# Dr. Their Radhi Nursing Process

Is a systematic, rational method of planning and providing individualized nursing care.

**Purposes of nursing process**:

1- To identify a client's health status and actual or potential health care problems or needs, 2-To establish plans to meet the identified needs

3-to deliver specific nursing interventions to meet those needs

**Phases of the nursing process:**

1- Assessment (of patient's needs)

2- Diagnosis (of human response needs that nurses can deal with)

3- Planning (of patient's care)

4- Implementation (of care)

5- Evaluation (of the success of the implemented care).

**Nurse must** explain what you are doing, provide privacy, and ask permission before you touch the patient.

**Components of the Health History : Demographic data**

CC: chief complaint. HPI: history of present illness.

PMH: past medical history. FMH: family medical history.

ROS: review of systems. Psychosocial history.

**Sources of the data:**

1- Patient is the primary source of information.

2- Family &significant others, friends.

3- Patient record, records from members of health care, provides essential information related to him.

4- Medical history, physical examination, & progress notes.

5- Laboratory test &other health professions.

**Types of data:**

**1. Objective data** (also known as **signs**). That can be observed, measured, and verified; e.g. swollen joints .

**2.Subjective:** (**symptoms**) That the patient describes; e.g. "I can't do anything for myself".

## Assessment

the first step of the nursing process, systematic collection, validation, and documentation of data. Nursing assessment should be comprehensive, holistic and accurate so that it provides all the necessary information about a patient. using various methods, collecting both **subjective and objective data**, and communicating information about assessments to other members of the health team.

**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 patient's current status to the base line data obtained earlier.

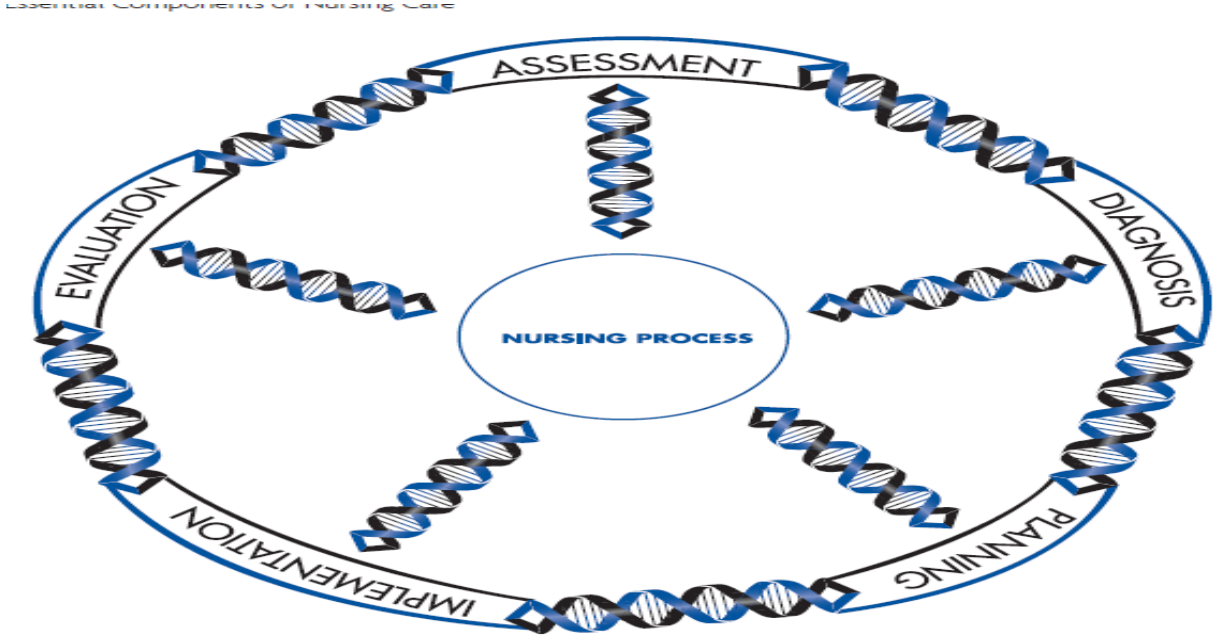
## Methods of Data Collection:

**1.Observation:** Requires practice and skill Systematic, head-to-toe.

**2.Interview:**Structured form of communication Purpose: to provide care specific to this individual's needs and problems.

**3- Physical examination techniques:** • Inspection,, Palpation,, Percussion a**nd** • Auscultation

**Essential Components of Nursing Care**



**Nursing Diagnosis:(patient problem)**

the second step of nursing process. Is a clinical judgment about individual, family or community response to actual or potential health problem. It provides the bases for selection of nursing intervention.

**you can write nursing diagnoses statements using the PES format:**

P= problem (high risk for injury, pain, constipation, impaired communication, etc.)

E= etiology (cause) (factors that cause the problem)

S = signs and Symptoms (the signs and symptoms that are associated with the problem).

**Activities of nursing diagnosis:**

1. Interpret & analyze patient data

2. Identify patient strength and health problem

3. Formulate and validate nursing diagnosis

4. Develop a prioritized list of nursing diagnosis

5. Detect & refer signs and symptoms that may indicate a problem beyond the nurse's experience

**Parts of Nursing Diagnosis**;

**Problem;** statement that describe the health problem of the patient .

**Etiology;** The reason (etiology) that identifies the physiological , psychological , social ,spiritual & environmental factors related to the problem.

**Defining characteristics: (**signs or symptoms **).**

**The subjective & objective data that signal the existence of the problem.**

**Planning phase**

The third step of the nursing process includes the formulation of guidelines that establish the proposed course of nursing action in the resolution of nursing diagnoses and the development of the client's plan of care.

 **Activities of planning phase :**

• Establish priorities.

• Identify expected patient outcome.

• Select evidence- based nursing intervention.

• Communicate the plan of care

**Stages of planning ;**

✓ **Initial planning;** is developed by the nurse, who performs the admission nursing history and the physical assessment.

✓ **Ongoing planning;** is carried by the nurse to keep the plan update, by analyzing data to make plan more accurate.

✓ **Discharge planning;** is best carried out by the nurse ,who has worked most closely with patient and family.

**The four critical elements of planning include:**

• Establishing priorities

• Setting goals and developing expected outcomes (outcome identification)

• Planning nursing interventions (with collaboration and consultation as needed)

• Documenting

**Implementing Phase**

Consists of doing and documenting the activities that are the specific nursing actions needed to carry out the interventions or nursing orders.

**Types of intervention**

o **Direct interventions:** actions performed through interaction with clients. •

o **Indirect interventions:** actions performed away from the client, on behalf of a • client or group of clients.

**The nursing care plan consists of three components:-**

• Expected outcomes •

• Client problems (nursing Diagnosis) •

• Interventions. •

**Evaluation**

The last phase of the nursing process, follows intervention of the plan of care, it's the judgment of the effectiveness of nursing care to meet client goals based on the client's behavioral responses.

**Measure how well the patient has achieved desired**

• Final phase of nursing process. •

• Occurs whenever nurse interacts with client. •

• Determining status of outcomes. And • Systematic & ongoing. •