# NURSING PROCESS

"the cornerstone of the nursing profession"

# HISTORY

- The term ***nursing process*** and the framework it implies are relatively new.
- In 1955, Hall originated the term (care, cure,core), 3 steps: note observation, ministration, validation
- Johnson (1959), "Nursing seen as fostering the behavioral functioning of the client".
- Orlando (1961), identified 3 steps: client's behavior, nurse's reaction, nurse's action. "Nursing process set into motion by client's behavior"
- Weidenbach (1963) were among the first to use it to refer to a series of phases describing the process.
- Wiche (1967) "Nursing is define as an interactive process between client and nurse". 4 steps: Perception, Communication, Interpretation, Evaluation.
- Yura and Walsh (1967) suggested the 4 components –APIE.
- Knowles (1967) described nursing process as: discover, delve, decide, do, discriminate.

# American Nurses Association

- Published standards of nursing practice. Diagnosis distinguished as separate step of nursing process (1973)
- Published Nursing – a Social Policy Statement. Diagnosis of **actual and potential** health problems delineated as integral part of nursing practice (1980)
- Published Standard of Clinical Nursing Practice. Outcome identification differentiated as a distinct step of the nursing process. Therefore, the six steps of the nursing process are as follows: A.D.OI.P.I.E. (1991).

# What is a Process?

It is a series of planned actions or operations directed towards a particular result or goal.

# Nursing Process

**It is a systematic, rational method of planning and providing individualized nursing care.**

# The Nursing Process

- Is the underlying scheme that provides order and direction to nursing care.
- It is the essence of professional nursing practice.
- It has been conceptualized as a systematic series of independent nursing actions directed toward promoting an optimum level of wellness for the client.
- It is cyclical; the components follow a logical sequence, but more than one component may be involved at any one time.

# Purpose of Nursing Process

- To identify a client's health status, actual or potential health care problems or needs, to establish plans to meet the identified needs, and to deliver specific nursing interventions to meet those needs.
- It helps nurses in arriving at decisions and in predicting and evaluating consequences.
- It was developed as a specific method for applying a scientific approach or a problem solving approach to nursing practice.

# Nursing Process...

Organized Systematic

Goal-Oriented

Humanistic Care

Efficient Effective

# PHASES OF THE NURSING PROCESS

- Assessment
- Diagnosis
- Outcome Identification
- Planning
- Implementation
- Evaluation

# ASSESSMENT

- To establish baseline information on the client.
- To determine the client's normal function.
- To determine the client's risk for diagnosis function.
- To determine presence or absence of diagnosis function.
- To determine client's strengths.
- To provide data for the diagnostic phase.

# Activities of Assessment

- COLLECT DATA
- VALIDATE DATA
- ORGANIZE DATA
- RECORDING DATA

**Assessment involves reorganizing and collecting CUES:**

**Objective (overt)  Subjective (covert)**

# Types of Assessment

- **Initial Assessment**

  - initial identification of normal function, functional status and collection of data concerning actual and potential dysfunction.

- **Focus Assessment**

  - status determine of a specific problem identified during previous assessment.

- **Time Lapsed Reassessment**

  - comparison of client' current status to baseline obtained previously, detection of changes in all functioning health problems after an extended period of time .

- **Emergency Assessment**

  - identification of life threatening situation.

# Clinical Skills used in Assessment

- **Observation** – act of noticing client cues.

  *looking, watching, examining, scrutinizing, surveying, scanning, appraising.

  *uses different senses: vision, smell, hearing, touch.
- **Interviewing** – interaction and communication.
- **Physical Examination**
  - INSPECTION
  - PERCUSSION
  - AUSCULTATION
  - INTUITION

    - defined as insights, instincts or clinical experiences to make judgment about client care.

# 4 PHASES OF INTERVIEW:

- Preparatory Phase
  (Pre-interaction)
- Introductory Phase
  (Orientation)
- Maintenance Phase
  (Working)
- Concluding Phase
  (Termination)

# COMMUNICATION

- A process in which people affect one another through exchange of information, ideas, and feelings.
- Documentation/Recording is a vital aspect of nursing practice.
- Include both oral and written exchange of information between caregivers.

# Modes of Communication

- **Verbal Communication**

  - Uses spoken or written words.

- **Non-verbal Communication**

  - Uses gestures, facial expression, posture/gait, body movements, physical appearance (also body language), eye contact, tone of voice.

# Characteristics of Communication

- SIMPLICITY

  - commonly understood words, brevity, and completeness
- CLARITY

  - exactly what is meant
- TIMING and RELEVANCE

  - appropriate time and consideration of client's interest and concerns
- ADAPTABILITY

  - adjustment – depending on moods and behavior
- CREDIBILITY

  - worthiness of belief

# Components of Communication

# Documenting & Reporting

- **DOCUMENTATION**

  - Serves as a permanent record of client information and care.
- **REPORTING**

  - takes place when two or more people share information about client care

**NURSING DOCUMENTATION**: the charting of documents, the professional surveillance of the patient, the nursing action taken in the patient's behalf, and the patient's programs with regards to illness.

# Purposes of Client's Record /Chart

1. Communication
2. Legal Documentation
3. Research
4. Statistics
5. Education
6. Audit and Quality Assurance
7. Planning Client Care
8. Reimbursement

# TYPES OF RECORDS

A. Source Oriented Medical Record
"traditional client record"

**FIVE BASIC COMPONENTS:**

4. Admission sheet
5. Physician's order sheet
6. Medical history
7. Nurse's notes
8. Special records and reports

B. Problem-oriented medical record (POMR)

- arranged according to the source of information.

**FOUR BASIC COMPONENTS:**

5. Database
6. Problem list
7. Initial list f orders or care plans
8. Progress notes:
   - Nurse's notes
     - (SOAPIE)
   - Flow sheets
   - Discharge notes or referral summaries

# KARDEX

- Concise method of organizing and recording data.
- Readily accessible to health care team.
- Series of Flip cards
- Ensure continuity of care
- Tool for change of shift report
- For planning & communication purposes.

# Parts of a Kardex

- Personal Data
- Basic needs
- Allergies
- Diagnostic tests
- Daily Nursing Procedures
- Medications and IV therapy, BT.
- Treatments like $O_2$, steam inhalation, suctioning, change of dressings, mechanical ventilation.

# Characteristics Of Good Recording

1. BREVITY.
2. USE OF INK / PERMANENCE.
3. ACCURACY.
4. APPROPRIATENESS.
5. COMPLETENESS & CHRONOLOGY / ORGANIZATION / SEQUENCE / TIMING.
6. USE OF STANDARD TERMINOLOGY.
7. SIGNED.
8. In case of ERROR.
9. CONFIDENTIALITY.
10. LEGAL AWARENESS.
11. LEGIBLE.
12. DO NOT use the word “PATIENT” or “PT” in the chart.
13. A HORIZONTAL LINE drawn to fill up a partial line.

# REPORTING

1. **CHANGE-OF-SHIFT REPORTS OR ENDORSEMENT.**
   -for continuity of care / health care needs.
2. **TELEPHONE REPORTS.**
   -provide clear, accurate, & concise information
   -includes: when, who made/was, whom, what info given/received.
3. **TELEPHONE ORDERS.**
   - RN's duty, must be signed w/in 24 hours.
4. **TRANSFER REPORTS**
   - from one unit to another.

# Some Legal Significance of CHARTING

1. Chart Accurately
2. Chart Objectively
3. Chart Promptly
4. Make No Mention of an Incident Report in the Chart
5. Write Legibly and Use Only Standard Abbreviations

# THIRTEEN CHARTING RULES

1. Write Neat and Legibly
2. Use Proper Spelling and Grammar
3. Write with Blue or Black Ink and Use Military time
4. Use Authorized Abbreviations
5. Transcribe Orders Carefully
6. Document Complete Information About Medication
7. Chart Promptly

1. Never Chart Nursing Care or Observation Ahead of Time.
2. Clearly Identify Care Given by Another Member of the Health Care Team.
3. Don’t Leave Any Blank Spaces on Chart Forms.
4. Correctly Identify Late Entries.
5. Correct Mistaken Entries Properly.
6. Don’t Sound Tentative – Say What You Mean.

# SIX More Charting Rules

1. Don’t Tamper with Medical Records.
2. Don’t criticize other Health Care Professionals in the chart.
3. Don’t Document any Comments that a patient or family member makes about a potential lawsuit against a health care professional or the hospital.
4. Eliminate bias from written descriptions of the patient.
5. Precisely document any information you report to the doctor.
6. Document any potentially contributing patient acts.

# How to Document Non-Compliance

1. Refusing to comply with dietary restrictions.
2. Getting out of bed without asking help.
3. Ignoring follow-up appointments at the clinic, emergency department, out-patient or doctor's office.
4. Leaving against medical advice (AMA)
5. Abusing or refusing to take medications.

# Personal Items at the Bedside

Your notes should contain a description of what was found and how you disposed of it.

**TAMPERING w/ MED. EQUIPMENT**

Document what you saw the patient doing or what you believe he's doing.

con't.

# SIX PHASES

# NURSING PROCESS

# ASSESSMENT

- To establish data base.

Sources of Data:

4. Primary: Patient / Client
5. Secondary: Family members, SOs, Record/Chart, Health team members, Related Lit.

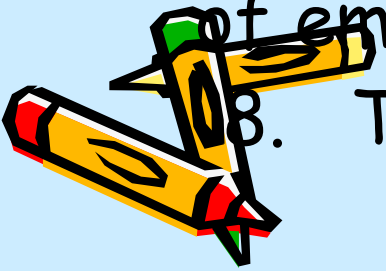
# Approaches to Collecting Data for Assessing Client's Health:

- ABDELLAH'S 21 Nursing Problems
- DOROTHEA OREM'S Components of Universal Self-Care
- GORDON'S Functional Health Patterns
- Correlating a Body Systems Physical Examination with Data Gathered by Functional Health Area.

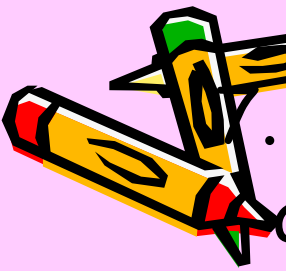
# ABDELLAH's 21 Nursing Problems:

1. To promote good hygiene and physical comfort.
2. To promote optimal activity, exercise, rest and sleep.
3. To promote safety through the prevention of accident, injury, or other trauma and through the prevention of the spread of infection.
5. To maintain good body mechanics and prevent and correct deformities.
6. To facilitate the maintenance of a supply of oxygen to all body cells.
7. To facilitate the maintenance of nutrition of all body cells.
9. To facilitate the maintenance of eliminations.

1. To facilitate the maintenance of food and electrolyte balance.
3. To recognize the physiological responses of the body to disease conditions – pathological, physiological, and compensatory.
4. To facilitate the maintenance of regulatory mechanisms and functions.
5. To facilitate the maintenance of sensory functions.
6. To identify and accept the positive and negative expressions, feelings, and reactions.
7. To identify and accept the inter-relatedness of emotions and organic illness.
8. To facilitate the maintenance of effective verbal and non-verbal communication.



1. To promote the development of productive interpersonal relationships.
2. To facilitate progress toward achievement of personal spiritual goals.
3. To create/or maintain a therapeutic environment.
4. To facilitate awareness of self as an individual with varying physical, emotional, and developing needs.
5. To accept the optimum goals in the light of physical and emotional limitations.
6. To use community resources as an aide in resolving problems arising from illness.
7. To understand the role of social problems as influencing factors in the cause of illness.



# Dorothea Orem's Components of Universal Self-Care

- Maintenance of sufficient intake of air, water and food.
- Provision of care associated with elimination process and excrements.
- Maintenance of a balance between solitude and social interaction.
- Prevention of hazards to life, functioning and well-being.
- Promotion of human functioning and development within social groups in accord with potential known limitations and the desire to be normal.

# GORDON'S FUNCTIONAL HEALTH PATTERNS

1. **Health Perception – Health Management Pattern**

   - describes client's perceived pattern of health and well being and how health is managed.

3. **Nutritional – Metabolic Pattern**

   - describes pattern of food and fluid consumption relative to metabolic need and pattern indicators of local nutrient supply.

5. **Elimination Pattern**

   - describes pattern of excretory function (bowel, bladder, and skin)

1. **Activity – Exercise Pattern**

   - describes pattern of exercise, activity, leisure, and recreation.

3. **Cognitive – Perceptual Pattern**

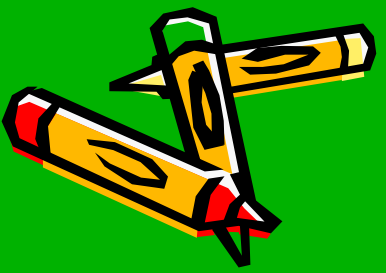
   - describes sensory, perceptual, and cognitive pattern

5. **Sleep – Rest Pattern**

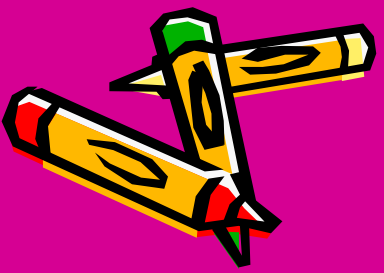
   - describes patterns of sleep, rest, and relaxation.

7. **Self-perception – Self-concept Pattern**

   -describes self-concept and perceptions of self (body comfory, image, feeling state)



1. **Role – Relationship Pattern**
   - describes pattern of role engagements and relationships.
4. **Sexuality – Reproductive Pattern**
   - describes client's pattern of satisfaction and dissatisfaction with sexuality pattern, describes reproductive patterns.
6. **Coping – Stress Tolerance Pattern**
   - describes general coping patterns and effectiveness of the pattern in terms of stress tolerance.
8. **Value – Belief Pattern**
   - describes pattern of values and beliefs, including spiritual and /or goals that guide choices or decisions.



# DIAGNOSING

- Clinical act of identifying problems.
- Identify health care needs.
- Prepare diagnostic statements.
- Uses critical thinking skills of analysis and synthesis. (PRS – PES)
- ACTIVITIES:
  - organize cluster or group data.
  - compare data against standards.
  - analyze data after comparing with standards.
  - identify gaps / inconsistencies in data.
  - determine health problems, risks, and strengths.
  - formulate Nursing Diagnosis.

# Outcome Identification

- refers to formulating and documenting measurable, realistic, client-focused goals.
- PURPOSES:
  - To provide individualized care
  - To promote client participation
  - To plan care that is realistic and measurable
  - To allow involvement of support people

# Classification of NURSING DIAGNOSIS:

- **High – priority**
  - **life threatening and requires immediate attention.**
- **Medium – priority**
  - **resulting to unhealthy consequences.**
- **Low – priority**
  - **can be resolve with minimal interventions.**

# Characteristics of Outcome Criteria:

- S - SPECIFIC
- M - MEASURABLE
- A - ATTAINABLE
- R - REALISTIC
- T - TIME – FRAMED

- CAN BE SHORT TERM OR LONG TERM GOAL.

# PLANNING

- **Involves determining beforehand the strategies or course of actions to be taken before implementation of nursing care.**

- **To be effective, involve the client and his family in planning!**

# IMPLEMENTATION

- Putting nursing care plan into ACTION!
- To help client attain goals and achieve optimal level of health.
- Requires: Knowledge, Technical skills, Communication skills, Therapeutic Use of Self.

**.....SOMETHING THAT IS NOT WRITTEN IS CONSIDERED AS NOT DONE!!!**

# EVALUATION

- IS ASSESSING THE CLIENT'S RESPONSE TO NURSING INTERVENTIONS.
- COMPARING THE RESPONSE TO PREDETERMINED STANDARDS OR OUTCOME CRITERIA.
- FOUR POSSIBLE JUDGMENTS:
  - The goal was completely met.
  - The goal was partially met.
  - The goal was completely unmet.
  - New problems or nursing diagnoses have developed.

# Characteristics of NURSING PROCESS...

- Problem-oriented.
- Goal oriented.
- Orderly, planned, step by step. (systematic)
- Open to new information.
- Interpersonal.
- Permits creativity.
- Cyclical.
- Universal.

# Benefits of the NURSING PROCESS: for the Client

- QUALITY CLIENT CARE
- CONTINUITY OF CARE
- PARTICIPATION BY CLIENTS IN THEIR HEALTH CARE

# Benefits of the NURSING PROCESS: for the Nurse

- CONSISTENT AND SYSTEMATIC NURSING EDUCATION.
- JOB SATISFACTION.
- PROFESSIONAL GROWTH.
- AVOIDANCE OF LEGAL ACTION.
- MEETING PROFESSIONAL NURSING STANDARDS.
- MEETING STANDARDS OF ACCREDITED HOSPITALS.

# HEART OF THE NURSING PROCESS...

- **KNOWLEDGE**
- **SKILLS**
  - manual, intellectual, interpersonal.
- **CARING**
  - willingness and ability to care.

# Willingness to CARE

- Keep the focus on what is best for the patient.
- Respect the beliefs / values of others.
- Stay involved.
- Maintain a healthy

# CARING BEHAVIORS

- Inspiring someone / instilling hope and faith.
- Demonstrating patience, compassion, and willingness to persevere.
- Offering companionship.
- Helping someone stay in touch with positive aspect of his life.
- Demonstrating thoughtfulness.
- Bending the rules when it really counts.
- Doing the “little things”
- Keeping someone informed.
- Showing your human side by sharing “stories”