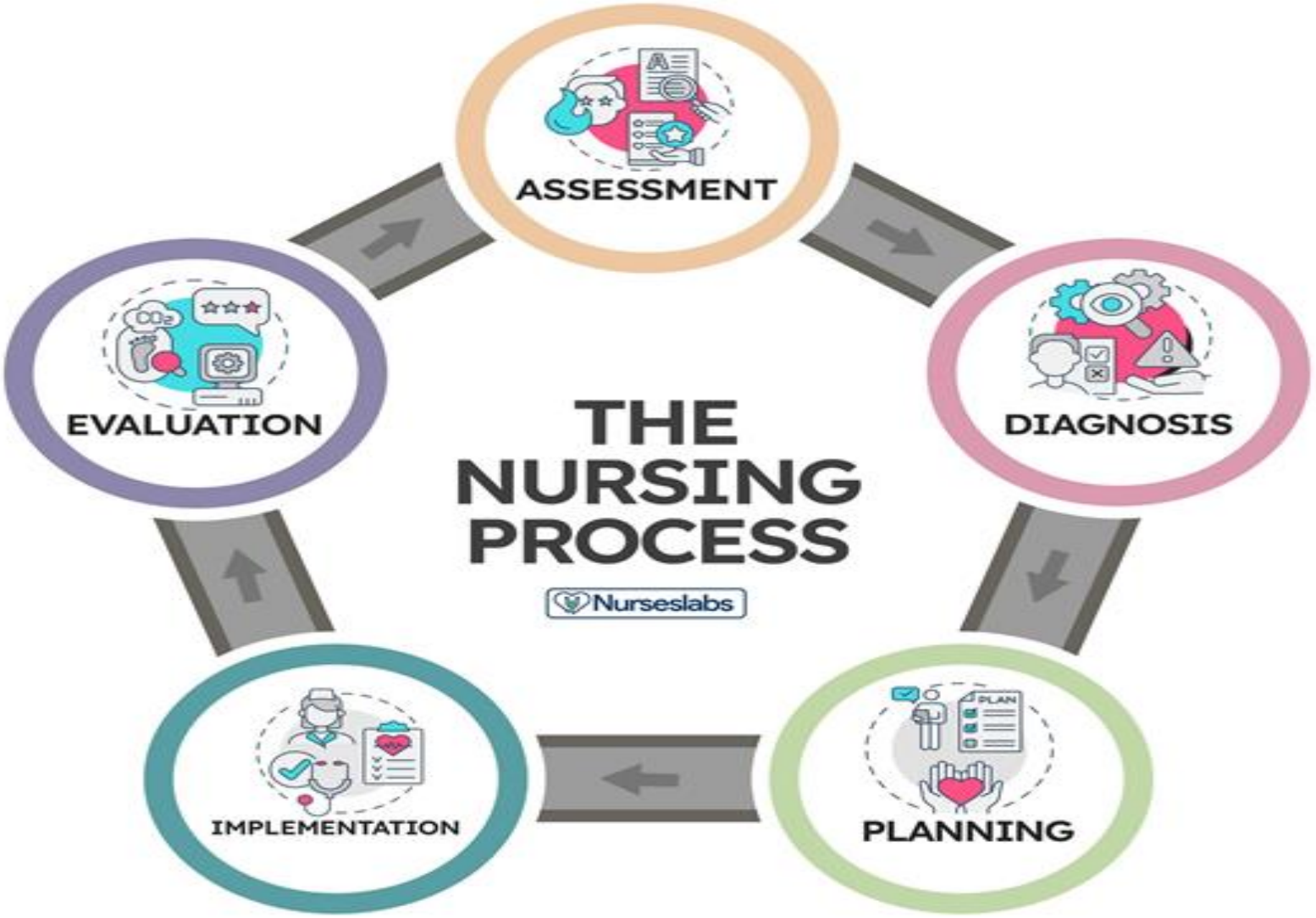
Nursing Process

Second course/practical lecture 3

Dr. wafaa Adnan


ASSESSMENT
DIAGNOSIS
PLANNING
IMPLEMENTATION
EVALUATION
THE NURSING PROCESS
Nurseslabs

Introduction

- Nursing process: systematic rational method of planning and providing individualized nursing care
- Cyclic, dynamic, interpersonal, collaborative and patient centered
- Uses problem solving and decision making skills and requires critical thinking and clinical reasoning

Assessing

- Collecting, organizing, validating, documenting data
- Purpose: database
- Activities: nursing health history,
  - conduct physical assessment within 24hrs of admission
    - review client records/ nursing literature
    - consult support persons and health professionals
- Remember DATA DATA DATA DATA

4 Types of Assessment

Initial assessment (usually within 24 hrs)

Problem-Focused Assessment- the status of a problem

Emergency Assessment –life threatening problem (ABC's) can be new or over looked

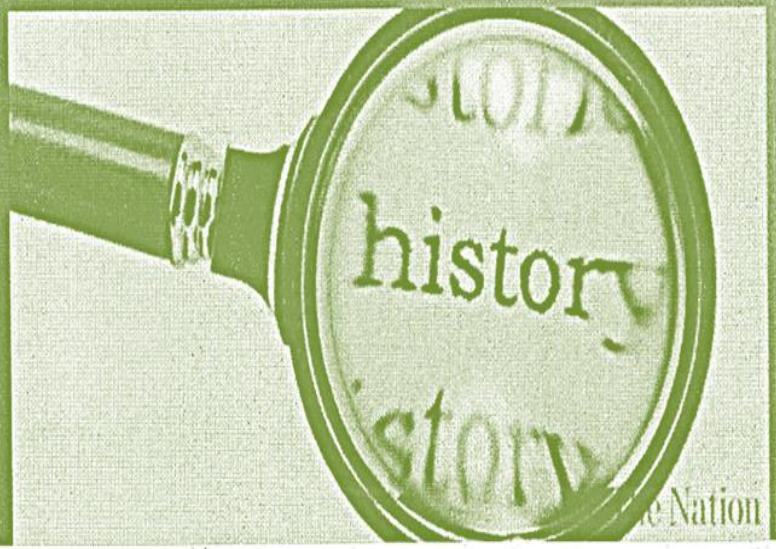
Time- lapsed assessment- compare current status with baseline

Data

Subjective: Information from the patient (symptoms, feelings).
Objective: Measurable data (vitals, labs, physical assessment).

Collecting Data

- Systematic and Continuous to reflect a changing health status
- Past History (allergies/surgeries) / current problems



Types of Data

- Subjective data- symptoms/ what the client states/ support persons interpretation of the clients behavior
  - sensations, values, beliefs, attitude, perception of personal health status;
  - support people (family, sig. others, or other health professionals if info is not based on fact >secondary subjective data/ interpretation of the client's behavior
- Objective data- signs; overt data; measured or tested against an accepted standard; observed or physical examination

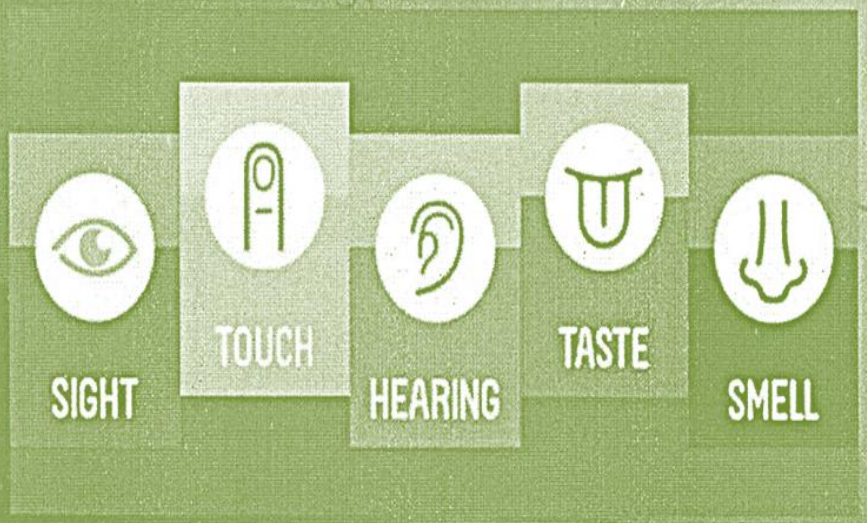
Can you guess?

- I feel weak when I try to stand?
- Client cried during interview
- Client states he has a cramping pain in his abdomen. States, "I feel sick to my stomach."
- Wife states: "He doesn't seem so sad today."
- Blood Pressure 90/50, Apical pulse 100 beats/min

- Subjective
- Objective
- Subjective
- Subjective and secondary source data
- Objective

Data collection methods

- Observing- data gathered with the senses



- Interviewing- defined as a planned communication or a conversation with a purpose
- Focused interview, directive interview, non-directive interview
- Closed questions- leading question
- Open ended questions- neutral questions

Interview Requirements

- Before Beginning an interview the nurse will need to review agency's data collection form (if no form prepare guide)
- Time- physically comfortable/ no interruptions
- Place- well lighted and ventilated/ free of distractions
- Seating Arrangements- eye level (do not speak above or down to a client(
- Distance- 2 to 3 ft

Validating/ Documenting Data

- Complete assessment/Collect any info missed
- Objective and subjective data agree
- Differentiate btw cues and inferences
- Cues are subjective or objective data
- Inferences are the nurse's interpretation or conclusions based on cues
  - Do not jump to conclusions
- Documentation should be accurate/ factual
- Should not include judgement or vague conclusions (good appetite)

Nursing diagnosis

- is a clinical judgment made by nurses about a patient's actual or potential health problems or life processes, based on data analysis .

- It is the second step of the nursing process, identifying patient needs to create targeted care plans. Common types include problem-focused, risk, health promotion, and syndrome-focused diagnoses.

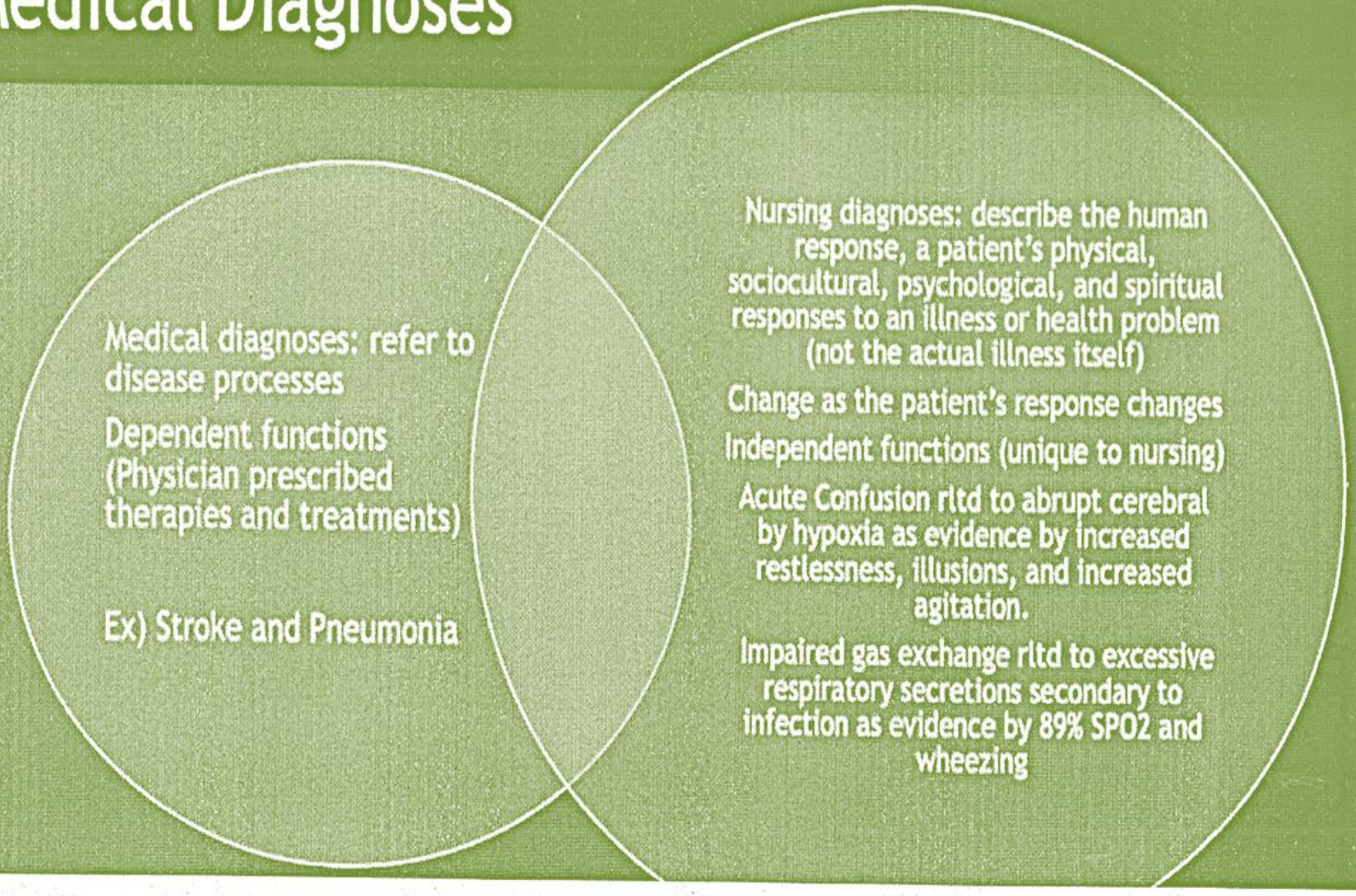
Nursing diagnoses are often structured using NANDA terminology:

Types of Diagnoses

- Actual diagnosis (present at time of assessment)
- Health promotion diagnosis(refers to readiness to improve health status)
- Risk nursing diagnosis (problem does NOT exist just risk factors)
- Syndrome diagnosis (describes a cluster of nursing diagnoses with similar interventions)

- Anxiety related to possible cancer diagnosis as evidence by
- Readiness for enhanced Nutrition
- Risk for Infection related to incision
- Chronic Pain Syndrome, Post trauma syndrome

Differentiating Nursing Diagnoses from Medical Diagnoses



Avoiding Errors in Diagnostic reasoning

- Verify
- Have a good knowledge base / clinical experience
- Know what is normal
- Consult resources
- Base on patterns and not one incident
- Improve critical thinking skills

Planning

- Planning is a deliberate systematic phase of the nursing process that uses problem solving and decision making skills
- Uses Assessment data and diagnostic statements (nursing diagnosis) to create goals and nursing interventions needed to prevent, reduce, or eliminate the client's health problems.
- Planning is a joint effort between support persons, other health professionals, and the patient

Type of planning

- Initial planning: after the initial assessment and based on the initial assessment
- Ongoing planning: beginning of each shift, done as new info is acquired and based on the patient's response to care which allows the plan of care to be individualized
- Discharge planning: needs of patient after discharge; begins as soon as the patient is admitted and requires comprehensive and ongoing assessment

Types of Nursing Care Plans

1- Formal Care Plan: A written or computerized guide that organizes and coordinates comprehensive patient care information.

2-Informal Care Plan: A strategy of action existing in the nurse's mind, often used for immediate, in-the-moment decisions.

3- Standardized Care Plan: Pre-developed, evidence-based plans for specific patient populations with common, routine needs.

4- Individualized Care Plan: Tailored to address the unique, specific needs of a particular patient not covered by standard plans.

IMPORTANT POINTS

- Planning is
  1. Prioritizing problems/diagnoses
  2. Formulating goals/ desired outcomes
  3. Select nursing interventions
  4. Write nursing interventions

- Discharge Planning begins as soon as a patient is admitted

Nursing intervention(Implementation)

Putting the plan into action, including reassessing, performing interventions, and documenting.

Process of implementing

- **Action-Oriented:** The nurse performs nursing interventions, such as administering medication, patient education, or providing comfort.
- **Skills Used:** Cognitive (critical thinking), interpersonal (communication), and technical skills are applied.
- **Key Activities:** Pre-assessment of the patient to ensure readiness, determining the need for assistance, delegating tasks, and ensuring patient safety.
- **Documentation:** Recording all actions, interventions, and patient responses is crucial for continuity of care.

Evaluation

-Assessing the patient's progress toward goals and modifying the plan if necessary

-the final, ongoing step of the nursing process, where nurses systematically assess patient progress toward established goals and determine the effectiveness of interventions examples:

Met: "Patient understanding of low-sodium diet and lists three foods to avoid".

Not Met: "Patient still experiencing pain at level 8/10; analgesic intervention ineffective, doctor notified".