Lecture 2

Subject

Nursing Process

Theoretical

Prepared by

Dr. Ali Ahmed

Dr: Hayder Mohammed

Definition

Nursing process: is an organized steps aim to provide the health care for patients and people within the circle of assessment, diagnosis, planning, implementation, and evaluation.

It scientific foundation to decision making and get better the fineness of planning for good nursing care.

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 deliver specific nursing interventions to meet those needs.

Steps (Phases) of Nursing Process

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

The Nursing Practice in Action

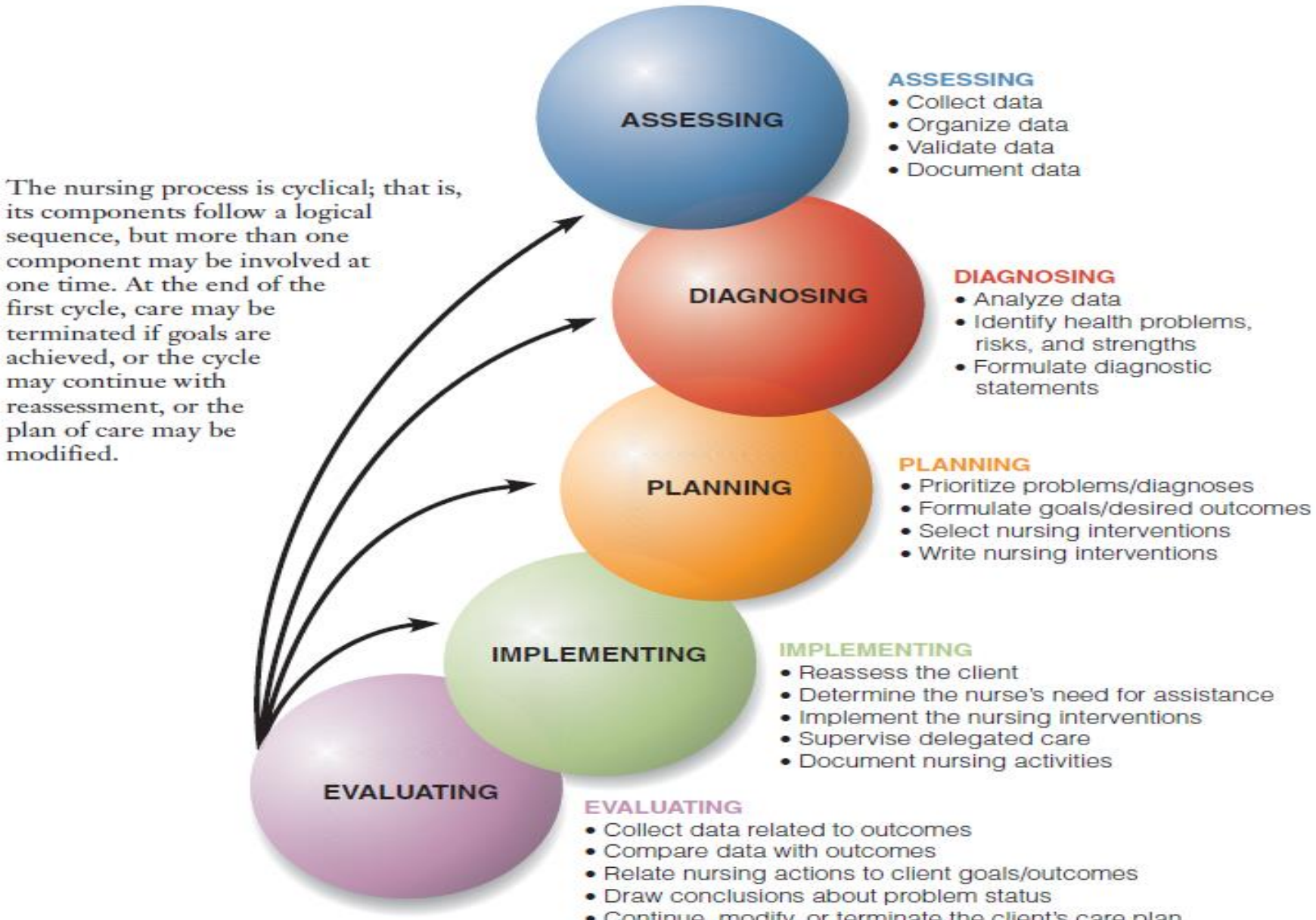

Figure 11–1 ■ The nursing process in action.

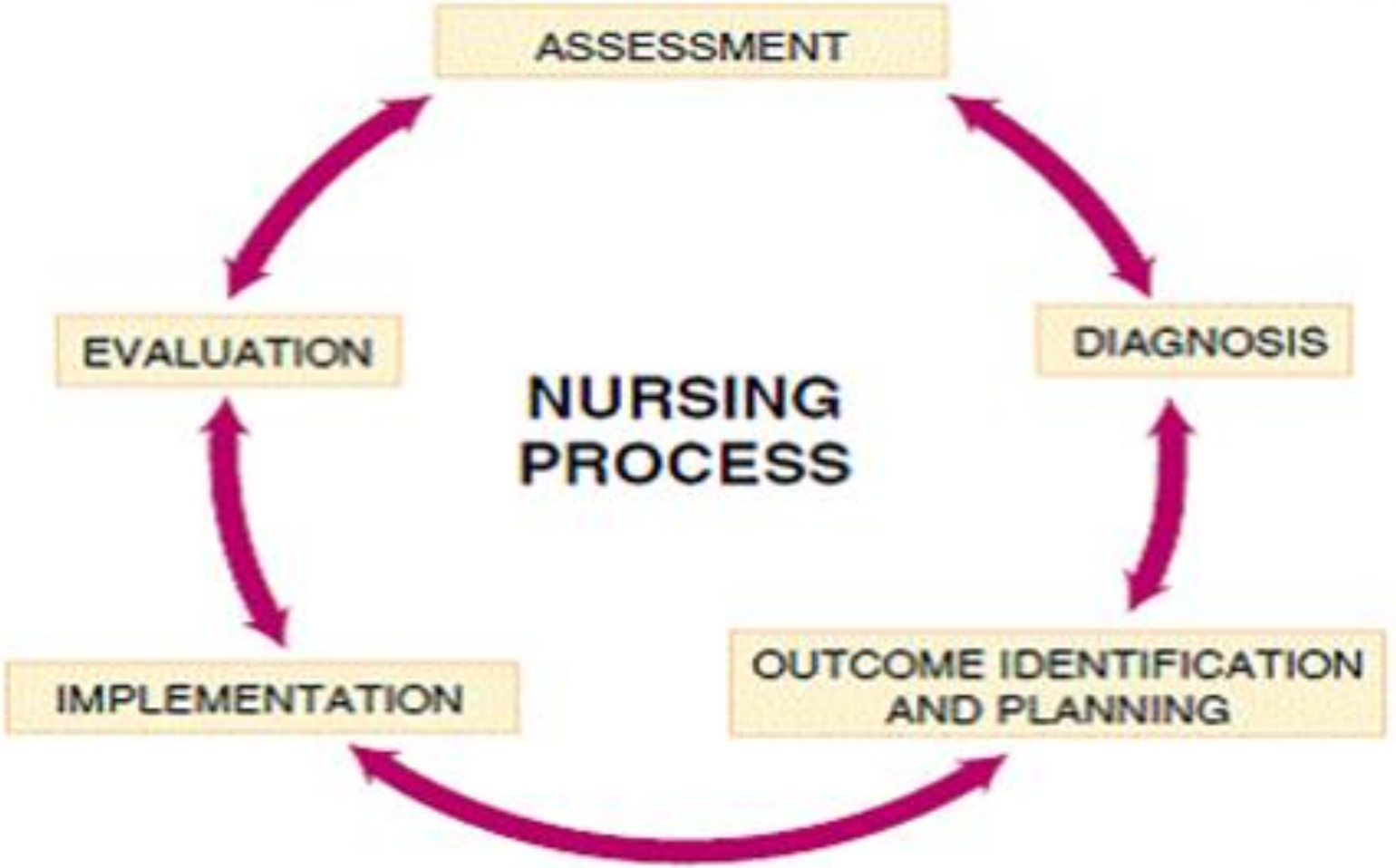

Figure 5-1 Components of the Nursing Process

Characteristics of the Nursing Process

1. Cyclic, Dynamic nature.
2. Client centered.
3. Focus on problem solving .
4. Decision making.
5. Interpersonal and collaborative style
6. Universal applicability.
7. Use of critical thinking.

1- 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**: To establish a complete database for problem identification, Performed within specified time after admission.

   Ex: Nursing admission assessment.

2. **Problem-focused assessment** : To determine the status of a specific problem identified in an earlier assessment.

   Ex: Hourly assessment of client's fluid intake and urinary output in an ICU.

3. **Emergency assessment:** During emergency situation to identify any life threatening situation.

   Ex: Rapid assessment of an individual's airway, breathing status, and circulation during a cardiac arrest.

4. **Follow up assessment (Ongoing assessment):** Several months after initial assessment. To compare the client's current health status with the data previously obtained.

Ex: Reassessment of a client's functional health patterns in a home care or outpatient setting or, in a hospital, at shift change

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 OR covert data)** (**say or speak**), **the only client can be described**. such as Itching, pain, and feelings of worry.

   EX: Biographical data or Demographical data, Present history, Past history, Family history, Life style

2. Objective data (signs OR overt data) are detectable by an observer or can be measured or tested. They can be seen, heard, felt, or smelled, and they are obtained by observation or physical examination.

For example: a discoloration of the skin , a blood pressure reading, pulse, redness, cyanosis are objective data .

TABLE 11–4 Examples of Subjective and Objective Data

SUBJECTIVE	OBJECTIVE
"I feel weak all over when I exert myself."	Blood pressure 90/50*
	Apical pulse 104
	Skin pale and diaphoretic
Client states he has a cramping pain in his abdomen. States, "I feel sick to my stomach."	Vomited 100 mL green-tinged fluid
	Abdomen firm and slightly distended
	Active bowel sounds auscultated in all four quadrants
"I'm short of breath."	Lung sounds clear bilaterally; diminished in right lower lobe
Wife states: "He doesn't seem so sad today." (This is subjective and secondary source data.)	Client cried during interview
"I would like to see the chaplain before surgery."	Holding open Bible
	Has small silver cross on bedside table

Sources of Data

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

2. Secondary: Family members, other 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** : An interview is a planned communication
3. **Examination** : To conduct the examination, the nurse uses techniques of Inspection, Palpation, Percussion and Auscultation.

Documentation of data

The nurse records client data. Accurate documentation is essential and should include all data collected about the client’s health status.

2- 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 (P)

(2) The etiology (E)

(3) The defining characteristics.(S)

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

Example:

- Problem
- Etiology
- Signs and symptoms

Ex: Anxiety related to Fear of death as manifested by patient verbalization.

Ex: Anxiety related to Effects of aging (reduced hearing, vision, mobility).

Ex: Activity intolerance related to obesity as manifested by body weight 140 KG.

Ex: Constipation related to Inactivity and insufficient fluid intake.

3- PLANNING

Planning involves decision making and problem solving.

4- Implementation(Nursing interventions)

A nursing intervention is any treatment, that a nurse performs to improve patient’s health.

IMPLEMENTATION

Implementation consists of doing and documenting the activities.

5- Evaluation

Both the patient’s status and the effectiveness of the nursing care must be continuously evaluated, and the care plan modified as needed.

Nursing Care Plan

Assessment	Diagnosis	Planning	Intervention	Evaluation
Objective data: Flashed skin. Skin is warm to touch. Temp. 38.2 C PR 109 bpm RR 34 bpm	Hyperthermia related to positive bacterial infection manifested by flushed and warm to touch skin.	**Short term:** within 1 hours of nursing intervention patient's temperature will lessen 37.4C **Long term**: within 3 consecutive days of nursing intervention , the patient's body temperature will return to it is normal range.	**Dependent:** • Administer antipyretic as order.	After all the nursing intervention the client's body temperature subsided within the normal range.

Reference

Kozier & Eerb's, Fundamentals of Nursing, *Concepts, Process, and Practice. Tenth edition. 2016*