NURSING PROCESS

Nursing process; is a systematic, patient-centered, goal-oriented method of caring to provide a frame work for nursing practice.

Objectives of N P;

The steps of the nursing process are not separated items, but rather are parts of whole used to;

Identify needs of the patient.
To establish priorities of care.
- To maximize strengths.
- To resolve actual & or potential patient problem.
- To apply health promotion to possible for each patient.

Documenting the nursing process;

Is the ability to record communicated nursing skills in a, 
Accurately, 
Concisely, 
Timely, &
Relevant, to provides the member of the care giver a complete picture of the patient health.

Steps of N P;

Assessment

Assessment; is the systematic & continuous collection, validation & communication of patient data.
-Data base; includes all patient information, collected by the health care professionals to enables an effective plan of care to be implemented for the patient.

**Sources of the data;**

- patient, is the primary source of information.
- family & significant others, friends.
- * patient record, records from members of health care, provide essential information related to him.
- Medical history, physical examination, & progress notes.
- laboratory test & other health professions.

**TYPES OF ASSESSMENT ;**

- Initial assessment; is performed shortly after patient admission to a health agency or hospital.
- Focused assessment; the nurse gathers data about a specific problem that has already been identified.
- Emergency assessment; the nurse performs this type of assessment on a physiological or psychological crisis to identify the life-threatening problems.
- Time-lapsed assessment; this assessment done to compare a patient's current status to the base line data obtained earlier.

**ACTIVITES OF ASSESSMENT**

*Identify assessment priorities determined by the purpose of the assessment and the patient condition.
* Organize or cluster the data to ensure systematic collection.
*Establish the data base by;
- nursing history
- nursing examination
  review of patient record & nursing literature.
- patient consultation & health care personnel
*Continuously update the database
*Validate the data.
*Communicate the data.

Diagnosing

Diagnosing ; (patient problem), the 2nd 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.

Activities of nursing diagnosis;
* Interpret & analyze patient data
* Identify patient strength and health problem
* Formulate and validate nursing diagnosis
* Develop a prioritized list of nursing diagnosis
* Detect & refer signs and symptoms that may indicate a problem beyond the nurses experience.
TYPES OF NURSING DIAGNOSIS

1-Actual Nursing Diagnosis; represent a problem that has been validated by the presence of its characteristics, ex, impaired physical mobility, fatigue, ineffective breathing pattern.

2-Risk NURSING Diagnosis; it's a clinical judgment that an individual, family, or community is more vulnerable (able) to develop the problem, ex, risk for deficient fluid volume,

3-Possible Nursing Diagnosis; are statements describing a suspected problem, ex, chronic low self-esteem.

4-Wellness Diagnosis; ITS a clinical judgment about individual, group, or community in transition from specific level of wellness to a higher level, ex, Readiness for enhanced health maintenance, or Readiness for enhanced self-esteem.

5-Syndrome nursing Diagnosis; a cluster of an actual or risk nursing diagnosis suspected to be present according to certain events or situation. Ex, post-Trauma syndrome.

Parts of Nursing Diagnosis;

*Problem; statement that describe the health problem of the patient clearly & concisely.
*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.
Example:

<table>
<thead>
<tr>
<th>characteristics</th>
<th>etiology</th>
<th>problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dry skin, dryness of the</td>
<td>Diarrhea</td>
<td>Deficient fluid</td>
</tr>
<tr>
<td>mouth</td>
<td></td>
<td>volume</td>
</tr>
</tbody>
</table>

Outcome identification & planning

Goal; is an aim or an end.
Patient Outcome; is an expected conclusion to patient health problem, it referred to the more specific measurable goal has been met.

Activities of planning phase (or step);
- 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 up date, 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

Implementation:

A step of nursing process in which a planned nursing action are carried out and documented.

The purpose of Implementation:
- is to assist the patient in achieving valued health outcome
- promote health
- prevent disease and illness
- restore health
- To facilitate coping with altered functioning

Types of nursing intervention:
*nursing intervention classification (NIC) project defines N intervention as (any treatment based upon clinical judgment and knowledge that nursing
performs to enhance patient/client outcomes.

Types of NURSING IMPLEMENTATION:

*Direct care intervention: Performed through intervention with patient and includes both physical and psychological nursing action also include both (laying of hands) or supportive and counselling in nature.

*Indirect care intervention: is a treatment performed away from the patient include management of patient environment.

*A community intervention: is targeted to promote and preserve the health of populations.
Evaluation: is the measurement of how well the patient achieved the outcomes specified in the plan of care.

Evaluating:
* Measure how well the patient has achieved desired outcomes.
* Identify factors contributing to the patient’s success or failure.
* Modify the plan of care, if indicated.