THE NURSING PROCESS

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Definition

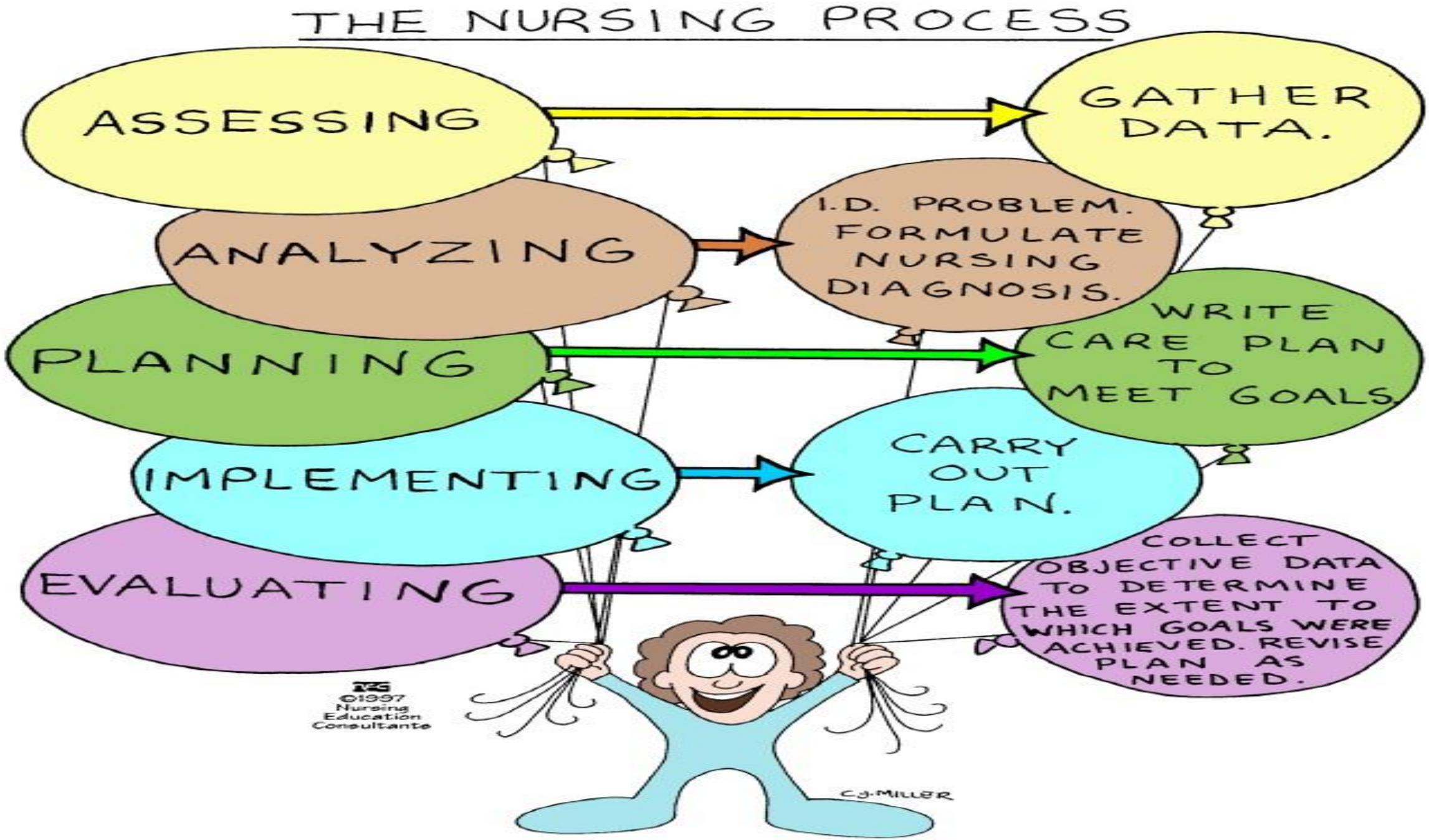
- is a deliberate problem-solving approach for meeting people's health care and nursing needs.
- Components include **assessment**, **diagnosis**, **planning**, **implementation**, and **evaluation**
- An organized sequence of problem-solving steps used to identify and to manage the health problems of clients (American Nurses Association)

The Nursing Process

- It is an organizational framework for the practice of nursing
- Cyclic and dynamic nature
- client- Centeredness
- Focus on problem-solving and decision making
- Use of critical thinking
- Includes all steps taken by the nurse in caring for a patient

The Traditional 5 Steps in Nursing Process

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


THE NURSING PROCESS
ASSESSING
GATHER DATA.
ANALYZING
I.D. PROBLEM. FORMULATE NURSING DIAGNOSIS.
PLANNING
WRITE CARE PLAN TO MEET GOALS
IMPLEMENTING
CARRY OUT PLAN.
EVALUATING
COLLECT OBJECTIVE DATA TO DETERMINE THE EXTENT TO WHICH GOALS WERE ACHIEVED. REVISE PLAN AS NEEDED.
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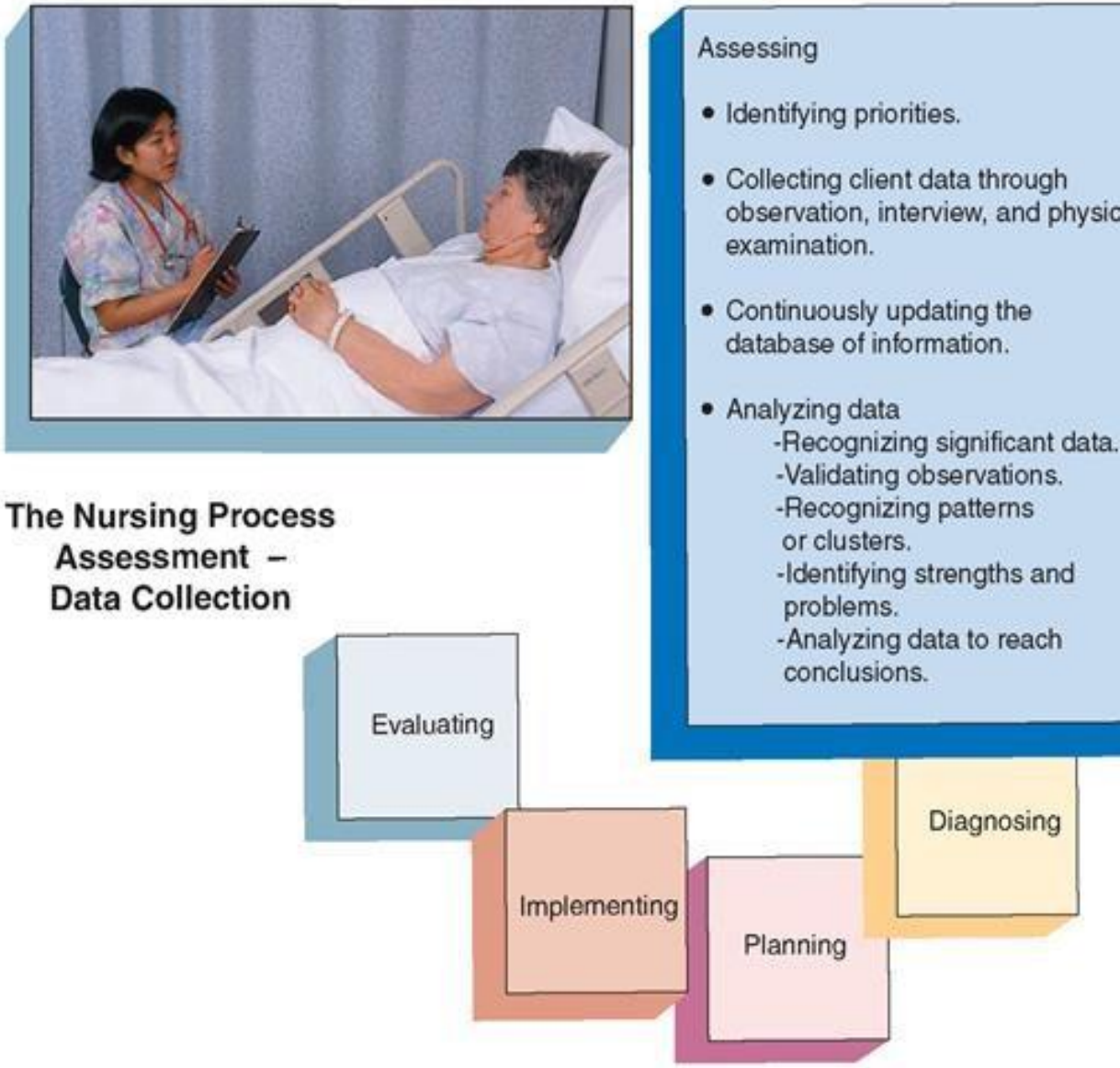
1.Assessment

- the systematic collection of data, through interview, observation, and examination, to determine the patient’s health status and any actual or potential problems .

1.Assessment

1. Conduct the health history.
2. Perform the physical assessment.
3. Interview the patient's family or significant others.
4. Study the health record.
5. Organize, analyze, synthesize, and summarize the collected data



The Nursing Process
Assessment –
Data Collection

Types of data: objective data

- Signs or overt data
- 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

Types of data: subjective data

- Symptoms or covert data
- Apparent only to the person affected
- Can be described only by person affected
- Includes sensations, feelings, values, beliefs, attitudes, and perception of personal health status and life situations

Examples:

SUBJECTIVE	OBJECTIVE
• "I feel warm."	• Temp: 37.8^{0}C; warm to touch
• Report of itchiness on face	• scratching the face; presence of red marks on face
• "My stomach makes me sick."	• vomited 3x with green-tinged fluid; abdomen is firm and distended
• "I feel afraid of the surgery."	• patient can't sit still; tremors on hands

Practice Exercises: Identify the following data as OBJECTIVE or SUBJECTIVE

- burning sensation on urination - Subjective
- BP = 120/70 mmHg – Objective
- tiredness – Subjective
- pain complaint – Subjective
- “I am afraid of injections.” – Subjective
- hard mass on the abdomen – Objective
- dry mouth – Objective
- shortness of breath – Subjective

Methods of data collection

1. Interview.

2. Observation.

3. History collection.

4. Physical examination.

5. Results of lab & diagnostic results.

Data sources

- **Primary source**: Client
- **Secondary source:**
  - Family members/friends,
  - Observed data
  - Diagnostics reports
  - Past medical records
  - Operation notes, progress notes.
  - Consultations by doctors.
  - Relevant literature

TABLE 11–3 Types of Assessment

TYPE	TIME PERFORMED	PURPOSE	EXAMPLE
Initial assessment	Performed within specified time after admission to a health care agency	To establish a complete database for problem identification, reference, and future comparison	Nursing admission assessment
Problem-focused assessment	Ongoing process integrated with nursing care	To determine the status of a specific problem identified in an earlier assessment	Hourly assessment of client's fluid intake and urinary output in an ICU Assessment of client's ability to perform self-care while assisting a client to bathe
Emergency assessment	During any physiological or psychological crisis of the client	To identify life-threatening problems To identify new or overlooked problems	Rapid assessment of a person's airway, breathing status, and circulation during a cardiac arrest Assessment of suicidal tendencies or potential for violence
Time-lapsed reassessment	Several months after initial assessment	To compare the client's current status to baseline data previously obtained	Reassessment of a client's functional health patterns in a home care or outpatient setting or, in a hospital, at shift change

2.Nursing Diagnosis

- **is the second phase of the nursing process**
- **Nurses use critical thinking skills to interpret assessment data and identify client strengths and problems**
- **DIAGNOSING – refers to the REASONING process**
- **DIAGNOSIS – statement or conclusion regarding the nature of a phenomenon**
- **DIAGNOSTIC LABELS - the standardized NANDA names for the diagnoses**

NURSING DIAGNOSIS

- **NURSING DIAGNOSIS - refers to the client's PROBLEM STATEMENT and its etiology**
- **NANDA definition ". . . a clinical judgment about individual, family, or community responses to actual and potential health problems/life processes. A nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable"**

Status of Nursing Diagnosis

Status refers to the actuality or potentiality of the diagnosis or the categorization of the diagnosis

- **Actual – a problem present at the time of the assessment; Presence of associated signs and symptoms**
  - **e.g. Ineffective breathing pattern & Anxiety**
- **Health Promotion - relates to clients' preparedness to implement behaviors to improve their health condition**
  - **e.g. Readiness for Enhanced Nutrition**

General Guidelines for Setting Priorities

- **Risk – a clinical judgment that a problem does not exist but the presence of risk factors indicates that a problem is likely to develop**
  - **e.g. An immunocompromised patient has higher risk to develop infection than others**
- **Wellness – "describes human responses to levels of wellness in an individual, family, or community that have a readiness enhancement"**
  - **e.g. Readiness for enhanced spiritual well-being**

Components of A NANDA Nursing Diagnosis

- Problem (Diagnostic label) and definition
- Etiology (related factors and risk factors)
- Defining characteristics (cluster of S/S)

TABLE 12–1 Components of a Nursing Diagnosis

DIAGNOSIS AND DEFINITION	RELATED FACTORS	DEFINING CHARACTERISTICS
Activity Intolerance: Insufficient physiological or psychological energy to endure or complete required or desired daily activities	Bed rest or immobility Generalized weakness Imbalance between oxygen supply/demand Sedentary lifestyle	Verbal report of fatigue or weakness Abnormal heart rate or blood pressure response to activity Electrocardiographic changes reflecting arrhythmias or ischemia Exertional discomfort or dyspnea

From *NANDA Nursing Diagnoses: Definitions and Classification, 2009–2011*, by NANDA International, 2009, Oxford, United Kingdom: Wiley-Blackwell. Adapted with permission.

Differentiating Nursing Diagnoses From Medical Diagnoses

Nursing diagnosis	Medical diagnosis
■ a statement of nursing judgment and refers to a condition that nurses, by virtue of their education, experience and expertise, are licensed to treat ■ describes the human response, a client's physical, sociocultural, psychological, and spiritual responses to an illness or a health problem	■ made by a physician and refers to a condition that only a physician can treat. ■ refers to disease processes— specific pathophysiologic responses that are fairly uniform from one client to another

Differentiating Nursing Diagnoses from Collaborative Problems

Nursing diagnosis

- involve human responses which vary greatly from one person to the next
- same diagnoses cannot be expected to occur with all persons having a particular disease or condition
- more individualized to a specific client and emphasize human responses to which the nurse can independently take action

Collaborative problem

- a type of potential problem that nurses manage using both independent and physician-prescribed interventions
- present when a particular disease or treatment is present
  - each disease or treatment has specific complications that are always associated

TABLE 12–3 Comparison of Nursing Diagnoses, Medical Diagnoses, and Collaborative Problems

	NURSING DIAGNOSES	MEDICAL DIAGNOSES	COLLABORATIVE PROBLEMS
Example	*Activity Intolerance* related to decreased cardiac output	Myocardial infarction	Potential complication of myocardial infarction: congestive heart failure
Description	Describe human responses to disease process or health problem; consist of a one-, two-, or three-part statement, usually including problem and etiology	Describe disease and pathology; do not consider other human responses; usually consist of not more than three words	Involve human responses—mainly physiological complications of disease, tests, or treatments; consist of a two-part statement of situation/pathophysiology and the potential complication
Orientation and responsibility for diagnosing	Oriented to the individual; nurses responsible for diagnosing	Oriented to pathology; physician responsible for diagnosing; diagnosis not within the scope of nursing practice	Oriented to pathophysiology; nurses responsible for diagnosing
Nursing focus	Treat and prevent	Implement medical orders for treatment and monitor status of condition	Prevent and monitor for onset or status of condition
Nursing actions	Independent	Dependent (primarily)	Some independent actions, but primarily for monitoring and preventing

Nursing Diagnosis

… IS:

- a statement of a patient's problem
- actual, potential or possible
- within the scope of nursing practice
- directive of nursing intervention

… IS NOT:

- a medical diagnosis
- a nursing action
- a physician's order
- a therapeutic treatment

2.Nursing Diagnosis

- Imbalanced nutrition less than body requirements related to less food intake, impaired absorption of nutrients, vomiting/diarrhea
- as evidenced by weight loss/decreased subcutaneous fat / muscle mass/Increased bowel sounds

2.Nursing Diagnosis

- **Ineffective individual coping related to chronic illness/death threats/severe pain/no adequate support system as evidenced by inability to face problems/ hopelessness/anxiety/depression and dependence.**
- **Risk for infection related to invasive procedures/ trauma/ tissue destruction/** immunosuppression / chronic disease/ indwellingcatheters/ endotracheal or tracheostomy tubes.

2.Nursing Diagnosis

- Knowledge Deficit related to disease condition/ prognosis /treatment secondary to misinterpretation of information
- as evidenced by asking questions, request of information, not following the instructions.

- Fluid volume excess related to excessive intake of sodium from foods/, intravenous (IV) solutions/, medications,/renal insufficiency/decreased cardiac output/ disease condition
- as evidenced by weight gain / edema/ polyuria

2.Nursing Diagnosis

- Ineffective Tissue Perfusion related to reduction in the number of red blood cells as
- evidenced by pallor/ Pale conjunctiva and mucous membranes

- *Anxiety related to* disease condition/changes in health status/, low socio-economic status
- as evidenced by increased tension/ distress,/fear/ irritability/reduced focus of attention

2.Nursing Diagnosis

- Fluid volume deficit related to inadequate fluid intake/vomiting/ diarrhea/ increased fluid loss/ fever
- as evidenced by dry skin or mucus membrane/ thirst/ decreased urine output.
- Sleep pattern disturbance related to pain/ hospitalization/ anxiety
- as evidenced by frequent yawning/ dark circle under eyes.

2. Nursing Diagnosis

- Self-Care Deficit bathing/hygiene; Dressing/Grooming/ Feeding/Toileting related to impaired mobility/ energy deficit/ neuromuscular impairment secondary to cerebrovascular accident (CVA)
- as evidenced by Inability to feed /dress /bathe and groom/ toileting independently.

Objectives/ Goals

It is the expected outcome.

- Expected outcomes are realistic, achievable & safe.
- It is patient centered rather than nurse centered.

Types

- *Short-Term Goals*
- Outcomes achievable in a few days or 1 week
- *Long-Term Goals*
- Desirable outcomes that take weeks or months

3. Planning

- **is a deliberative, systematic phase of nursing process that involve decision making and problem solving**
- **It involves a written guidance for nursing intervention to minimize or solve the identified problems.**

Figure 13–1 ■ Planning. The third phase of the nursing process, in which the nurse and client develop client goals/desired outcomes and nursing interventions to prevent, reduce, or alleviate the client's health problems.

Types of Planning

1. Initial Planning

- **The nurse who performs the admission assessment usually develops the initial comprehensive plan of care**

2. Ongoing planning

- **done by all nurses who work with the client and occurs at the beginning of a shift**

3. Discharge planning:

- **The process of anticipating and planning for needs after discharge**
- **Effective discharge planning begins at first client contact needs**

3. Planning

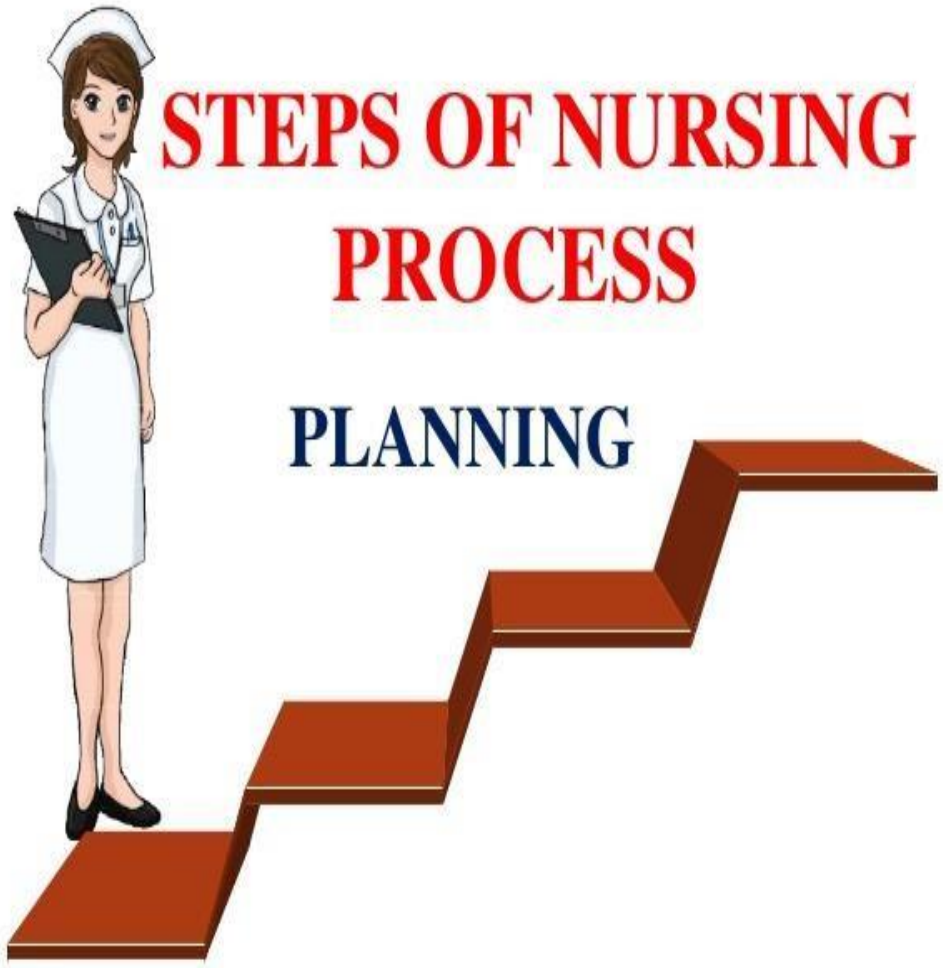
- Determine problems that require immediate action of problems of the patient.

- For example: Ineffective Airway Clearance would pose more threat to life than the diagnosis Risk for Impaired skin integrity.

3. Planning

Planning process:

- Prioritize problem.
- Formulate goal.
- Select nursing intervention.
- Write nursing order.
- Record and modify



3. Planning

Setting Priorities

- Determine problems that require immediate action
- Maslow's Hierarchy of Human Needs.

The Nursing Process – Planning

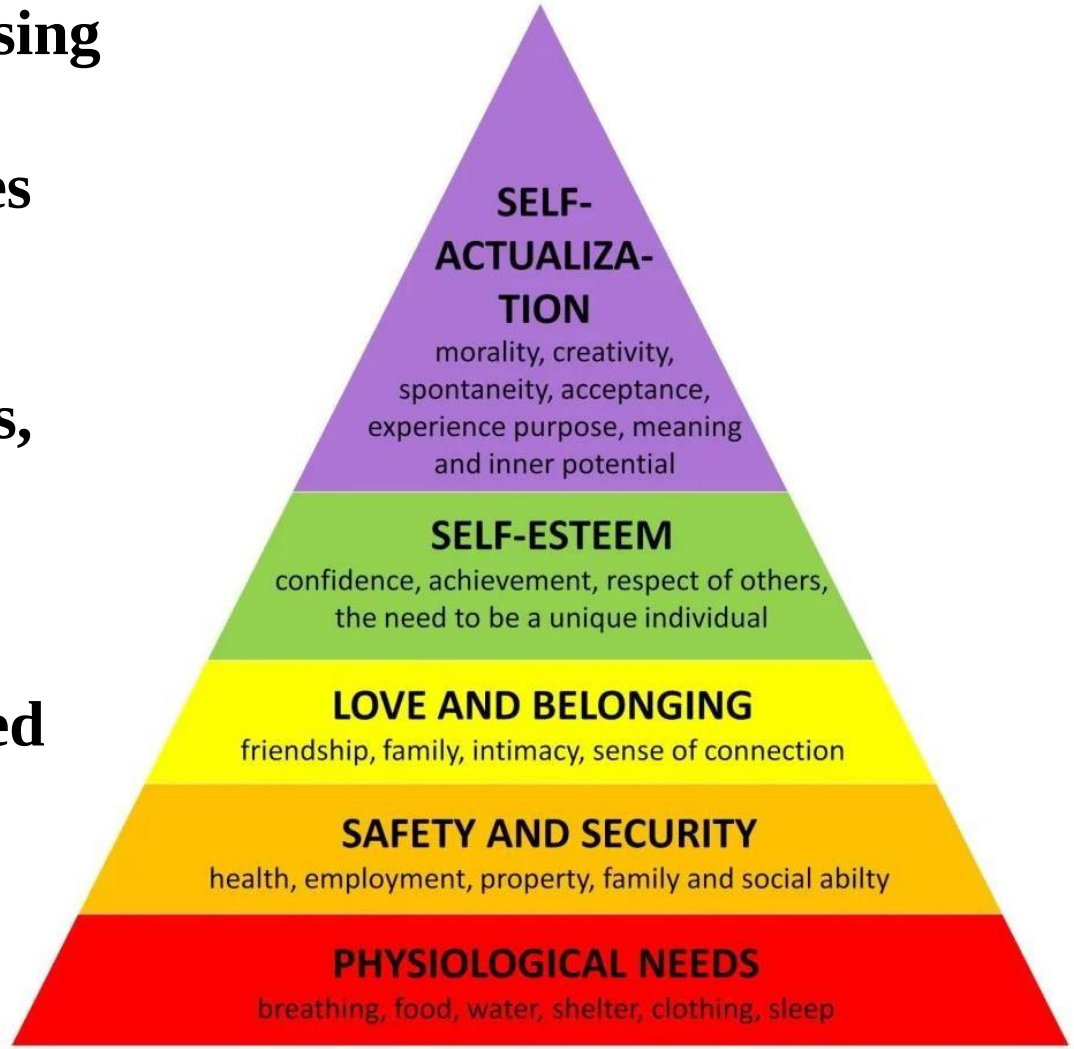
3. Planning

Setting Priorities : is the process of establishing a preferential sequence for addressing nursing diagnoses and interventions

- **deciding which nursing diagnosis requires attention first, which second..**

Group the diagnosis according to:

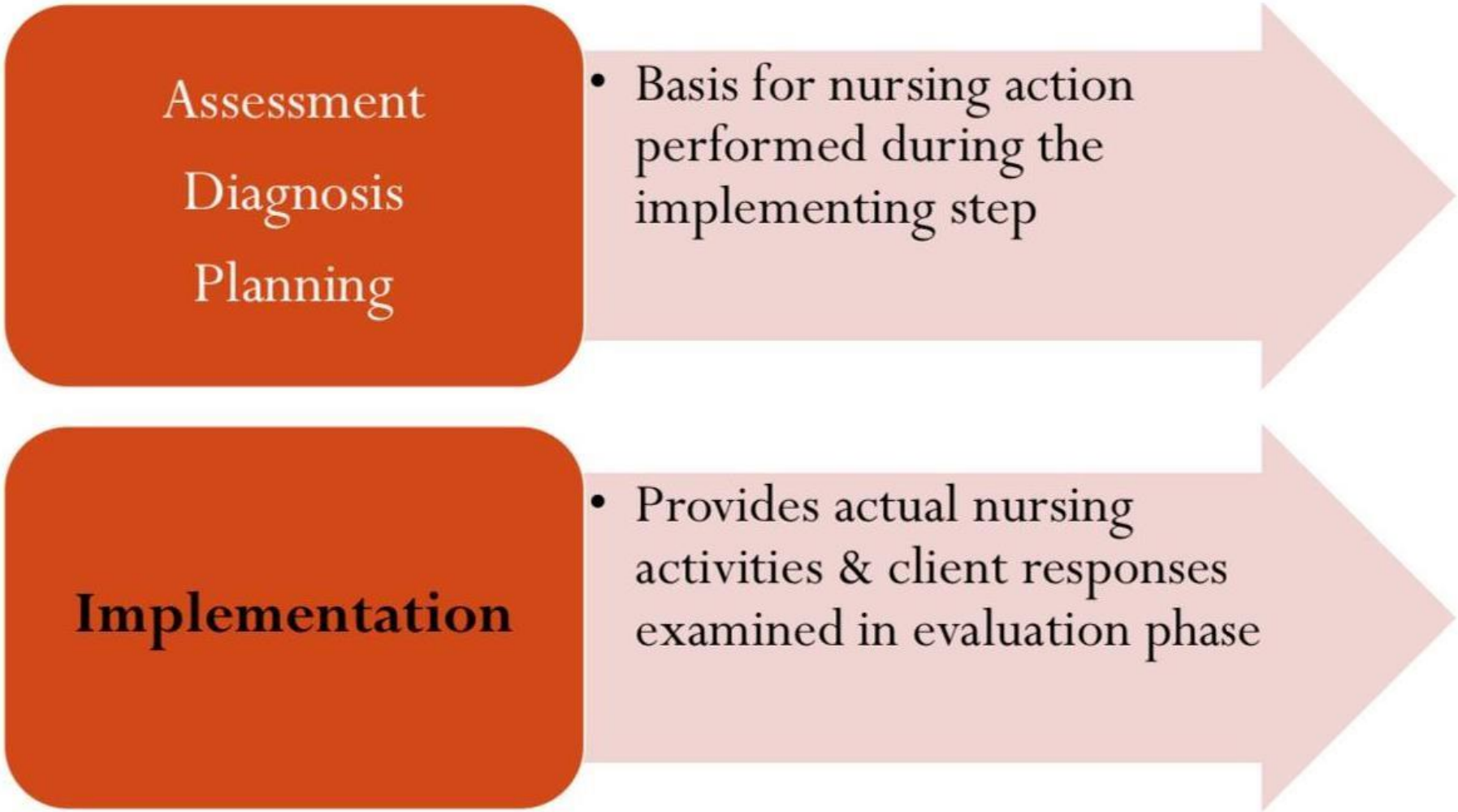
- **High Priority - Life-threatening problems, such as impaired respiratory or cardiac function**
- **Medium Priority - Health-threatening problems, such as acute illness and decreased coping ability**
- **Low Priority - arises from normal developmental needs or that requires only minimal nursing support**
- **Nurses use Maslow's hierarchy of needs when setting priorities**



4. Implementation

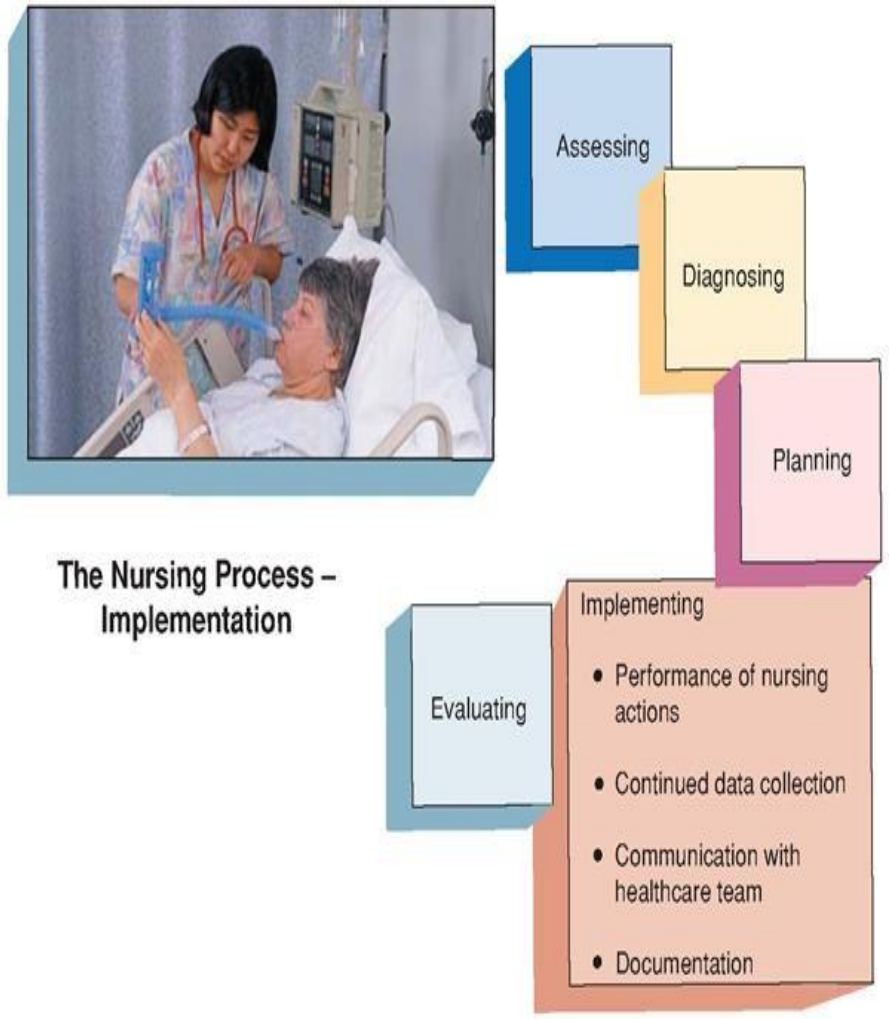
- the action phase in which the nurse performs the nursing interventions - “puts the plan into action”
- Nursing Interventions Classification (NIC) - consists of doing and documenting the activities that are the specific nursing actions needed to carry out the interventions
- Performs or delegates the nursing activities for the interventions that were developed in the planning step and recording nursing activities and the resulting client responses

Relationship of Implementing to Other Nursing Process Phases



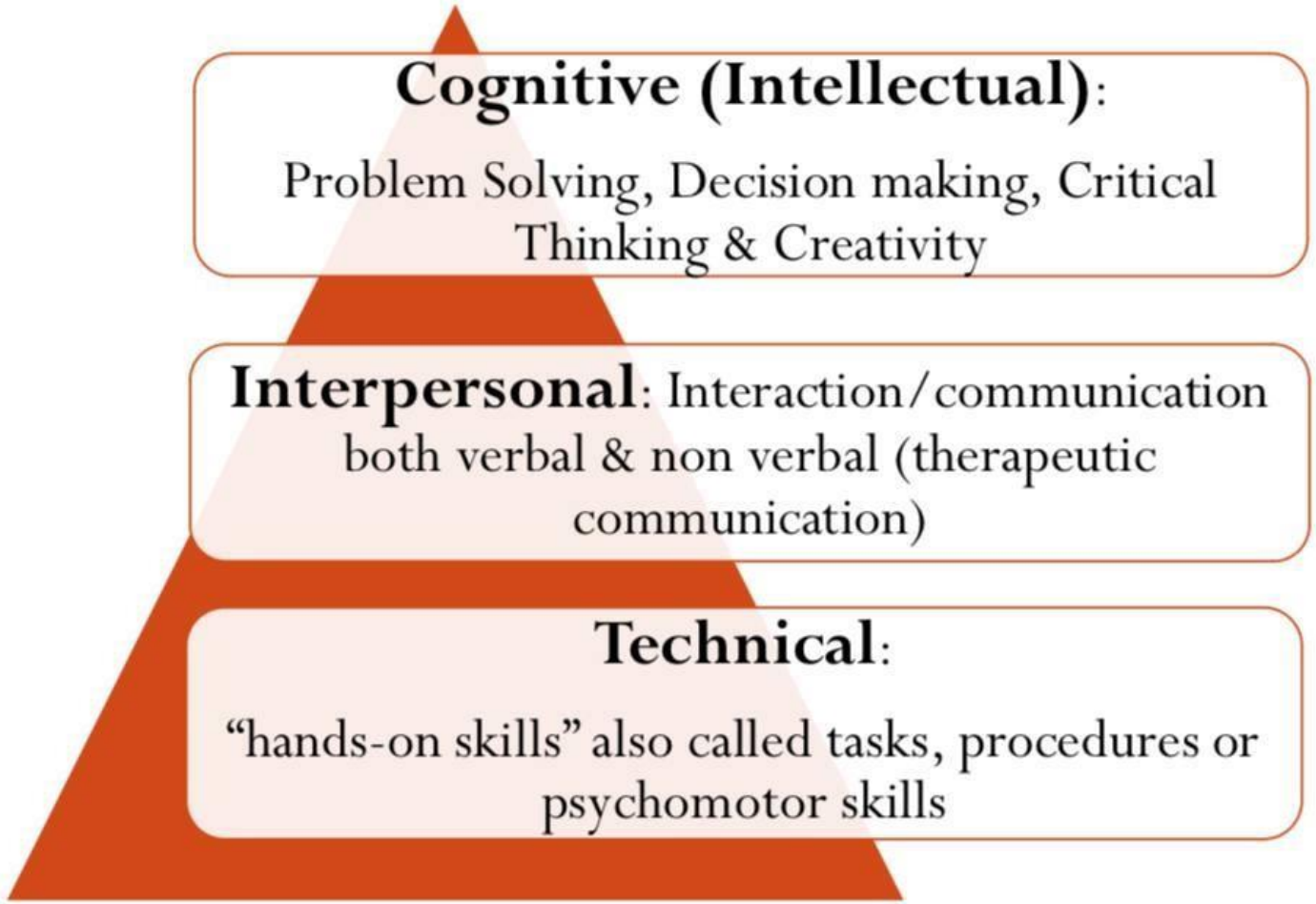
Examples

- Airway Management - “Auscultate breath sounds q4h.”
- The nurse is both carrying out the intervention (implementing) and performing an assessment
- While bathing an older client, the nurse observes a reddened area on the client’s sacrum
- When emptying a urinary catheter bag, the nurse measures 200 mL of offensive smelling, brown urine



The Nursing Process – Implementation

Implementing Skills



Guidelines in Implementing the Nursing Interventions

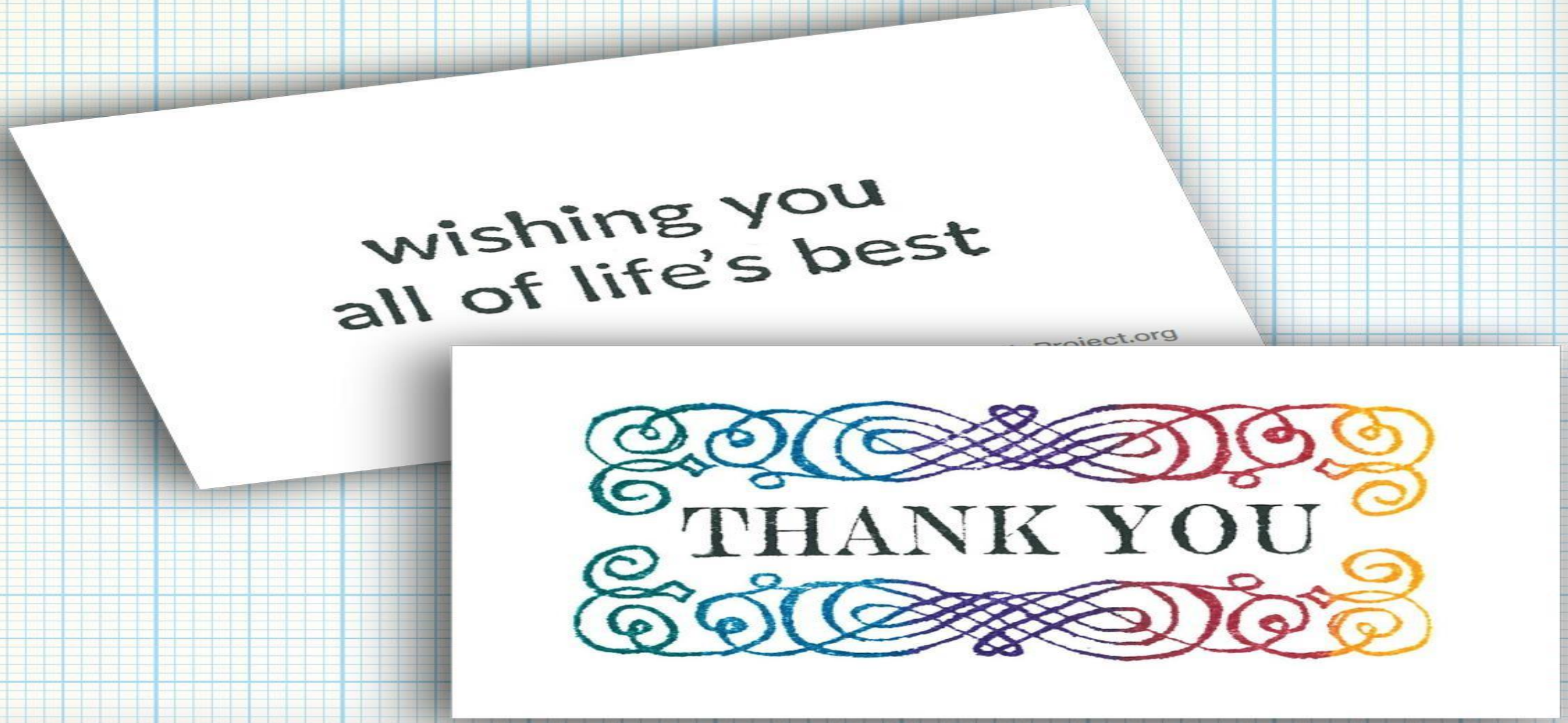
- Based on scientific knowledge, nursing research & professional standards of care (**Evidence-based Practice**)
- Clearly understand the interventions to be implemented and question any that are not understood
- Adapt activities to client (beliefs, values, age, health status, and environment)
- Implement safe care
- Provide teaching, support, and comfort
- Be holistic (viewing **client & responses as a whole**)
- Respect the **dignity** of the client and enhance self-esteem (**Privacy** and allowing clients to make own decisions)
- Encourage clients to participate actively

Documenting Nursing Activities

- Record the interventions and client responses in the **nursing progress notes**
- Nursing care must not be recorded in advance
- May record routine or recurring activities (mouth care) in the client record at the end of a shift (personal record on a worksheet)
- Nursing activities are communicated verbally as well as in writing
- It is important to record a nursing intervention immediately after implemented especially for administration of medications and treatments
- Recorded data about a client must be up to date, accurate, and available
- to other nurses and health care professionals
- Immediate recording helps safeguard the client, for example, from receiving a duplicate dose of medication
- Report client status at a change of shift and on a client's discharge to another unit or health agency in person, via a voice recording, or in writing

Evaluation

- "to judge or to appraise"
- "Planned, Ongoing, Purposeful activity" – determines client's progress toward achievement of goals/outcomes and the effectiveness of the nursing care plan
- Conclusions drawn determine whether the nursing nterventions should be terminated, continued, or changed
- "**Continuous**" - enable to make on-the-spot modifications in an intervention
- "**Responsibility and Accountability for actions**" - interest in the results of the nursing activities and not perpetuate ineffective actions but to adopt more effective ones


Wishing you
all of life's best
THANK YOU