Al Rasheed College University

Nursing Programme

Adult Nursing I (NUR 201)

Week 1

Nursing Process

Outline:

- Learning objectives
- Definition of nursing process
- Benefits of Nursing Process
- Steps of nursing process
  - ❖ Assessment
  - ❖ Nursing diagnosis
  - ❖ Planning
  - ❖ Implementation
  - ❖ Evaluation
  - ❖ Documentations

Learning Objectives

On completion of this lecture the learner will be able to:

1. Define the term nursing process.
2. Discuss the term assessment and describe how it influences the nursing process.
3. Define the term nursing diagnosis.
4. Define outcome identification and planning, and give an example of this step in the nursing process.
5. Define what is meant by the implementation phase of the nursing process.

Nursing Process

Definition:

- Is a systematic, rational method of planning and providing individualized nursing care.
- It is a systematic problem- solving approach for meeting a person's health care and nursing needs.
- An organized sequence of steps that nurses use to solve the health problems of patients

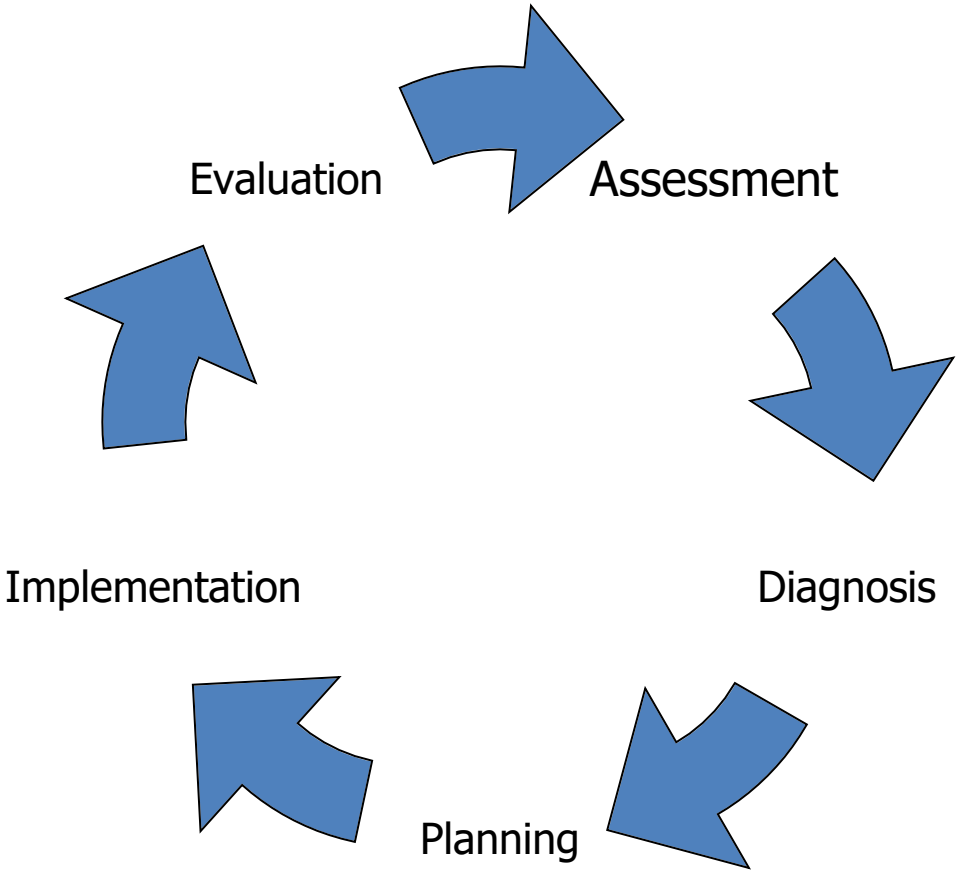
Purpose of Nursing Process:

1. Identify a client health status and actual or potential health care problems and needs.
2. Establish plans to meet the identifying needs.
3. Deliver specific nursing intervention to meet needs

Benefits of Nursing Process

1. Provides an orderly & systematic method for planning & providing care
2. Enhances nursing efficiency by standardizing nursing practice
3. Provides a unity of language for the nursing profession
4. Is economical
5. Stresses the independent function of nurses
6. Increases care quality through the use of deliberate actions

The Nursing Process consist of a series of five component or phases:



Characteristics of nursing process:

- It is cyclic and dynamic.
- It is client centered.
- It is planned.
- It is goal directed.
- It is universally applicable.

Assessment:

1-Assessing:

Systematic collection of data to determine the patient health status and identify any actual or potential health problem.

The assessment process involve four closely activities:

I- Collecting data.

II- Organizing data.

III- Validating data.

IV- Documenting data.

I-Assessment:

***Collecting Data:**

Is the process of gathering information about clients, and health status.

***Data collection methods**:

1. Interviewing.
2. Physical examination

***Source of data:**

a. client, Client records.
b. Health care professionals.
c. Support people
d. laboratory and diagnostic studies.

II-Nursing Diagnosis:

Nursing Diagnosis: is a clinical judgment about individual, family or community responses to actual and potential health problems/life processes.

Nursing Diagnosis process:

1- Analyzing data.

2- Identifying health problem, risks and strengths.

3- Formulating nursing diagnosis statement.

Types of nursing diagnosis:

1- **An actual diagnosis**: is a client problem that is present at the time of nursing assessment.

2- **A risk nursing diagnosis**: is a clinical judgment that a problem does not exit, but the presence of risk factors indicate that a problem is likely to develop unless nurses intervention. e.g. risk for infection

Nursing Diagnosis:

Components of NANDA nursing diagnosis:

I- Basic two or three-part statement:

1- Problem: (diagnostic label)

There are words that have been added to some NANDA label to give additional meaning.

2-Etiology :(related factor and risk factor):

Identifies one or more probable causes of the health problem. The two components are linked by the related to (r/t) term.

Nursing Diagnosis:

3- Defining characteristics:

Are cluster of sign and symptoms that indicate the presence of a particular diagnostic label. The characteristics are linked to the other two components by the term" as evidenced by " statement".

APPENDIX C 2007–2008 NANDA-Approved Nursing Diagnoses

- Activity Intolerance
- Activity Intolerance, Risk for
- Airway Clearance, Ineffective
- Anxiety
- Anxiety, Death
- Aspiration, Risk for
- Attachment, Parent/Infant/Child, Risk for
- Impaired
- Autonomic Dysreflexia
- Autonomic Dysreflexia, Risk for
- Blood Glucose, Risk for Unstable
- Body Image, Disturbed
- Body Temperature: Imbalanced, Risk for
- Bowel Incontinence
- Breastfeeding, Effective
- Breastfeeding, Ineffective
- Breastfeeding, Interrupted
- Breathing Pattern, Ineffective
- Cardiac Output, Decreased
- Caregiver Role Strain
- Caregiver Role Strain, Risk for
- Comfort, Readiness for Enhanced
- Communication: Impaired, Verbal
- Communication, Readiness for Enhanced
- Confusion, Acute
- Confusion, Acute, Risk for
- Confusion, Chronic
- Constipation
- Constipation, Perceived
- Constipation, Risk for
- Contamination
- Contamination, Risk for
- Coping: Community, Ineffective
- Coping: Community, Readiness for Enhanced
- Coping, Defensive

An ***Actual Nursing Diagnosis/*** written as a three-part statement:

- ***Diagnostic Label*** Ineffective air way clearance
- ***Etiology or Cause*** Related to accumulation of tracheo-bronchial secretion or decrease energy secondary to surgery
- ***Sign and symptom*** Evidenced by abnormal breath sound, cough , change rate and depth of respiration

A Risk or Potential Diagnosis, written as a two-part statement

- **Diagnostic Label:**

  Impaired skin integrity

- **Etiology or Cause:**

  Related to prolonged bed rest

III- PLANNING

Planning: should be directly toward solving or alleviating the problem identified in nursing diagnosis

Types of planning:

1- Initial planning: the nurse who performs the admission assessment usually develops the initial comprehensive plan of care.

2- Ongoing planning:

- Is done by all nurses who work with the client.
- It is the beginning of shift as the nurse plans the care to be given that day.

3- Discharge planning:

The process of anticipating and planning for needs after discharge.

Planning Process:

1. Setting priorities.
2. Establishing client goals/desired out comes.
3. Selecting nursing strategies(action or intervention).
4. Writing nursing care plan**.**

1-Setting priorities:

The nurse establishes the priorities of the nursing diagnoses by ranking them in order of importance to meet the client's immediate needs

Prioritis are classified as high, Intermediate , low priority.

- **High priority** ——Ineffective airway clearance after surgery related to abdominal incision pain
- **Intermediate priority** ——Altered nutrition less than body requirements related to chronic diarrhea for 3 weeks.
- **Low priority** ____ knowledge deficit related to smoking cessation programs.

2- Establishing client goal/desired out comes:

- Client goals are stated in terms of the patient behaviors and time period in which they are to be achieved.
- These goals must be realistic, measurable, and specific, indicate a definite time frame for achievement and consider patients desired and resources.
- Examples of measurable verbs are state that, report that, demonstrate, perform, identifies adapt, increase, decrease

*e.g. patient will ambulate using cane within 48hrs after surgery

*e.g. patient will identifies nutritional needs within 36hrs

Client goals may be divided into:

- **Immediate goals**: can be reached within a short period e.g. demonstrates the intake of 1500 calories of diabetic diet spaced in three meals and one snack per day.

- **Intermediate and long term goals**: required longer time to be achieved and usually involves preventing complications and other health problem and promoting self-care and rehabilitation e.g. plans meals for 1 week based on diabetic exchange list or adheres to prescribed diabetic diet.

3-Selecting nursing strategies(intervention or action)

- Selecting nursing intervention and activities are actions that nurse performs to a achieve client goals.
- The specific strategies chosen should focus on eliminating or reducing the etiology.

Types of Nursing Intervention:

1- Independent intervention: are those activities that nurses are licensed to initiate on the basis of their knowledge and skills.

2- Dependent intervention: are activities carried out under the physician orders.

3- Collaborative intervention: are actions the nurse carries out in collaboration with other health team member.

Criteria for choosing nursing strategies:

1- Safe and appropriate for patient.

2- An achievable with the resources available.

3- Congruent with other strategies.

4- Determined by state law.

4- Writing Nursing Orders:

1- Date. 2- Action verb.

3- Content area. 4- Time element.

5- Signature.

IV-Implementing:

Is the phase in which the nurse puts the nursing care plan into action.

*** Process of implementing:**

1- Implementing the nursing orders(strategies)..

2- Determining the nurse need for assistance.

3-Delegating and Supervising.

4- Communicating the nursing actions.

V- Evaluating:

- Is a planned, ongoing, purposeful activity in which clients and health care professionals determine:

  - The clients progress toward goals an achievement.

  - The effectiveness of the nursing care plan.

*** Process of evaluating client responses:**

1-Reassessment of client.

2-Compare the data with desired out comes

3- Relate nursing actions to client goals/desired outcomes.

4- Draw conclusions about problem status.

5- Continue to modify or terminate the clients care plan.

Exercise (1)

- Mrs. Fatima 50 years old was admitted to the hospital with a diagnosis of congestive heart failure. She has lived alone for the last 2years since her husband died. She had not seen the physician for at least 2 years. At the last visit, the physician prescribed a moderately low-sodium diet, Lasix 40 mg daily, Calan, and multiple vitamins. On admission her vital signs were BP 180/90, P 98, R 22. Her weight indicated a gain of 10 pounds since the last visit. Her physical assessment indicated rales in the lung bases, 3+ edema of the ankle and difficulty of breathing in the supine position**.**

Nursing care Plan

Nursing diagnosis (patient problem)	**Expected Out come /Goal The patient will**	**Nursing Intervention**	**Evaluation**
Breathing pattern ineffective related to pulmonary congestion as evidenced by rales sound on base of lung and difficulty in breathing in supine position	Be able to breath easily within one hour	1- Put on fowler position 2- Administer oxygen therapy 3- Provide good ventilated room 4- Administer medication as prescribed 5- Reassessment	❑ No rales sound on base of lung ❑ Respiration pattern within normal limit

Question?