

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 (Nursing process);

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.

Phases

The six phases of the nursing process are

- 1- assessment,**
- 2- diagnosis,**
- 3-out come identification,**
- 4- planning,**
- 5- implementation,**
- 6- and evaluation.**

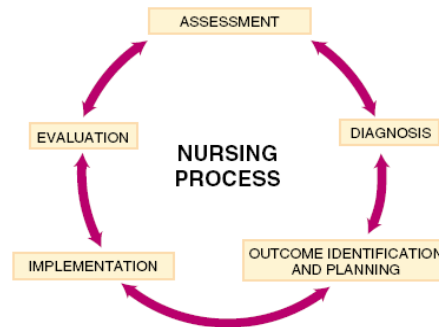


Figure 5-1 Components of the Nursing Process

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 patients current status to the base line data obtained earlier .

Assessment skills

1- Observation

2- Interviewing

- *directive interview*

- *nondirective interview*

3- Physical examination techniques:

-**Inspection**

- **Palpation**

-**Percussion**

-**Auscultation**

Assessment Activities-

*Identify assessment priorities determined by the purpose of the assessment and the patient condition.

*Organize or cluster the data to ensure systematic collect

- *Establish the data base by;
 - nursing history
 - nursing examination -
 - review of patient record & nursing literature.
 - patient consultation,& health care personal
- *Continuously update the database
- *Validate the data.
- *communicate the data.

Nursing Diagnosis

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.

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;

characteristics	etiology	problem
Dry skin	Diarrhea	Deficient fluid
,dryness of the		volume
mouth.		

Differentiating Nursing Diagnosis versus Medical Diagnosis

Nursing	Medical Diagnosis
- focus on unhealthy responses to health and illness.	- identify diseases
- describe problems treated by nurses within the scope of independent nursing practice.	- describe problems for which the physician directs the primary treatment .
- may change from day to day as the patient's responses change	- remains the same for as long as the disease is present

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 ; its 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

Nursing Planning

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 (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

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

Implementation :

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

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-Direct interventions: actions performed through interaction with clients.

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

Types of interventions •

- Dependent
- Independent
- Collaborative

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.

Evaluating:

- *Measure how well the patient has achieved desired
- Final phase of nursing process
- Occurs whenever nurse interacts with client

- Determining status of outcomes
- Systematic & ongoing

outcomes

- *Identify factors contributing to the patient's success or failure
- *Modify the plan of care, if indicated.

Three possible outcomes of evaluation •

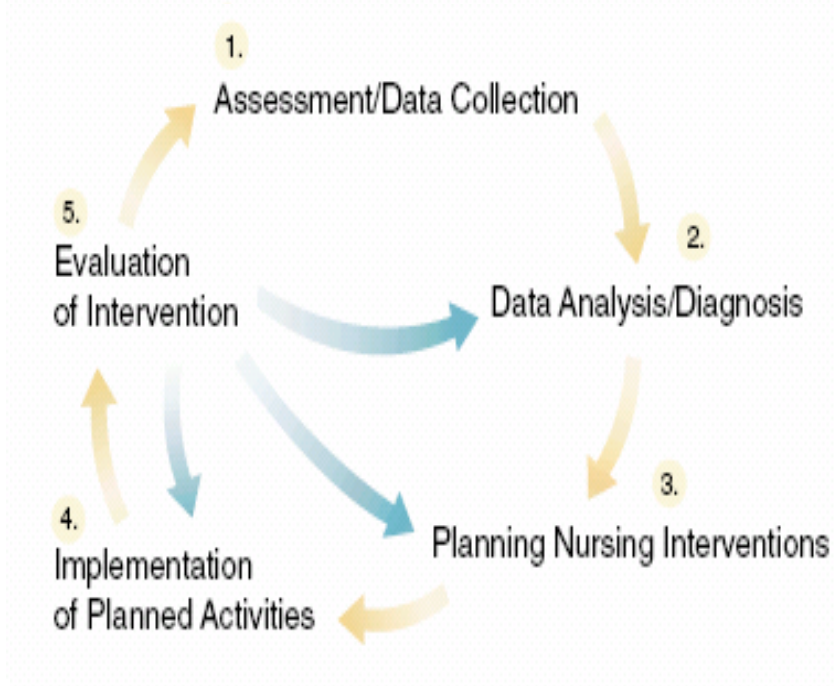
- Outcomes not met – continue plan as written
- Outcomes not met – modify the plan
- Outcomes met – terminate the plan

Factors affecting outcome attainment:-

- 1- facilitators
- 2-barriers

Evaluating compliance:

- 1-performance appraisal
- 2-quality assurance



Relationship of Evaluation to Nursing Process

