



# **Nursing Process**

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- **Nursing process**
- is a process by which nurses deliver care to patients, supported by nursing models or philosophies.
- The nursing process was originally an adapted form of problem-solving and is classified as a deductive theory.

- **Characteristics of Nursing Process**
- **A problem-solving method**
- **Systematic, goal-directed, flexible, rational approach**
- **Ensures consistent, continuous, quality nursing care**
- **Provides a basis for professional accountability**
- **Input of nurse and patient/family critical**

- **A- Assess (what is the situation?)**
- **D- Diagnose (what is the problem?)**
- **P- Plan (how to fix the problem)**
- **I- Implement (putting plan into action)**
- **E- Evaluate (did the plan work?)**
- **All together equaling **ADPIE****

**The nursing process not only focuses on ways to improve the patient's physical needs, but also on social and emotional needs as well.**

**Cyclic and dynamic**

**Goal directed and client centered**

**Interpersonal and collaborative**

**Universally applicable**

**Systematic**

# Phases of the nursing process

- **Assessment** (of patient's needs)
- **Diagnosis** (of human response needs that nurses can deal with)
- **Planning** (of patient's care)
- **Implementation** (of care)
- **Evaluation** (of the success of the implemented care).

## Assessment

Answers the questions: “What is happening?”  
(actual problem), or  
“What could happen?” (potential problem)

**Involves** collecting, organizing, and analyzing  
information/data about the patient

**Results in Nursing Diagnoses**

## Two parts: Data collection & Data analysis

### 1. Data Collection: A Holistic Approach

#### Types of data

***Subjective:*** “symptoms” that the patient describes; e.g. “I can’t do anything for myself”

***Objective:*** signs that can be observed, measured, and verified; e.g. swollen joints

#### Sources of data

- ***Primary:*** the patient; is always the best source
- ***Secondary:*** everything/everybody else



# Methods of Data Collection

## 1- *Observation:*

Requires practice and skill Systematic, head-to-toe

## 2- *Interview:*

Structured form of communication Purpose: to provide care specific to this individual's needs and problems

# Components of the Health History

## Demographic data

CC: chief complaint

HPI: history of present illness

PMH: past medical history

FMH: family medical history (genogram)

ROS: review of systems

Psychosocial history

### 3- *Examination:*

**A- Inspect**

**B- Palpate**

**C- Percuss**

**D- Auscultate**

**Nurse must:** explain what you are doing, provide privacy, and ask permission before you touch the patient

## 2. Data Analysis

### *Data review*

Are data accurate and complete?

### *Data interpretation*

What are the patient's actual and/or potential problems?

❖ Develop a problem list based on the data Prioritize the patient's problems

## Diagnosing Phase:

The purpose of this stage is to identify the patient's nursing [[problems]].

Nursing Diagnosis: a statement that describes a specific human response to an actual or potential health problem that requires nursing intervention.

## Written in P E format

**P** = Problem: use North American Nursing Diagnosis Association (NANDA) category  
[due to or related to]

**E** = Etiology: cause of the problem

**you can write nursing diagnoses statements using the PES format:**

**Problem - (high risk for injury, pain, constipation, impaired communication, etc.)**

**related to (r/t)**

**E**

**tiology (cause) - (factors that cause the problem)**

**manifested by (m/b)**

**S**

**igns and Symptoms - (the signs and symptoms that are associated with the problem)**

## Examples:

- **Impaired communication** related to **laryngectomy** manifested by **inability to talk**.
- **Fear** related to **upcoming surgery** manifested by **verbalization**, "I'm really scared to go to surgery tomorrow. What if I die?"

**Altered respiratory patterns** related to **bed rest** and **pneumonia** manifested by chest x-ray with bilateral **atelectasis**, respirations 28, refusal to cough and deep breathe, complaints of pain when coughing.



## '''Components of a Nursing Diagnosis

- **Problem Statement**(diagnostic label)- describes the clients health problem
- **Etiology**(related factor)-the probable cause of the health problem
- **Defining Characteristic**-a cluster of signs and symptoms

## Planning Phase

Plan: to provide consistent, continuous care that will meet the patient's unique needs.

Includes Patient Goals & Nursing Orders

***Patient Goals: describe the desired result of nursing care***

## *Patient Goals are:*

- **Focused on the patient**
- **Clear and Concise**
- **Observable, Measurable, Realistic: how much? how far? how long? how well?**
- **Written with a specific time frame: by when should the goal be accomplished?**
- **Determined by the nurse and the patient**

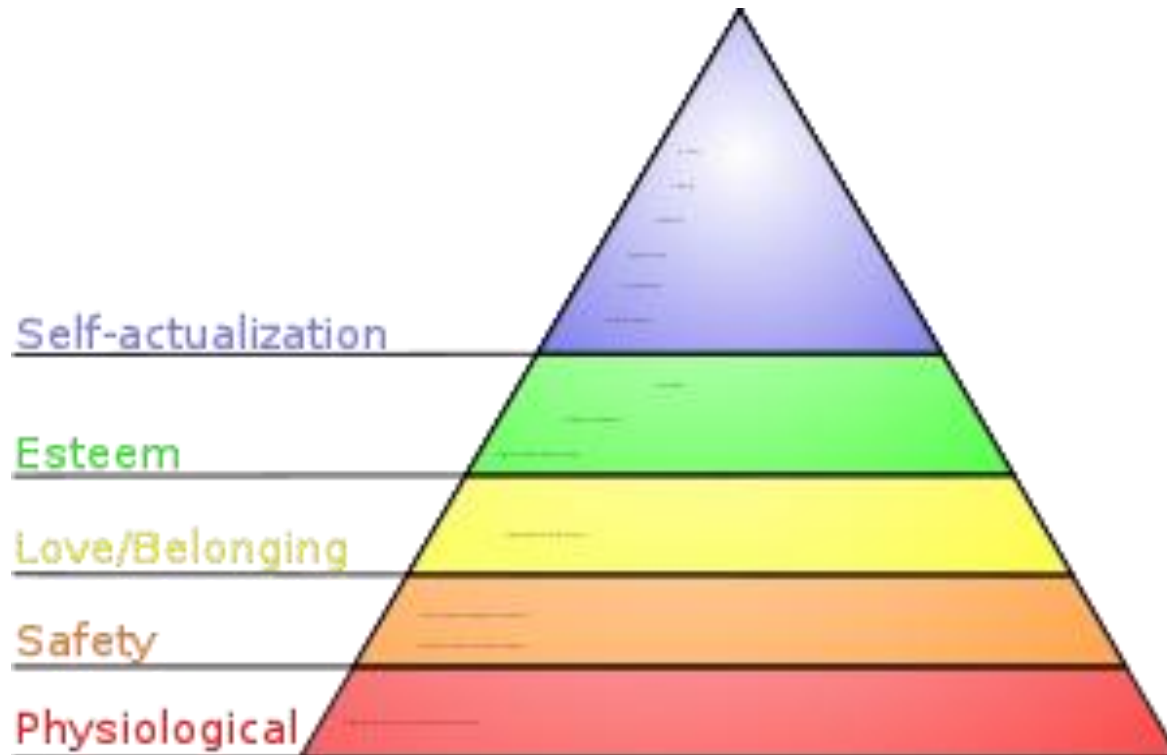
## *Nursing Orders*

Describe what the nurse will do to help the patient achieve the goals.

## **Priority Setting**

Priority setting is an essential aspect of clinical judgment. Your attention and actions should be focused on the most urgent needs of your client. You should look at the problems or diagnoses you have identified and ask:

Maslow's hierarchy of needs is used when the nurse prioritizes identified nursing health problems from the patient.



- 1- **Survival/physiological needs**: e.g. air, circulation, water, food, elimination, temperature regulation, physical comfort, activity, and rest.
- 2- **Safety/Security Needs**: e.g. environmental hazards, domestic violence, fear, anxiety, protection, immunizations.
- 3- **Love and Belonging**: e.g. sex, companionship, loss of a loved one, grief, closeness.
- 4- **Self-esteem needs**: e.g. inability to perform normal activities, loss of job, poverty.
- 5- **Self-actualization**: e.g. inability to achieve personal goals.

## Expected Outcomes

Before you **decide what you are going to do**, you need **to identify what you want to accomplish**.

Identification of expected outcomes is **very more important** for nursing because of efforts to improve **efficiency and quality of care**. An expected outcome is measurable, patient centered, and specific

## Nursing outcomes Classification (NOC) System.

The purpose of NOC is to provide language for the development of expected outcomes and the evaluation component of the nursing process.



- Implementing Phase

The methods by which the goal will be achieved is also recorded at this stage.

- Implementation - Your plan of care is put into action. During implementation, you assess the patient's current status to see if his/her plan is still appropriate or whether there are new problems.

The interventions and activities are then performed and you continue to assess the patient to see if there is any response or whether the intervention made a difference.

Finally, you report any data that requires additional treatment, e.g., physician consultation, and record the nursing actions, patient response, and other significant assessment data.

- **Step Five of the Nursing Process**

Evaluate: Compare the patient's current status with the stated Patient Goals

The purpose of this stage is to evaluate progress toward the goals identified in the previous stages.

Were the goals achieved? Why not?  
Review the nursing process

**Evaluation** helps you to identify problems and make changes early before you complete your day's work

- evaluation involves a determination of

The patient's response to the interventions you performed.

Whether expected outcomes were met, not met, or partially met.

Factors affecting the achievement of the outcomes.

Whether to change, modify, or terminate the plan of care.



**Thank you for you**