NURSING PROCESS

By : M.ScN. Kareem Waheed Abu Kheta
Al-Mustaqbal University College
Department of Anesthesiology
Nursing

lecture: 2

Definition

Nursing process is a systematic method of providing care to clients.

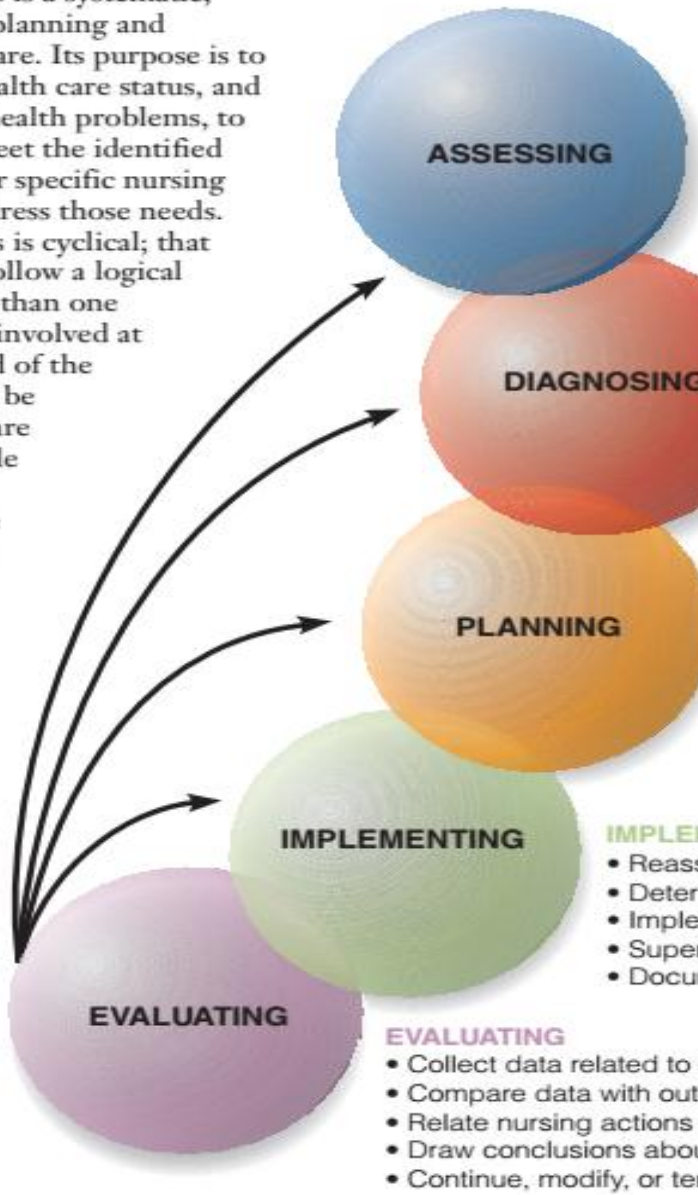
Purposes of nursing process

- To identify a client's health status and actual or potential health care problems or needs.
- To establish plans to meet the identified needs.
- To provide specific nursing interventions to meet those needs.

Components of nursing process

1. Assessment (data collection),
2. Nursing diagnosis
3. Planning
4. Implementation
5. Evaluation.

The nursing process is a systematic, rational method of planning and providing nursing care. Its purpose is to identify a client's health care status, and actual or potential health problems, to establish plans to meet the identified needs, and to deliver specific nursing interventions to address those needs. The nursing process is cyclical; that is, its components follow a logical sequence, but more than one component may be involved at one time. At the end of the first cycle, care may be terminated if goals are achieved, or the cycle may continue with reassessment, or the plan of care may be modified.



ASSESSING
- Collect data
- Organize data
- Validate data
- Document data

DIAGNOSING
- Analyze data
- Identify health problems, risks, and strengths
- Formulate diagnostic statements

PLANNING
- Prioritize problems/diagnoses
- Formulate goals/desired outcomes
- Select nursing interventions
- Write nursing interventions

IMPLEMENTING
- Reassess the client
- Determine the nurse's need for assistance
- Implement the nursing interventions
- Supervise delegated care
- Document nursing activities

EVALUATING
- Collect data related to outcomes
- Compare data with outcomes
- Relate nursing actions to client goals/outcomes
- Draw conclusions about problem status
- Continue, modify, or terminate the client's care plan

Figure 11–1 ■ The nursing process in action.

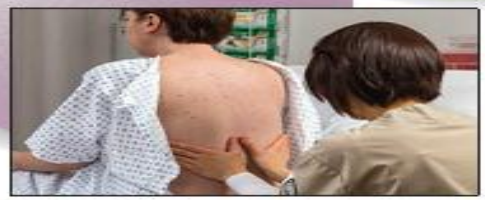
Margaret O'Brien is a 33-year-old nursing student. She is married and has a 13-year-old daughter and 5-year-old son. She is admitted to the hospital with an elevated temperature, a productive cough, and rapid, labored respirations. While taking a nursing history, Mary Medina, RN, finds that Margaret has had a "chest cold" for 2 weeks and has been experiencing shortness of breath upon exertion. Yesterday she developed an elevated temperature and began to experience "pain" in her "lungs."

ASSESSING Nurse Medina's physical assessment reveals that Margaret's vital signs are: Temperature, 39.4°C (103°F); pulse 92 beats/min; respirations 28/min; and blood pressure, 122/80 mmHg. Nurse Medina observes that Margaret's skin is dry, her cheeks are flushed, and she is experiencing chills. Auscultation reveals inspiratory crackles with diminished breath sounds in the right lung.

DIAGNOSING After analysis, Nurse Medina formulates a nursing diagnosis: *Ineffective Airway Clearance* related to accumulated mucus obstructing airways.

PLANNING Nurse Medina and Margaret collaborate to establish goals (e.g., restore effective breathing pattern and lung ventilation); set outcome criteria (e.g., have a symmetrical respiratory excursion of at least 4 cm, and so on); and develop a care plan that includes, but is not limited to, coughing and deep-breathing exercises q3h, fluid intake of 3,000 mL daily, and daily postural drainage.

IMPLEMENTING Margaret agrees to practice the deep-breathing exercises q3h during the day. In addition, she verbalizes awareness of the need to increase her fluid intake and to plan her morning activities to accommodate postural drainage.



EVALUATING Upon assessment of respiratory excursion, Nurse Medina detects failure of the client to achieve maximum ventilation. She and Margaret reevaluate the care plan and modify it to increase coughing and deep-breathing exercises to q2h.

Figure 11–1 ■ *Continued*

Characteristics of Nursing Process

- Cyclic
- Dynamic nature
- Client centeredness
- Focus on problem solving
- Interpersonal and collaborative style
- Universal applicability
- Use of critical thinking and clinical reasoning.

ASSESSMENT

Nursing assessment is the first step in the nursing process, is the systematic and continuous collection, organization, and documentation of data (information).

Types of assessment

1. **Initial nursing assessment**
2. **Problem-focused assessment**
3. **Emergency assessment**
4. **Time-lapsed reassessment**

Collection of data

Data collection is the process of gathering information about a client's health status. It includes the health history, physical examination, results of laboratory and diagnostic tests.

Types of Data

1. Subjective data(symptoms): are clear only to the person affected and can be described only by that person. Itching, pain, and feelings of worry.

2. Objective data(signs): are detectable by an observer or can be measured or tested for example, a discoloration of the skin or a blood pressure reading is objective data.

Sources of Data

1. Primary : The client is the primary source of data.

2. Secondary: Family members, health professionals, records and reports, laboratory and diagnostic results.

Methods of data collection

1. **Observation** : It is gathering data by using the senses: vision, smell and hearing are used.
2. **Interview** : is a structured conversation where one participant asks questions, and the other provides answers.
3. **Examination** : To conduct the examination, the nurse uses techniques of inspection, palpation, percussion and auscultation.

Nursing Diagnosis

The nursing diagnosis is the nurse's clinical judgment about the client's response to actual or potential health conditions or needs.

Components Nursing Diagnosis

(1) The problem

(2) The etiology

(3) The defining characteristics.

Acute pain related to **abdominal surgery** as evidenced by **patient discomfort and pain scale.**

Writing Diagnostic Statements

For example:

1 _____ [nursing diagnosis] 2 related to _____ [cause/related factors] 3 as evidenced by _____ [symptoms/defining characteristics].

1 *ineffective airway clearance* 2 related to *excessive mucus and asthma* 3 as evidenced by decreased breath sounds bilaterally, crackles over left lobe and persistent, ineffective coughing.

Back

PLANNING

Planning is the third step of the nursing process involves decision making and problem solving.

Nursing implementation (interventions):

is the fourth step of the nursing process. A nursing intervention is any management or activity, that a nurse performs to improve patient’s health.

Nursing Intervention Activities

- Assistance with ADLs
- Therapeutic interventions
- Monitoring and surveillance
- Teaching
- Discharge planning
- Supervision and coordination of personnel

Evaluation

Evaluation is the fifth step in the nursing process. It involves determining if the client's goals have been met, partially met, or not met.


ASSESSMENT
ANALYSIS
PLANNING
IMPLEMENTATION
EVALUATION

Relationship of Evaluation to Nursing Process

Thanks