Nursing Process

Nursing Fundamentals

Introduction

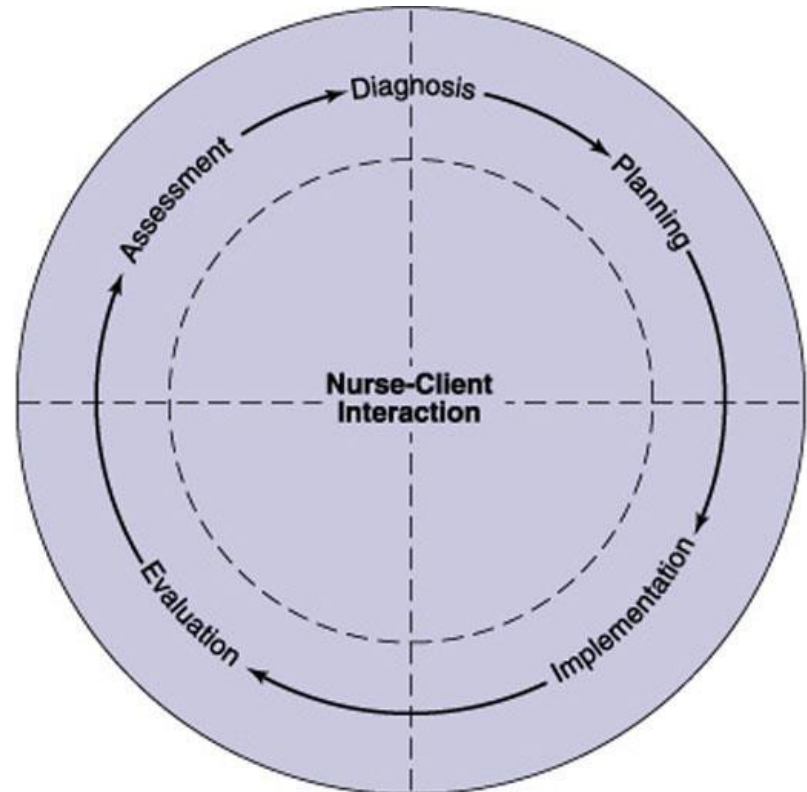- Nursing process
  - is a <u>systematic</u> method of providing <u>care</u> to clients
  - Allows nurses to <u>communicate</u> plans and activities to
    - <u>Clients</u>
    - Other <u>health</u> care professionals
    - <u>Families</u>
  - Encourages <u>orderly</u> thought, analysis, planning

Overview of the Nursing Process

- Process:
  - "A series of <u>steps</u> or acts that lead to accomplishment of some <u>goal</u> or <u>purpose</u>"
- Purpose is to provide client care that is:
  - <u>Individualized</u>
  - <u>Holistic</u>
  - <u>Effective</u>
  - <u>Efficient</u>

Overview of the Nursing Process

- Consists of <u>5</u> steps
  - <u>Assessment</u>
  - <u>Diagnosis</u>
  - <u>Planning</u>
  - <u>Implementation</u>
  - <u>Evaluation</u>
- <u>Build</u> on each other
- Not <u>linear</u>

- Nursing process is <u>dynamic</u> and requires creativity in its application
  - Steps remain the same
  - Application and results different
- Used throughout the <u>life</u> span in <u>any</u> care setting

Assessment

- Step #1
- Involves
  - <u>Collecting</u> data (from variety of sources)
  - <u>Validating</u> the data
  - Organizing the <u>data</u>
  - Interpreting the <u>data</u>
  - <u>Documenting</u> the data

Assessment

- Purpose of assessment:
  - <u>Data</u> collection
- Types of assessment:
  - Comprehensive assessment
  - Focused
  - Ongoing

Assessment

- Comprehensive assessment
  - Baseline
  - Physical & psychosocial

Assessment

- Focused Assessment
  - <u>Limited</u> in scope
  - Screening for a <u>specific</u> problem
  - <u>Short</u> stay
- Ongoing assessment
  - Follow-<u>up</u>
  - Monitoring and <u>observation</u> related to specific problems

Assessment

- Sources of Data
  - Primary sources
    - Client
    - Interview
    - Physical examination
  - Secondary sources
    - Family members
    - Other health care providers
    - Medical records

Assessment

- Types of data
  - Subjective
    - Data from the client's point of view
      - Feelingsمشاعر, Perceptionsتصورات, Concernsمخاوف
    - Main way to collect subjective data:
      - Interview
  - Objective
    - Observable & measurable data
    - Main way to collect objective data:
      - Physical assessment
      - Lab and diagnostic testing

Assessment

- Validating the Data
- Organizing the Data
- Interpreting the Data
  - Relevant vs. irrelevant
  - Gaps?
  - Identify patterns
- Document the Data

Diagnosis

- Step 2 in the nursing process
  - Formulating a nursing diagnosis
  - Analysis and synthesis of data

- Nursing diagnosis:
  - "A clinical <u>judgment</u> about individual, family or community responses to actual or potential heal problems / life processes.
  - A nursing diagnosis provides the basis for selection of nursing <u>interventions</u> to achieve outcomes for which the nurse is accountable."

Medical vs. Nursing diagnosis

Medical diagnosis	Nursing diagnosis
Identifies conditions the MD(Doctor of Medicine) is licensed & qualified to treat	Identifies situations the nurse is licensed & qualified to treat
Focuses on <u>illness</u>, injury or disease processes	Focuses on the clients <u>responses</u> to actual or potential health / life problems

Medical vs. Nursing diagnosis

Medical diagnosis	Nursing diagnosis
Remains <u>constant</u> until a cure is effected	<u>Changes</u> as the clients response and/or the health problem changes

Medical vs. Nursing diagnosis

Medical diagnosis	Nursing diagnosis
i.e. Breast cancer	i.e. Knowledge deficit Powerlessness Grieving, anticipatory Body image disturbance Individual coping, ineffective

Planning & Outcome identification

- Step 3
  - Types of planning
    - <u>Initial</u> planning
    - <u>Ongoing</u> planning
   - <u>Discharge</u> planning

Planning & Outcome identification

- Identifying outcomes
  - Goals
    - An aim,

    -Short term goals
    - Hours to days (less than a week)
  - Long term goals
    - Weeks to months

Planning & Outcome identification

- 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

Maslow's Hierarchy of Needs
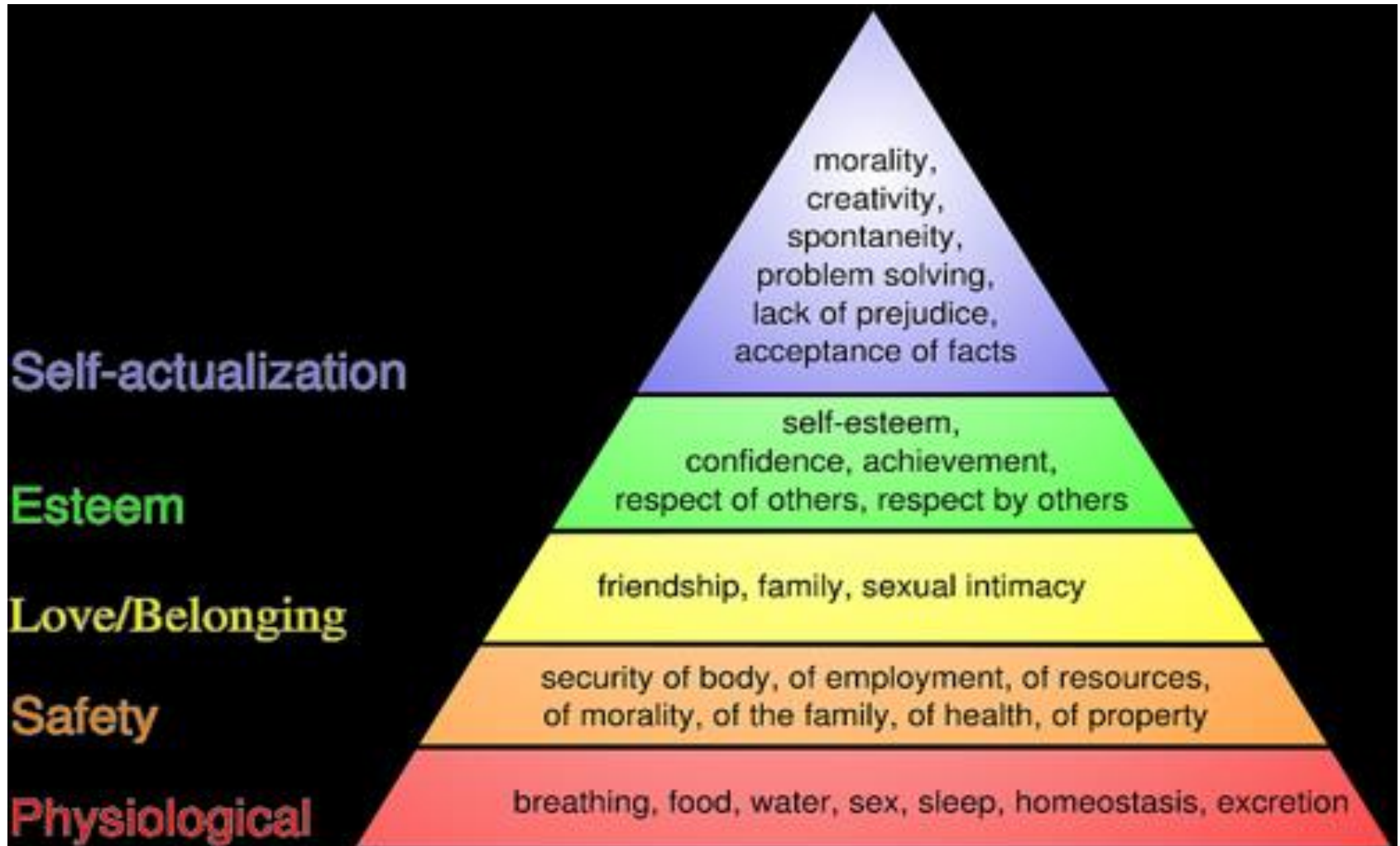
Implementation

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

Evaluation

- 5th step
  - Determining whether the clients <u>goals</u> have been met, partially met or not met.