	*Risk for Impaired Skin Integrity* related to immobility	*Impaired Skin Integrity* related to ulceration of sacral area (response and probable cause are the same)
5. Be sure that cause and effect are correctly stated (i.e., the etiology causes the problem or puts the client at risk for the problem).	*Pain: Severe Headache* related to fear of addiction to narcotics	*Pain* related to severe headache
6. Word the diagnosis specifically and precisely to provide direction for planning nursing intervention.	*Impaired Oral Mucous Membrane* related to decreased salivation secondary to radiation of neck (specific)	*Impaired Oral Mucous Membrane* related to noxious agent (vague)
7. Use nursing terminology rather than medical terminology to describe the client's response.	*Risk for Ineffective Airway Clearance* related to accumulation of secretions in lungs (nursing terminology)	*Risk for Pneumonia* (medical terminology)
8. Use nursing terminology rather than medical terminology to describe the probable cause of the client's response.	*Risk for Ineffective Airway Clearance* related to accumulation of secretions in lungs (nursing terminology)	*Risk for Ineffective Airway Clearance* related to emphysema (medical terminology)

PLANNING

Third step of the Nursing Process

- This is when the nurse prepares a **nursing care plan** based on the nursing diagnoses.
  - It involves
  - Goal Formulation
    - Nurse and client **formulate goals** to help the client with their problems
  - Identification of outcomes
    - Expected outcomes are identified
  - Identification and selection of interventions
    - Interventions (nursing orders) are selected to aid the client reach these goals.

PRIORITISATION OF NEEDS

- Essential due to urgency of need and resource limitations
- Nursing diagnoses are prioritised using Maslow's hierarchy of needs
  - Ranked as
    - High,
    - Intermediate
    - Low
- The goals must be Client specific
  - Priorities can change

Factors to Consider When Setting Priorities

- Client's health values and beliefs
- Client's priorities
- Resources available to the nurse and client
- Urgency of the health problem
- Medical treatment plan

Developing a Goal and Outcome Statement

- Goal = broad statement
- Expected outcome = Objective criterion for measurement of goal
- Goal and outcome statements are client focused.
  - Must be Worded positively
  - Must be : SMART Measurable, Specific Observable, Time-limited, and Realistic
  - Utilize Nursing Outcome Criteria as standard
    - Example
      - Goal:

      Client will achieve therapeutic management of disease process….
      - Outcome Statement:

      AEB B/P readings of 110-120 / 70-80 and client statement of understanding importance of dietary sodium restrictions by day of discharge.

Types of Goals

- Classified according to
- Time frame
  - Short term goals
  - Long term goals
- Domain of functioning targeted
  - Cognitive goals
  - Psychomotor goals
  - Affective goals

GOALS ARE PATIENT-CENTERED AND SMART

Specific
Measurable
Attainable
Relevant
Time Bound

Pt will walk 50 ft.
Pt will eat 75% of meal
Pt will be Out Of Bed 2-4hrs
Pt will maintain Heart Rate<100
Pt will state pain level is acceptable 6 (0-10)

SELECTION OF INTERVENTIONS

- Interventions are selected and written.
- The nurse uses clinical judgment and professional knowledge to select appropriate interventions that will aid the client in reaching their goal.
- Interventions should be examined for feasibility and acceptability to the client
- Interventions should be written clearly and specifically.

TYPES OF INTERVENTIONS

- **Independent (Nurse initiated)**- any action the nurse can initiate without direct supervision
- **Dependent (Physician initiated)**-nursing actions requiring MD orders
- **Collaborative**- nursing actions performed jointly with other health care team members

IMPLEMENTATION

- The **fourth** step in the Nursing Process
- This is the "Doing" step
- It involves Carrying out nursing interventions (orders) selected during the planning step
- This includes
  - monitoring,
  - teaching,
  - further assessment,
  - reviewing the NCP,
  - incorporating physicians orders
  - monitoring cost effectiveness of interventions
- Utilize Nursing Intervention Criteria (NIC) as standard

EVALUATION

- **This is the Final step** of the Nursing Process but also done concurrently throughout client care
- It constitutes
  - A comparison of client behavior and/or response to the established outcome criteria
  - Continuous review of the nursing care plan
  - Examines if nursing interventions are working
  - Determines changes needed to help client reach stated goals.

- Outcome criteria met
  - Problem resolved!
- Outcome criteria not fully met
  - Continue plan of care- ongoing.
- Outcome criteria unobtainable-
  - Review each previous step of NCP and determine if modification of the NCP is needed.
- It also involves an assessment of whether the nursing interventions were appropriate/effective

EVALUATION

Factors that impede goal attainment:

- Incomplete database
- Unrealistic client outcomes
- Nonspecific nsg interventions
- Inadequate time for clients to achieve outcomes.

Student Nursing Care Plans

Client: Jon Stark
Care Plan by: W. Smith, RN
Date initiated: 12-29-2018

ASSESSMENT	DIAGNOSIS	OUTCOMES	INTERVENTIONS	RATIONALE	EVALUATION
(+) Dyspnea (+) Abnormal breath sounds Heart rate = 128bpm Restlessness (+) Productive cough	Impaired gas exchange RT collection of mucus in airways	Patient will maintain optimal gas exchange.	1. Assess respirations: note quality, rate, rhythm, depth, use of accessory muscles, ease, and position assumed for easy breathing. 2. Elevate head and encourage frequent position changes, deep breathing, and effective coughing.	1. Manifestations of respiratory distress are dependent on/and indicative of the degree of lung involvement and underlying general health status as patients will adapt their breathing patterns to facilitate effective gas exchange. 2. These measures promote maximum chest expansion, mobilize secretions and improve ventilation.	Patient maintained optimal gas exchange AEB normal respiratory rate, (-) dyspnea, effective coughing techniques.

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