Ishik International University Nursing

Department

Fundamental of Nursing

Nursing process

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The Nursing Process

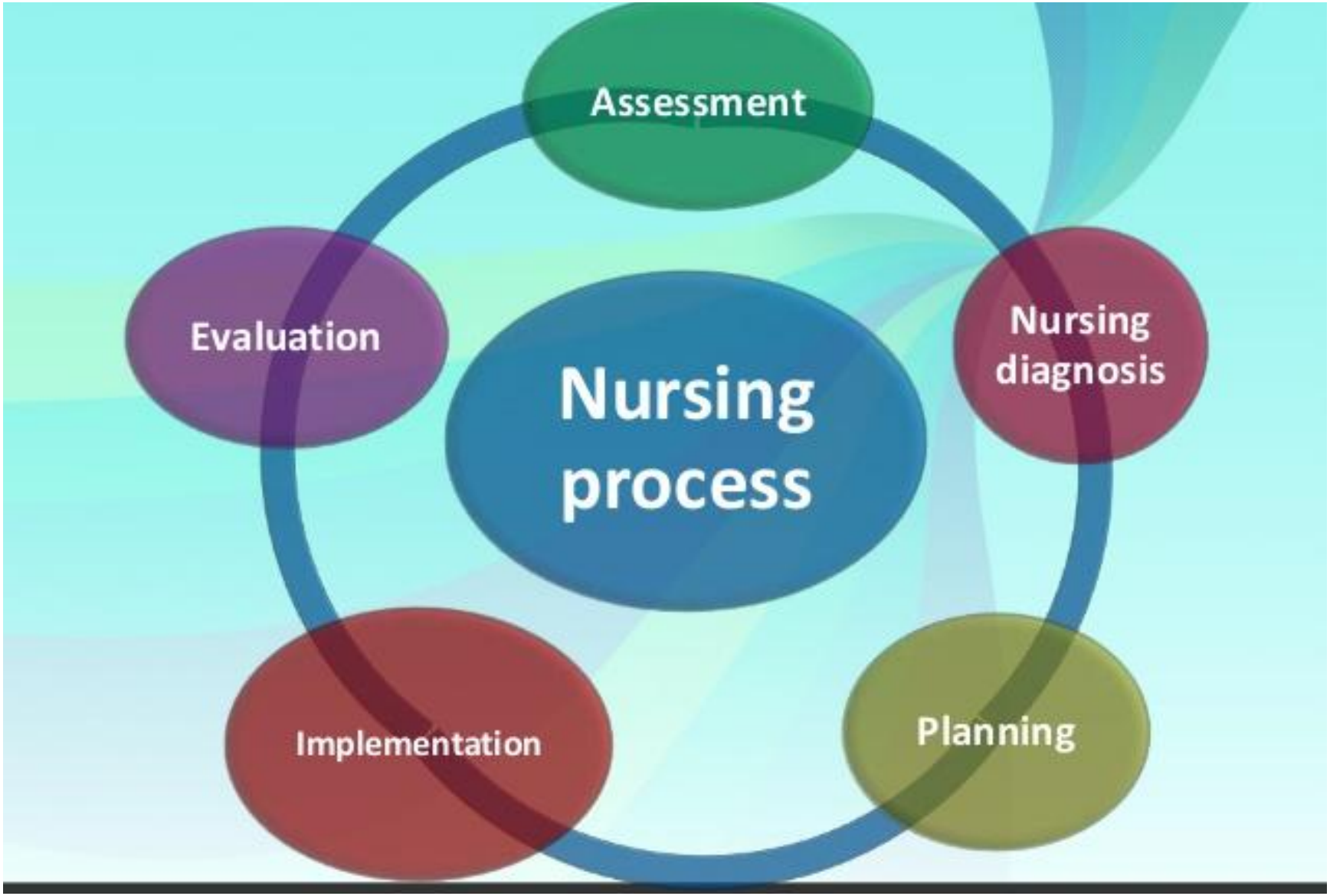
INTRODUCTION

- The nursing process: Is a systematic, rational method of planning and providing individualized nursing care.
- Its purposes are to
- identify a client's health status and 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.
- The client may be an individual, a family, a community, or a group.

Phases of the Nursing Process

- This text, and most others, uses five phases: **assessing, diagnosing** (which includes outcomes identification and analysis), **planning, implementing, and evaluating.**


Assessment
Nursing diagnosis
Planning
Implementation
Evaluation
Nursing process

- Although nurses may use different terms to describe the phases (or steps) of the nursing process.
- Each phase of the nursing process affects the others; they are closely interrelated.

Assessing

After completing this chapter, you will be able to:

1. Describe the phases of the nursing process.
2. Identify the purpose of assessing.
3. Identify the four major activities associated with the assessing phase.

4. Differentiate objective and subjective data and primary and secondary data.

5. Identify three methods of data collection, and give examples of how each is useful.

Assessing

- Is the systematic and continuous collection, organization, validation, and documentation of data (information).
- The four different types of assessments are the initial nursing assessment, problem-focused assessment, emergency assessment, and time-lapsed reassessment.

- Assessments vary according to their purpose, timing, time available, and client status.
- Nursing assessments focus on a client's responses to a health problem. A nursing assessment should include the client's perceived in needs, health problems, related experience, health practices, values, and lifestyles.

COLLECTING DATA

- Data collection is the process of gathering information about a client's health status.
- Data collection must be both systematic and continuous to prevent the omission of significant data and reflect a client's changing health status.

- A database contains all the information about a client; it includes the nursing health history, physical assessment.
- Client data should include past history as well as current problems. For example, a history of an allergic reaction to penicillin is a vital piece of historical data.

- Past surgical procedures.
- Chronic diseases.
- Current data relate to present circumstances, such as pain, nausea, sleep patterns, and religious practices. To collect data accurately, both the client and nurse must actively participate.

Types of Data

- **Subjective data**, also referred to as symptoms or covert data, are apparent only to the person affected and can be described or verified only by that person.

- **Objective data,** also referred to as signs or overt data, are detectable by an observer or can be measured or tested against an accepted standard.
- They can be seen, heard, felt, or smelled. blood pressure, level of pain.

Sources of Data

CLIENT

- The best source of data is usually the client, unless the client is too ill, young, or confused to communicate clearly.
- Family members or significant others can be secondary sources of data if the client cannot speak for themselves.

SUPPORT PEOPLE

- Family members, friends, and caregivers who know the client well often can supplement or verify information provided by the client.
- Support people are an especially important source of data for a client who is very young, unconscious, or confused.

CLIENT RECORDS

- Client records include information documented by various health care professionals.
- Client records also contain data regarding the client's occupation, religion, and marital status.

HEALTH CARE PROFESSIONALS

- Because assessment is an ongoing process, verbal reports from other health care professionals serve as other potential sources of information about a client's health.

LITERATURE

- The review of nursing and related literature, such as professional journals and reference texts, can provide additional information for the database.

Data Collection Methods

- The principal methods used to collect data are observing, interviewing, and examining.
- Observing occurs whenever the nurse is in contact with the client or support persons.
- Interviewing is used mainly while taking the nursing health history.

- Examining is the major method used in the physical health assessment.

ORGANIZING DATA

- The nurse uses a written (or electronic) format that organizes the assessment data systematically.
- This is often referred to as a nursing health history, nursing assessment, or nursing database form.

- The format may be modified according to the client's physical status such as one focused on musculoskeletal data for orthopedic clients.

VALIDATING DATA

- Validation is the act of “double-checking” or verifying data to confirm that it is accurate and factual.

DOCUMENTING DATA

- To complete the assessment phase, the nurse records client data.
- Accurate documentation is essential and should include all data collected about the client's health status.

Diagnosing

- Diagnosing is the second phase of the nursing process.
- In this phase, nurses use critical thinking skills to interpret assessment data and identify client strengths and problems.

- In 1982, the conference group accepted the name North American Nursing Diagnosis Association **(NANDA)**, recognizing the participation and contributions of nurses in the United States and Canada.

Status of the Nursing Diagnoses

1- An actual nursing diagnosis is a client problem that is present at the time of the nursing assessment. **Examples** are Ineffective Breathing Pattern and Anxiety. An actual nursing diagnosis is based on the presence of associated signs and symptoms.

2- A risk nursing diagnosis is a clinical judgment that a problem does not exist, but the presence of risk factors indicates that a problem is likely to develop unless nurses intervene.

For example, all people admitted to a hospital have some possibility of acquiring an infection.

Components of a NANDA Nursing Diagnosis

- A nursing diagnosis has three components:
- (1) the problem
- (2) the etiology,
- and (3) the defining characteristics.

1. **Problem** (P): statement of the client's response (NANDA label).

2. **Etiology** (E): factors contributing to or probable causes of the response

3. **Signs and symptoms** (S): defining characteristics manifested by the client.

Planning

- **Planning** is a deliberative, systematic phase of the nursing process that involves decision making and problem solving.
- **In planning,** the nurse refers to the client's assessment data and diagnostic statements for direction in formulating client goals and designing the nursing interventions required to prevent, reduce, or eliminate the client's health problems.

THE PLANNING PROCESS

- Setting priorities.
- Establishing client goals.
- Selecting nursing interventions and activities.
- Writing individualized nursing interventions on care plans.

Setting Priorities

- Priority setting is the process of establishing a preferential sequence for addressing nursing diagnoses and interventions.
- The nurse and client begin planning by deciding which nursing diagnosis requires attention first, which second, and so on.

- Nurses can group them as having high, medium, or low priority.
- Life-threatening problems, such as impaired respiratory or cardiac function, are designated as high priority.

- **Health-threatening problems,** such as acute illness and decreased coping ability, are assigned medium priority because they may result in delayed development.
- **A low-priority problem** is one that arises from normal developmental needs or that requires only minimal nursing support.

Establishing Client Goals

- After establishing priorities, the nurse and client set goals for each nursing diagnosis.
- On a care plan, the goals describe, in terms of observable client responses, what the nurse hopes to achieve by implementing the nursing interventions.

Selecting Nursing Interventions and Activities

- Nursing interventions and activities are the actions that a nurse performs to achieve client goals.
- The specific interventions chosen should focus on eliminating or reducing the etiology of the nursing diagnosis.

- When it is not possible to change the etiologic factors, the nurse chooses interventions to treat the signs and symptoms.
- Interventions for risk nursing diagnoses should focus on measures to reduce the client's risk factors.

Writing Individualized Nursing Interventions

- After choosing the appropriate nursing interventions, the nurse writes them on the care plan
- Date nursing interventions on the care plan when they are written and review regularly at intervals that depend on the individual's needs. In an intensive care unit, for example, the plan of care will be continually monitored and revised.

Implementing

- In the nursing process, implementing is the action phase in which the nurse performs the nursing interventions.
- implementing consists of doing and documenting the activities that are the specific nursing actions needed to carry out the interventions.

- The nurse performs or delegates the nursing activities for the interventions that were developed in the planning step and then concludes the implementing step by recording nursing activities and the resulting client responses

- While implementing nursing care, the nurse continues to reassess the client at every contact, gathering data about the client's responses to the nursing activities and about any new problems that may develop.

Implementing Skills

- To implement the care plan successfully, nurses need cognitive, interpersonal, and technical skills.
- These skills are distinct from one another; in practice, however, nurses use them in various combinations and with different emphasis, depending on the activity.

- For instance, when inserting a urinary catheter, the nurse needs cognitive knowledge of the principles and steps of the procedure, interpersonal skills to inform and reassure the client, and technical skill in draping the client and manipulating the equipment.

Process of Implementing

- Reassessing the client
- Determining the nurse's need for assistance
- Implementing the nursing interventions
- Supervising the delegated care
- Documenting nursing activities.

REASSESSING THE CLIENT

- Just before implementing an intervention, the nurse must reassess the client to make sure the intervention is still needed.
- Even though an order is written on the care plan, the client's condition may have changed.

- For example, a client has a nursing diagnosis of Disturbed Sleep Pattern related to anxiety and unfamiliar surroundings.
- During rounds, the nurse discovers that the client is sleeping and therefore defers the back massage that had been planned as a relaxation strategy

DETERMINING THE NURSE'S NEED FOR ASSISTANCE

- When implementing some nursing interventions, the nurse may require assistance for one or more of the following reasons:
- The nurse is unable to implement the nursing activity safely or efficiently alone (e.g., ambulating an unsteady obese client).

- Assistance would reduce stress on the client (e.g., turning a person who experiences acute pain when moved).
- The nurse lacks the knowledge or skills to implement a particular nursing activity (e.g., a nurse who is not familiar with a particular model of traction equipment needs assistance the first time it is applied).

SUPERVISING DELEGATED CARE

- If care has been delegated to other health care personnel, the nurse responsible for the client's overall care must ensure that the activities have been implemented according to the care plan.

DOCUMENTING NURSING ACTIVITIES

- After carrying out the nursing activities, the nurse completes the implementing phase by recording the interventions and client responses in the nursing progress notes.
- These are a part of the agency's permanent record for the client.

EVALUATING

- Evaluating is a planned, ongoing, purposeful activity in which clients and health care professionals determine (a) the client's progress toward achievement of goals/ outcomes and (b) the effectiveness of the nursing care plan.

- Evaluation is an important aspect of the nursing process because conclusions drawn from the evaluation determine whether the nursing interventions should be terminated, continued, or changed.