// تمريض صحة المجتمع// المرحلة الرابعة

Nursing Process

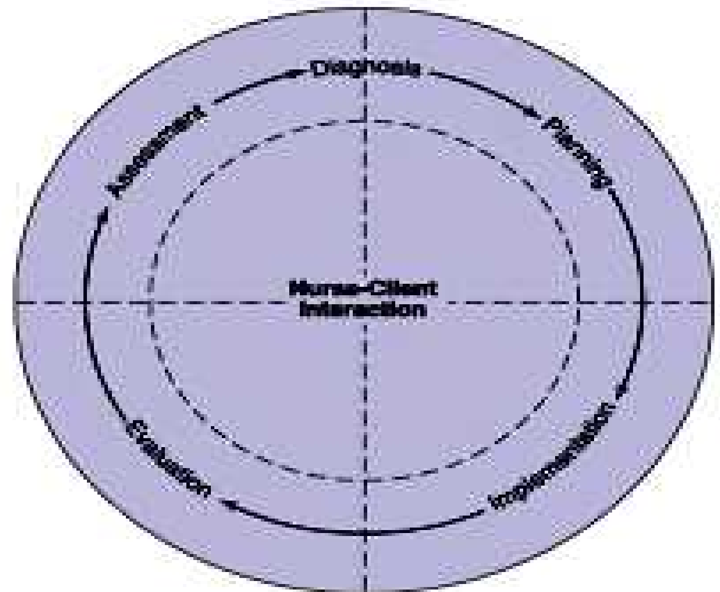
Introduction:-

- Nursing process:
  - o is a systematic method of providing care to clients
  - o Allows nurses to communicate plans and activities to
    - Clients
    - Other Health Care Professionals
    - Families
  - o Encourages orderly thought, analysis, planning (goal oriented method of caring that provides a Framework for Nursing Practice).

Overview of the Nursing Process:-

- Process: **"A series of steps or acts that lead to accomplishment of some goal or purpose"**

- Purpose is to provide client care that is:
  - ❖ Individualized
  - ❖ Holistic
  - ❖ Effective
  - ❖ Efficient
- Consists of 5 steps
  - ❖ Assessment
  - ❖ Diagnosis
  - ❖ Planning
  - ❖ Implementation
  - ❖ Evaluation
- Build on each other



- Not linear

- Nursing process is dynamic

and requires creativity in its application (Dynamic-always changing, flexible):
  - ❖ Steps remain the same
  - ❖ Application and results different
- Used throughout the life span in any care setting.
- Utilizes critical thinking processes.

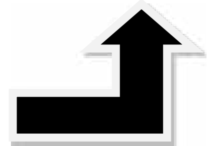
Small group questions:-

1. How many steps are in the nursing process?
2. What are the names of each of the steps?
3. What is the purpose of the nursing process?
4. In what clinical setting is the nursing process used?

Assessment:-

- Step #1
- Involves
  - ✓ Collecting data (from variety of sources)
  - ✓ Validating the data
  - ✓ Organizing the data
  - ✓ Interpreting the data
  - ✓ Documenting the data
- Purpose of assessment:
  - ✓ Data collection
- Types of assessment:
  - ✓ Comprehensive assessment
  - ✓ Focused
  - ✓ Ongoing
- Comprehensive assessment
  - ✓ Baseline
  - ✓ Physical & psychosocial
- Focused Assessment
  - ✓ Limited in scope
  - ✓ Screening for a specific problem
  - ✓ Short stay
- Ongoing assessment
  - ✓ Follow-up
  - ✓ Monitoring and observation related to specific problems
- Sources of Data
  - ✓ Primary sources
    - o Client
    - o Interview
    - o Physical examination
  - ✓ Secondary sources
    - o Family members
    - o Other health care providers
    - o Medical records

- Types of data
  - ✓ Subjective: (symptom)
    - o Data from the Client's point of view
      - Feelings, Perceptions, Concerns
    - o Main way to collect subjective data:
      - Interview (e.g. "I have a headache"
  - ✓ Objective:
    - o Observable & measurable data
    - o Main way to collect objective data:
      - Physical assessment
      - Lab. and diagnostic testing
- Validating the Data
- Organizing the Data
- Interpreting the Data
  - ✓ Relevant vs. irrelevant
  - ✓ Gaps?
  - ✓ Identify patterns
- Document the Data



<u>Small group questions</u>: - ((Home Work))

1.Baby Jane a 2 month infant goes into the doctor for her initial immunization and well baby check-up. What type of assessment should the nurse perform?

A. Comprehensive
B. Focused
C. Ongoing

2.Give an example of a primary source of data?

3.Give an example of a secondary source of data?

4. Which of the following are objective data and which are subjective data?

A. Nausea
B. Vomiting
C. Unsteady gait
D. Anxiety
E. Bruises on the right arms and face
F. Temperature 101 F

Diagnosis:-

- Step 2 in the nursing process
  - Formulating a nursing diagnosis
  - Analysis and synthesis of data
- Nursing diagnosis:
  - A clinical judgment about individual, family or community responses to actual or potential health problems / Life Processes (Move, Reproduce, Sensitive, Nutrition, Excrete, Respire, Grow).
  - A nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable."
- Types of Nursing Diagnoses: Actual, Risk for, Possible, Wellness.

Medical vs. Nursing diagnosis:-

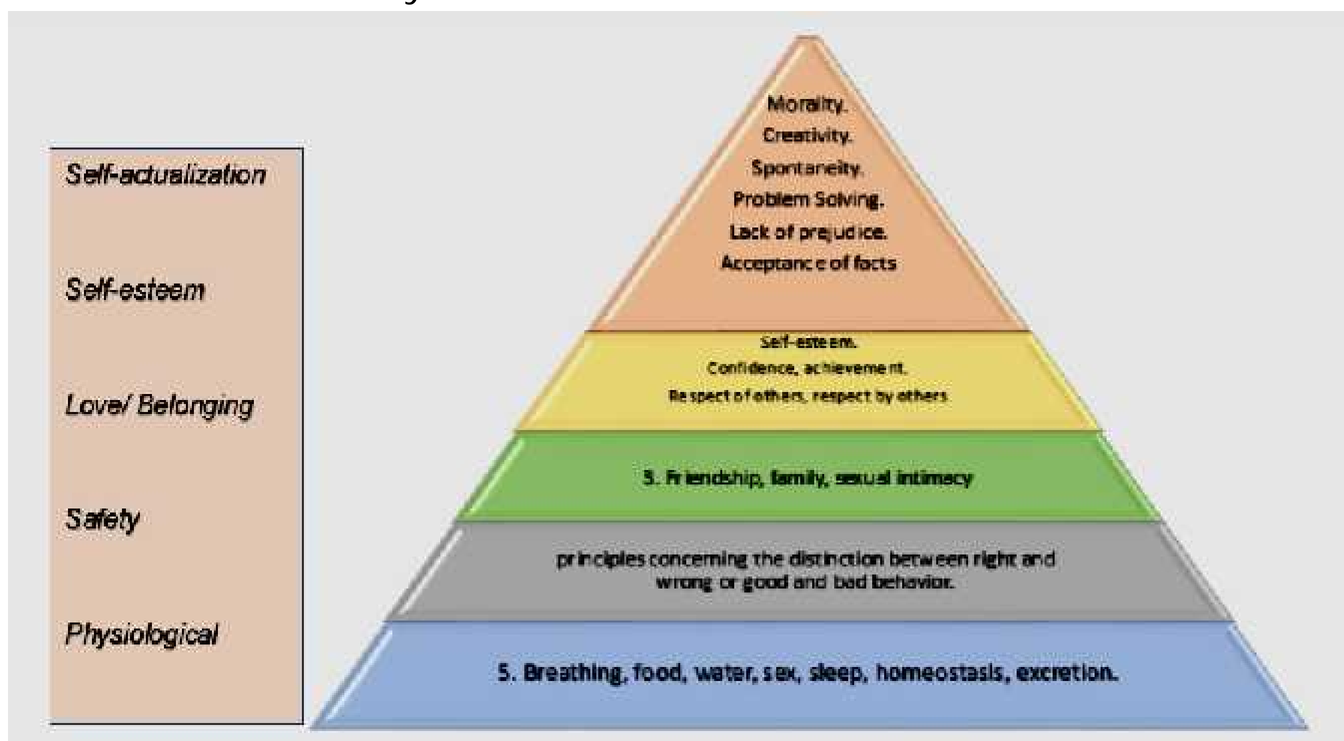
Nursing diagnosis	Medical diagnosis
Identifies situations the nurse is licensed & qualified to treat	Identifies conditions the MD is licensed & qualified to treat
Focuses on the clients responses to actual or potential health / Life Problems	Focuses on illness, injury or disease processes
Changes as the clients response and/or the health problem changes	Remains constant until a cure is effected
i.e. Knowledge deficit Powerlessness Grieving, anticipatory Body image disturbance Individual coping ineffective	i.e. Breast cancer

Diagnosis:-

Nursing diagnosis	Medical diagnosis
Breathing patterns, ineffective	Chronic obstructive pulmonary disease
Activity intolerance	Cerebrovascular accident
Pain	Appendectomy
Body image disturbance	Amputation
Body temperature, risk for altered	Strep throat

Planning & Outcome identification:-

- Step 3
  - ❖ Types of planning
    - Initial planning
    - Ongoing planning
    - Discharge planning
- Identifying outcomes
  - ❖ Goals
    - An aim, intent or end.
  - ❖ Short term goals
    - Hours to days (less than a week)
  - ❖ Long term goals
    - Weeks to months
- Developing specific nursing interventions
  - ❖ Independent nursing interventions
    - No order needed
      - Elevate edematous legs
  - ❖ Interdependent nursing interventions
    - In conjunction with an interdisciplinary team member
      - Assist client with physical therapy exercises
  - ❖ Dependent nursing interventions
    - Require an order
      - Administering of medications
- Prioritizing the nursing diagnosis
  - Maslow's hierarchy of needs



Implementation:-

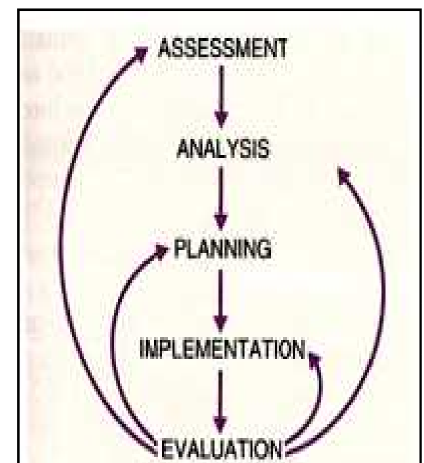
- 4th step:
  - ❖ Execution of the nursing care plan
  - ❖ Delegation
    - ✓ DO IT
    - ✓ DO IT RIGHT
    - ✓ DO IT RIGHT NOW!

5 Rights of Implementation include of Nursing Process:

- ❖ Right patient
- ❖ Right medication
- ❖ Right route
- ❖ Right dose / amount
- ❖ Right time

Evaluation:-

- 5th step
  - o Determining whether the clients goals have been met, partially met or not met.



Benefit of Evaluation:

1. To determine the Effectiveness of Nursing Process.

2. To identify the Sufficiency of a Nursing Plan.

3. To find out the Cost of the Nursing Plan.

4. To find out the Impact of the Nursing Plan & the Nursing Process.

5. To evaluate the Progress of the Nursing Plan & the Nursing Process.

6. To determine Relevancy of the Nursing Plan.

7. Measures Efficiency of the Nursing Plan.

Goals of Nursing Process:

To Help the Nurse Manage Each Patient's or Client's Care Scientifically, Holistically, And Creatively to Promote Wellness, Prevent Disease or Illness, Restore Health, and Facilitate Coping with Altered Functioning.

Criteria of Nursing Process:

1- **Solving problem approach.**

2- **Management process- organization.**

3- **Changing of Behavior.**

Note:- Life Process include:-

1. Move
2. Reproduce
3. Sensitive
4. Nutrition
5. Excrete
6. Respire
7. Grow