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Nursing process

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Introduction to nursing processes

- According to NANDA (**N**orth **A**merican **N**ursing **D**iagnostic **A**ssociation), the nursing process is defined as :
- It is a **problem solving process** that nurses use in interacting with patients, their families or significant others in providing nursing care

☞ **A problem solving** is the basic skill of identifying a problem and taking steps to resolve it

Nursing process…

- In general, the nursing processes is a **continuous, scientific, systematic** client oriented, and goal oriented approach where the nurse and client work together:
  - To ensure quality care
  - To determine the need for nursing care
  - To plan and implement the care and evaluate the results
- Unlike the medical model, which focuses on treating the **disease**, the nursing processes is **holistic** .

The purpose of Nursing processes

Nursing processes is important for:

- Restoring, maintaining and promoting health
- Enabling individual or groups to manage their own health care to the best of their ability
- Providing nursing care

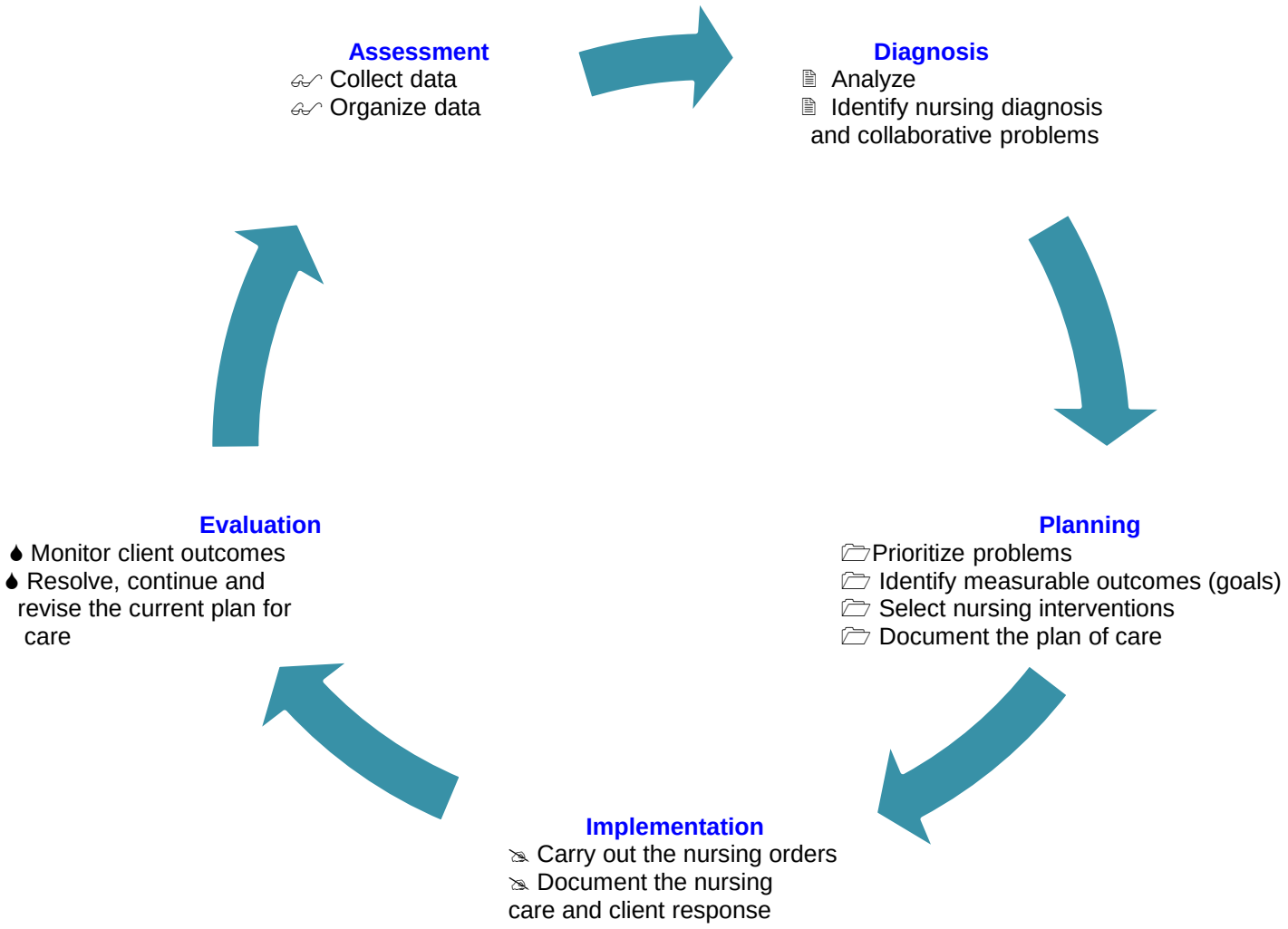
Characteristics of Nursing Process:

- It is goal directed.
- It is orderly and systematically organized.
- It is dynamic and always changing.
- It is interrelated and interactive.
- It provides individual care.
- It is patient centered.
- It is practical for use over the life span.
- It can be used for all setting.

Components of The Nursing process

- Assessment
- Diagnosis
- Planning
- Implementation
- Evaluation

Component of the nursing …



A, Assessment

- Is a systematic and continuous collection and analysis of data or information about the client.
- The purpose of assessment is to identify whether the person is:
- well,
- has risk factors for problems, or
- has actual problems

Assessment…

- Identify the following data as subjective or objective?
  - Headache
  - Bp =170/110 mmHg
  - Nausea
  - Abdominal pain
  - Skin lesion
  - Pain, fear , mood
  - Fever
  - Temperature =38 °C

Assessment…

Methods of data collection

☞ There are different methods of data collection and some of which includes:

- Observation
- Interview
- Laboratory testes
- Physical examination

Assessment…

Sources for the collecting data:

- The patients (the best source) and their family
- The physical examination
- Health professionals
- The patient's pervious and present records,
- The laboratory reports

Assessment…

- **The processes of gathering information include the following activities:**

- Collecting data
- Recognizing significant data or validating data
- Recognizing patterns or clusters
- Identifying strengths and problems
- Prioritizing the data
- Reaching conclusions

Types of Assessment

1. **Initial assessment** ; is performed shortly after patient admission to a health agency or hospital .
2. **Focused assessment** ; the nurse gathers data about a specific problem that has already been identified.
3. **Emergency assessment** , the nurse performs this type of assessment on a physiological or psychological crisis to identify the life – threatening problems.
4. **Time – lapsed assessment** , this assessment done to compare a patients current status to the base line data obtained earlier .

B, The Nursing Diagnosis

- **Diagnosis**: Is the careful, critical study of something to determine its nature
- According to NANDA, the nursing diagnosis is defined, as "It is a clinical judgment about **individual, family or community** response to actual or potential health problems".
- It provides the basis for selection of nursing intervention to achieve outcome for which the nurse is accountable

The Nursing diagnosis …

- Medicine clearly emphasizes the disease processes (HTN, pneumonia and DM).
- Nursing, however emphasizes on the person: the individual's response to his or her health and its focus became one of treating the whole person, not just the disease.

Medical Diagnosis vs Nursing Diagnosis

Medical Diagnosis	Nursing Diagnosis
Focuses on the illness, injury, or disease process.	Focuses on the responses to actual or potential health problems or life processes.
Remains constant until a cure is effected.	Changes as the client's response and/or the health problem changes.
Identifies conditions the health care practitioner is licensed and qualified to treat.	Identifies situations in which the nurse is licensed and qualified to intervene.

Medical Diagnosis vs Nursing Diagnosis

E.g

- Medical Dx = pneumonia

- Nursing Dx =

Ineffective Airway clearance R/t tracheobronchial secretion.

The nursing diagnosis …

Purpose of nursing diagnosis:

- Helps to identifies nursing priorities
- Directs nursing interventions to meet the clients high priority needs
- Provides communication between nursing professionals and the health care team
- Provides a base of evaluation

Components of Nursing Diagnosis

Nursing diagnoses has three components(PES)

1.Human response/Problem statement/diagnostic label/definition = P

- It could be an actual problem or potential problem

2.Causative factor(Etiology)=E: which is the cause of the problem

3.**Defining characters=S** :are sign and symptoms that the pt manifests

TYPES OF NURSING DIAGNOSES

1. Actual nursing diagnosis → three part statement
2. Possible nursing diagnosis
3. Risk nursing diagnosis

→ Tow part statement

4. Wellness nursing diagnosis
5. Syndrome nursing diagnosis

→ One part statement

Actual nursing Dx

- ✓ It is client problem that is present at the time of the nursing assessment.
- ✓ It is considered as a 3 part statement i.e. it consists human response, causative factor and defining characters.

e.g

- ✓ Feeding self-care deficit **related to** right hemi paresis **as manifested by** inability to grasp utensils.
- ✓ Altered body °T **related to** the disease process **as evidenced by** body °T of 38 °C.

Possible nursing Dx

- Is a statement about a health problem that the client might have now, but the nurse doesn't yet have enough information to make an actual diagnosis. but a problem is only considered possible to occur.
- It is a two part statement, i.e. human response and causative factors will be included.

Examples:

- Possible nutritional deficit r/t nausea.
- Possible low self-esteem r/t loss job.

Risk Nursing diagnosis

- Is a clinical judgment that a problem does not exist, but special risk factors are present.
- Therefore no S/S are present, but the presence of RISK FACTORS is indicates that a problem is only is likely to develop unless nurse intervene or do something about it.
- Is a statement about a health problem that the client doesn't have yet, but it is at a higher than normal risk of developing in the near future.

Risk…

Examples:

- Risk for infection r/t surgical procedure.
- Risk for Constipation r/t inactivity and insufficient fluid intake
- Risk for infection r/t compromised immune system.

Wellness nursing diagnosis

- Clinical judgment about an individual, family and community in transition from a specific level of wellness to a higher level of wellness
- It is a one part statement ,i.e. only human response is described

E.g

- Effective therapeutic regimen
- Readiness for enhanced spiritual well-being

Syndrome nursing diagnosis

- It comprises a cluster of problems

E.g -: Rape-trauma syndrome.

Disuse Syndrome,

Post-Trauma Syndrome, and

Impaired Environmental Interpretation Syndrome

C. Planning

- This is the 3rd step of the nursing process which describes the development of goals to prevent, reduce or eliminate problems
- It also helps to identify nursing interventions that will assist clients in meeting the goals
- This is the step in which nurse will determine how to give nursing care in an organized, individualized, goal -directed manner

Planning…

- Planning involves several steps; that are important for preparing plan of nursing care, these steps are

✍ Establishing or setting priorities to the nursing diagnosis and collaborative problems

✍ Defining or establishing **goals** and **outcomes**

✍ Determining specific nursing interventions

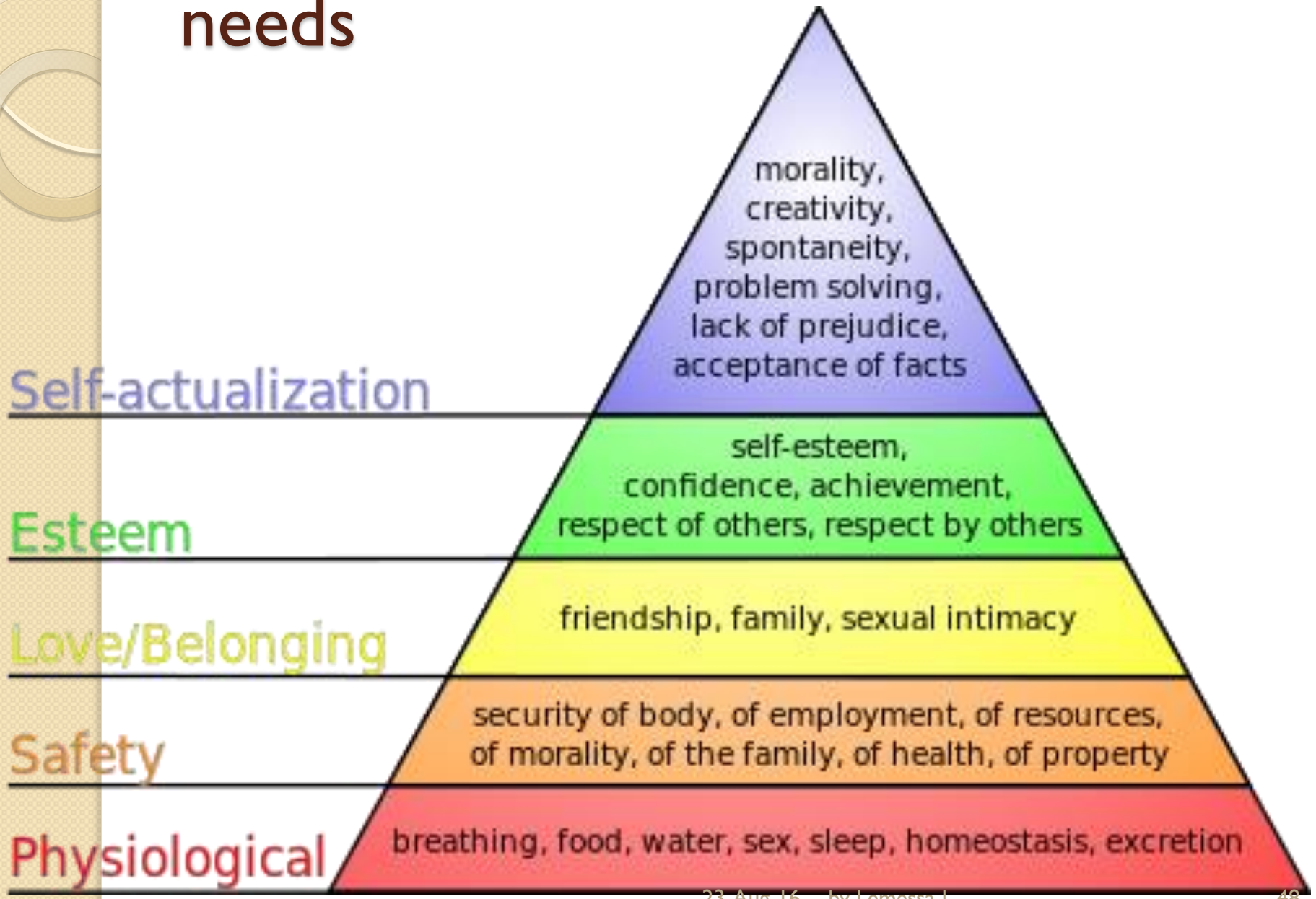
✍ Recording the plan of care

Planning…

Establishing or setting priorities

- The nurse prioritizes the clients multiple problems by ranking first the diagnosis that are related to the client's most important, serious or immediate needs

Maslow proposed five levels of needs



Planning…

Look these examples of multiple nursing diagnoses:

- Spiritual distress
- Infective breathing pattern
- Risk for injury

Then, after looking your nursing diagnosis ask yourself "which problem is need immediate attention and remember the framework that helps you for prioritizing the problems; Abraham Maslow.

Establishing goals and expected outcomes

Goals:

- Is an educated guess.
- addresses directly the problem stated in nursing diagnosis.

Expected outcome:

- Is a measurable client behavior that indicates whether the person has achieved the expected benefit of nursing care.

Con….

Example:

- Nursing diagnosis: knowledge deficit regarding postoperative care at home.

  Goals: client will state three postoperative risk before discharge.

  Expected outcomes:

- 1. Client will indentify need to drink 2-3 liters of every day.
- 2. Client will name three signs of infections.
- 3. Client will demonstrate aseptic wound care.

Planning…

- Look these examples of short and long-term outcomes respectively
  - ✓The client will walk for 20 min longer each day of the first 3 postoperative day
  - ✓The client will ambulate with a walker by the end of 3 weeks

Planning…

- Therefore, expected outcomes are the most important part of the care planning process, which are client oriented, specific, reasonable and measurable

- **The expected outcomes are:**
  - ✓Used to measure to what extent progress toward resolving the problem has been made.
  - ✓It is the basis for evaluating the effectiveness of the nursing diagnosis.
  - ✓ Helps in deciding whether additional nursing care is needed or whether the plan of care needs to be revised.

D,Implementation

- the 4 th step of the nursing process is called implementation.
- It is the action phase of the nursing process in which nursing care is provided.

Implem…

- These are also called nursing orders or nursing actions, are activities that will most likely produce the desired outcomes (short term or long term) or
- They are specific nursing activities or actions that a nurse must perform:
  - ✓ To prevent complications,
  - ✓ Provide comfort (physical, psychological, and spiritual), and
  - ✓ Promote, maintain and restore health

Example of implementation

- Infective airway clearance related to physiologic effects of pneumonia as evidenced by increased sputum, coughing, abnormal breath sounds, tachypnea, and dyspnea

Implementation

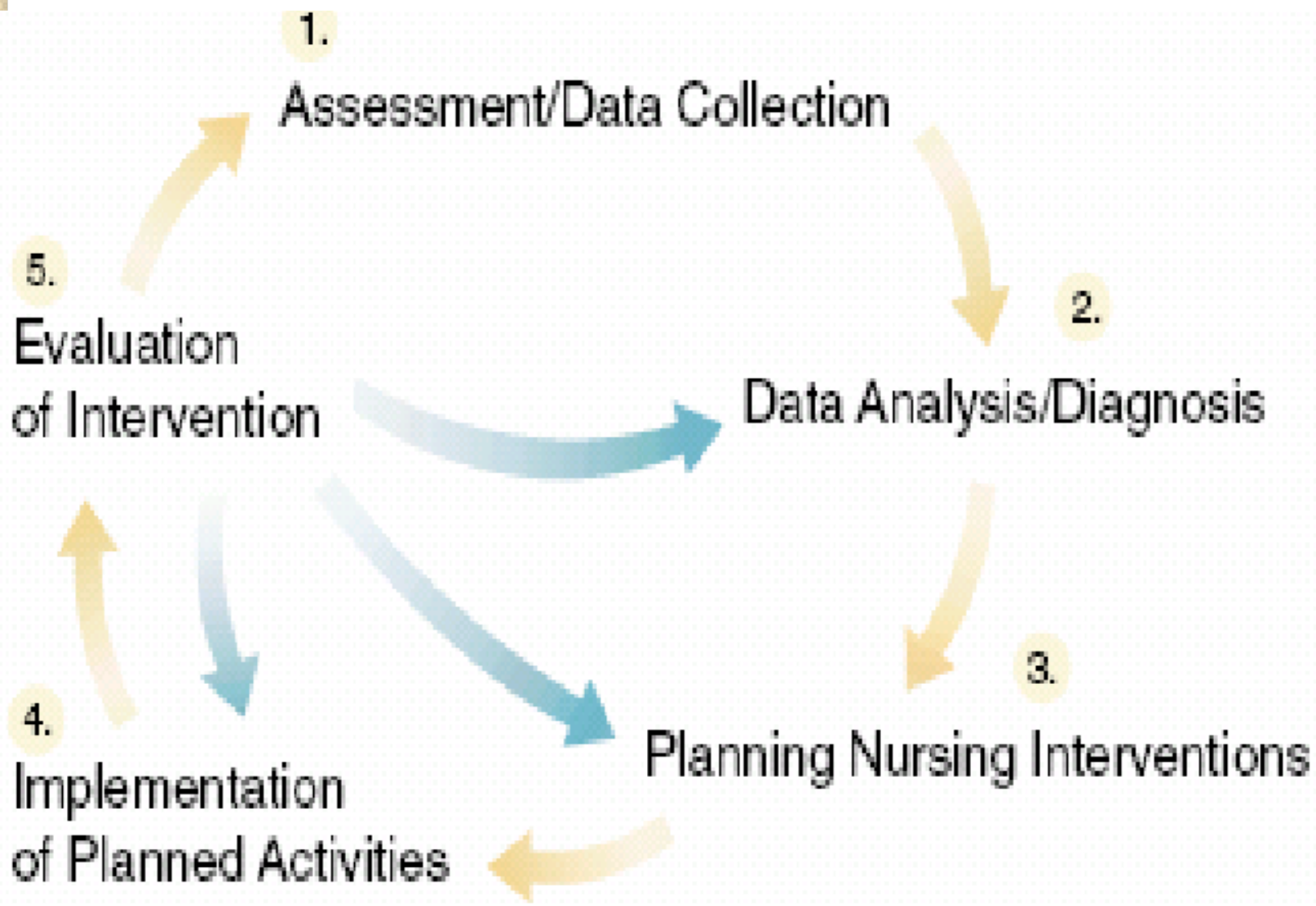
- Administering supplemental humidified oxygen via nasal cannula at the prescribed flow rate
- Positioning the patient
- Assessing vital signs and respiratory status

Example of implementation…

- Begin intravenous (IV) fluid
- Instruct client in coughing
- Gradually increase client's activity level, assessing client out of bed to the chair
- Continue monitoring vital signs and respiratory status every 4 hours or as indicated,

E, Evaluation

- The final step of the nursing process, which is used to measuring the effectiveness of assessing, diagnosing, planning and implementing
- It also allow the nurse to determine the patients response to the nursing interventions and the extent to which the objectives have been achieved
- During evaluation, nurses compare the actual outcomes to the expected outcomes.
- Because this process enables the nurse to revise the expected outcomes



Relationship of Evaluation to Nursing Process

Unit Two: Learning Assessment skills

- **Definition**
  - **Nursing health history** (NHH) – focus on events in physical status, on patterns of daily living, wellness practices and self care activities as well as socio cultural and environmental factors that inference the health status.
  - It has a goal of helping in making nursing diagnosis.

Purpose of history taking:

- To establish trusting relationship between nurse and patient.
- Develop understanding about the patient.
- Help the patient to feel understood.
- Guides on which body parts or systems to focus during P/E.
- It can be therapeutic.

Phases of history taking:

- Introductory/orientation / phase
- Working/maintenance/ phase
- Concluding /termination/ phase

Techniques of effective history taking

Setting for interview

- Review chart
  - Always see the chart of the patient for identification and revision of past illness
- Create a conducive environment:

  Externally

  Internally

Techniques…..

Externally:

- Maintain considerable distance between the patient and you, so that both of you are able to see each other.
- There should be sufficient light to see each other
- Avoid any noise which may divert attention.

Techniques of effective…

Internally :

- **Empathy :-** The ability to understand and share the feelings ,thoughts and emotions of another person.
- **Listening-** listen carefully and give the patient to talk what he meant
- Do not judge the patient

Techniques…..

- While interviewing a patient you should be:
  - Clean and Neat
  - Dressing well

While you take note:

- Always Wright after the patient finishes what he/she talk.
- While eliciting the patient illness, do not attempt to write full note rather take short phrases and words

Techniques of effective…

Techniques:

- Start with greeting and calling the patient by his name.
- If the pt. is pediatric patient ask the parents by calling their child by his/her name

Verbal skills :

- Verbal skills Includes **questions** and **response**

Question :

- Proceed from general to specific
- Avoid leading questions as much as possible
- Ask one question at a time
- Use language –understandable and appropriate to pt.

Techniques of effective…

- There are two types of questions

1. Open ended questions

- The beginning for interviewing
- Unbiased, leave the patient to say more things about your questions

e.g. What happened to you?

Tell me why you are here today?

Techniques of effective…

2. Closed ended questions

- Display specific information
- Answers are yes or No
  - E.g. Have you ever been in malaria area?

Techniques of effective…

Response:

- Method of helping and guiding patients
- It should not divert the patient from their idea.
- Includes:

1. Facilitation
2. Reflection
3. Clarification
4. Empathic responses
5. Confrontation
6. Interpretation