NURSING PROCESS.

It is process by which we provide care to the patient.

- **Introduction** – The origin of Nsg process has been credited to USA, where there was tremendous discontent due to the lack of body of knowledge for the discipline of Nsg. This stimulated a series of research projects which eventually led to the application of scientific principles to Nsg.

- Def – Nursing process is a systematic problem solving approach used to identify, prevent and treat actual or potential Health Problems and promote wellness.

- Nursing process is an organized systematic method of giving individualized nursing care that focuses on identifying and treating unique responses.

- NP is a deliberate problem solving approach to meet the health care needs of the patients.
- Laryea (2004)

- It provides a frame work with which individualized needs of the patient/family/ community can be met. It is an efficient method of organizing thought process for clinical decision making and problem solving.

- The North American Nursing diagnosis Association (NANDA) has developed and classified nursing diagnosis. NANDA helps in identifying a communication pattern among nurses. It also gives a clear distinction between nursing diagnosis and medical diagnosis.

- PLACE OF NURSING PROCESS IN NURSING EDUCATION – Nsg Edn emphasizes on critical thinking and clinical judgment on the part of the student nurse to make diagnostic and therapeutic judgment. NP has served to make nursing more visible in its contribution to health care in western countries.

ADVANTANGES

- 1. NP enables the nurse to organize and deliver Nsg care.

- 2.The Nsg actions are based on scientific reasons.
- 3.It is used to identify, diagnose and treat human responses to health and illness.
- 4. It is dynamic continuous process as the clients needs change.

- 5. It promotes individualized Nsg care and assists the nurse in responding to client needs in a timely and reasonable manner to improve or maintain clients level of health.

- 6. It allows the nurses to organize, systematic and conceptualize nsg. practice.

- 7. It allows nurses to differentiate their practice from that of physicians and other health care professionals.
- 8. The client is an active participant.
- 9. Helps to prov9ide comprehensive individualized care.

- NP is a process is a problem solving approach
- What is a problem? A problem is a **difficulty** or an **obstacle**.
- **Webster's** dictionary defines problem as " A question raised for inquiry, consideration or solution.
- **Process** means a state of being in progress a series of actions or events or sequence of operation.

- Problem solving approach includes reflective thinking, critical thinking, reasoning and finding solutions to problems.

- **Steps**- Identifying/recognizing problem area.
- Define problem, distinguish the essential features of the situation, collect necessary information from patient and family members.

- Data will include –
- Personal history
- Medical history
- Family history
- Socio-economic history.

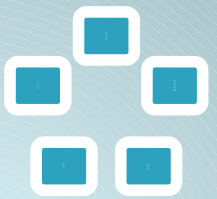
- Nanda is the organization responsible for development review and approval of nursing diagnoses. ND made by professional nurses describe actual or potential problems which nurses by their virtue of their education and experience are capable and licensed to treat.

BENEFITS OF NURSING PROCESS

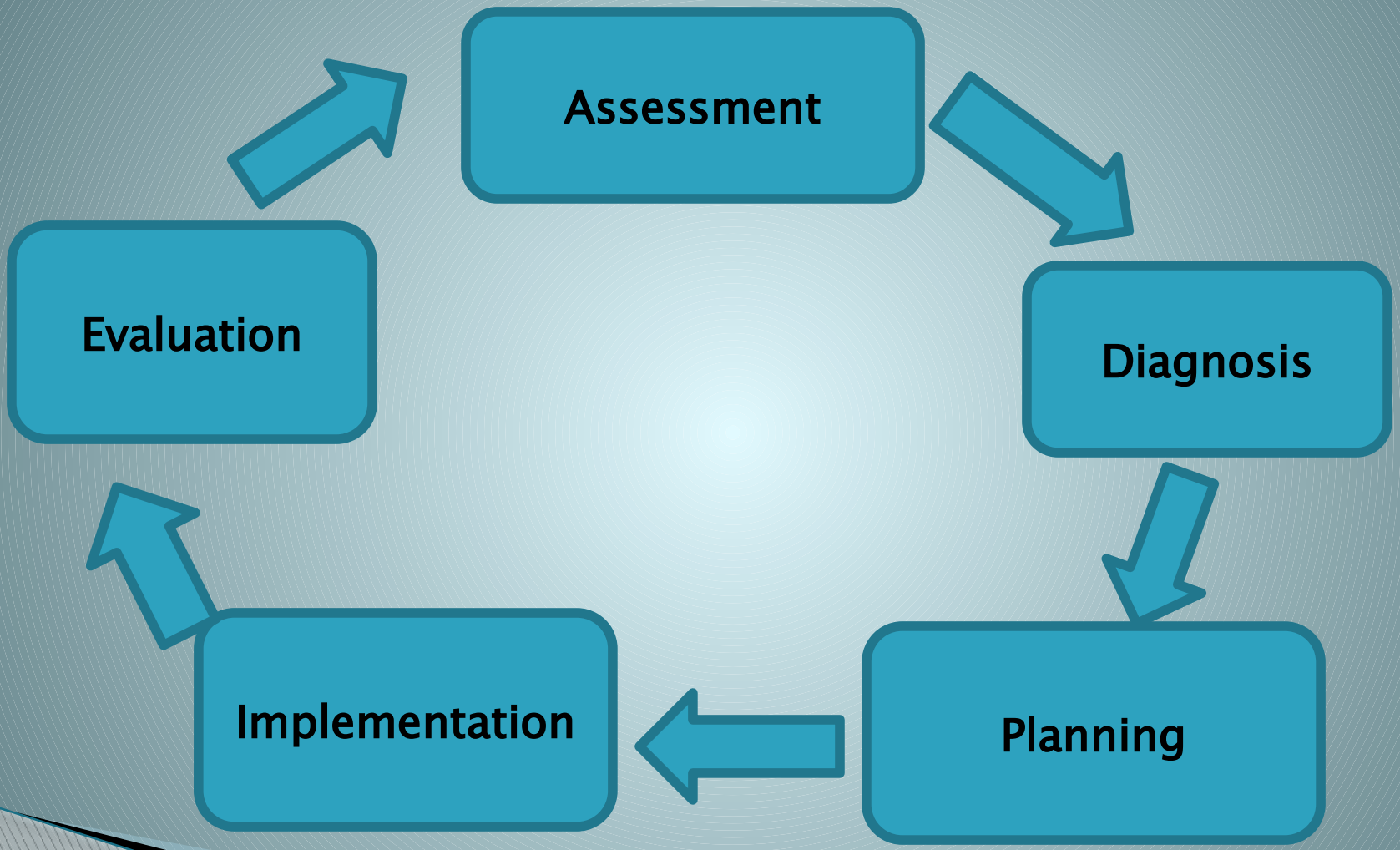
- 1. Nurse gets to plan individualized care which helps her to develop a professional relationship
- 2. It involves the patient activity in all phases, so that the nurse and patient derives satisfaction.
- It gives the nurse a framework to use in patient care.
- It makes the nurse to be aware of the skills and abilities used by her in patent's care.

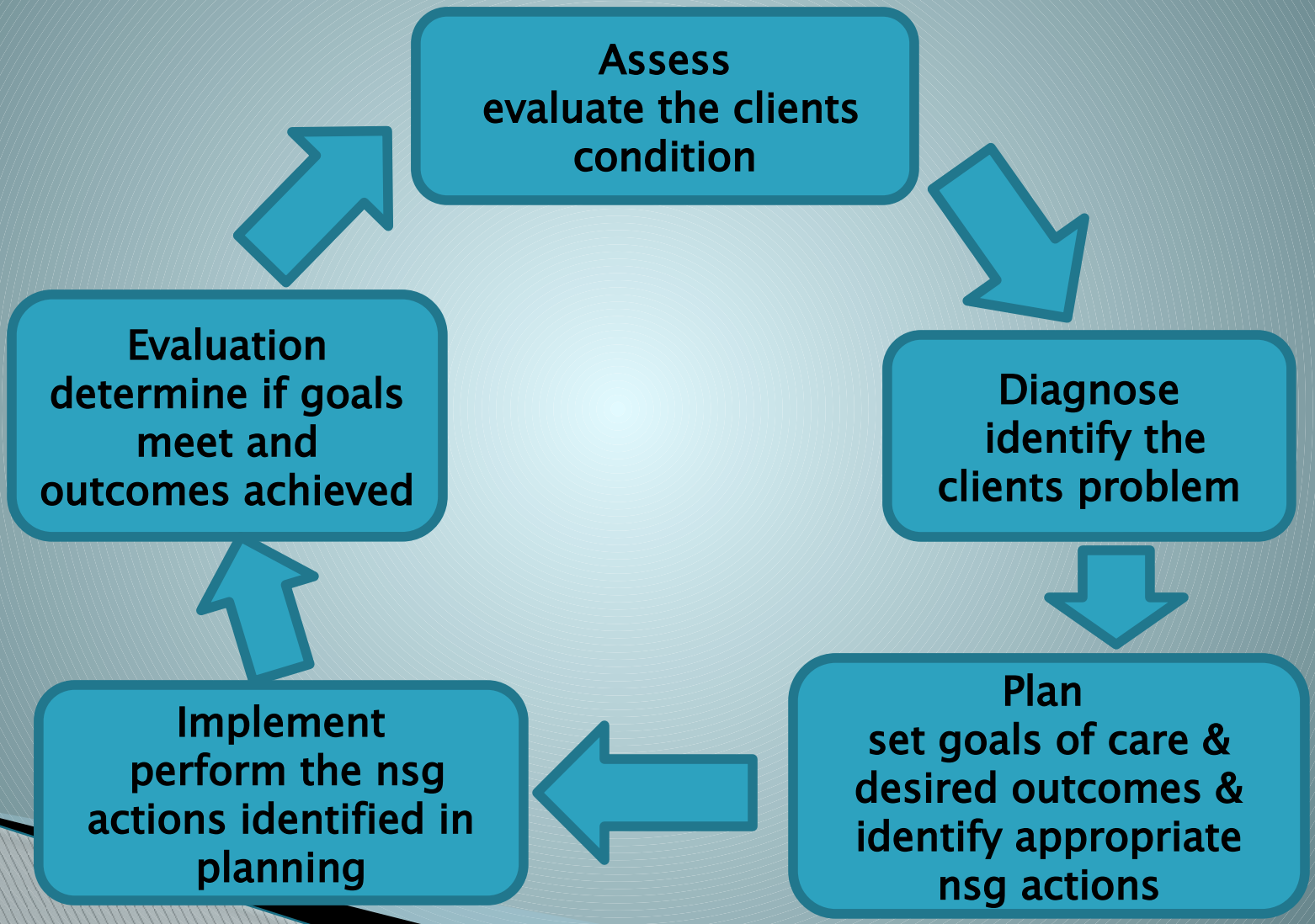
Steps of Nursing process.

- Assessment
- Nursing diagnosis
- Planning
- Implementation
- Evaluation



Phases of Nursing Process




Assess
evaluate the clients condition
Diagnose
identify the clients problem
Plan
set goals of care & desired outcomes & identify appropriate nsg actions
Implement
perform the nsg actions identified in planning
Evaluation
determine if goals meet and outcomes achieved

ASSESSMENT

- Assessment is a systematic process of collecting data focusing on the total person. (physical, psychological, spiritual, social, emotional, and economic). It's purpose is to identify patient problems. The process required observation, Interpersonal relationship skills, knowledge from biological and social sciences , Lab and other investigations.

- **Sources of Information**
- 1. Patient is the first source.
- 2. Family, close relatives, friends, co-workers.
- 3. Nurses, doctors, members of the health team.
- 4. Previous records and diagnostic findings.

- **Focus of assessment** – Patient is the focus. In order to make a successful assessment the nurse should –
- 1. develop a therapeutic relationship with the patient
- 2. Encourage the patient to actively participate.
- 3. Communicate and listen.
- 4. Genuine interest and concern.
- 5. Understand the effects of illness on the patient life style

- 6. Appreciate the patients life style.

VITAL SKILL FOR ASSESSMENT.

1. Observation (What do you observe)

It includes Look, Listen, Feel,
Inspection, Auscultation, Palpation.

- 2. **Measuring-** TPR, Bp, height, weight, Intake and out put (Physical , Physiological, and Biological)

- **3 Interview** – Language (Verbal and Non-verbal) IPS, Posture, Intonation, modulation, Paraphrasing etc.

- Steps in data collection –
- Stage1. Assessment usually done on admission.
- Stage 2. Detailed information – Personal, Medical and social.

- **Baseline data –**
- Present medical history
- Past Medical history
- Surgical history
- Basic physiological data – TPR, BP, HT,WT Etc.
- Physical assessment
- Family history including socio-economic history.

Nursing diagnosis

- It is the second steps of N.P. this step gives meaning to the data. The process of diagnosing is the result of the identification of specific client response to health care problems.

- The goals and objectives of a Nsg diagnosis differ from medical diagnosis. The goal of a Nsg diagnosis is to identify actual & potential client responses where as the goals of a medical diagnosis are to identify the cause of an illness or injury & design a treatment plan.

- **Nursing diagnosis** - Is the clinical judgment about individual, family, or community response to actual or potential health problems or life process.

- NANDA has identified several types of Nsg diagnosis.

Types.

Actual Nsg diagnosis:- describes human response to health conditions or life process that exist in an individual, family or community. It is supported by defining characteristics that cluster in pattern of related cues or inferences.

- Risk Nsg Diagnosis (Potential)
- describes human responses to health conditions or life process that may develop in a vulnerable individual, family or community.

Diagnostic process:-

1. Analysis & interpretation of data.
2. Identification of client needs.
3. Formulation of Nsg diagnosis.

- **Analysis & interpretation of data:-**

During assessment collect data from a variety of sources. We should continually revise the clients database to include changes in the clients physical and emotional status.

- **Identification of clients needs:-**

- Identifying client needs enables us to individualize Nsg diagnosis by considering all assessment data and focusing on the more relevant data.

Formulation of Nsg. diagnosis:-

The Nsg. diagnosis are stated in a two part format. The problem is followed by a related factor. The related factor is a condition or etiology identified during the assessment. (Secondary to)

Problem

Decreased physical functioning – Rt. Limited physical activity, strength coordination and nutrition.

Risk for injury related to altered mobility and generalized weakness.

- **Planning**
- Planning is the category of Nsg behavior in which client centered goals are established and interventions are designed to achieve the goals. Planning requires to use deliberate decision making and problem solving skills to design Nsg. care for each client.

During planning :-

- priorities are set
- Develop expected outcome with time limit
- Formulate a plan of care.

Establishing priorities :- It involves ranking Nsg diagnosis in order of importance, because clients have multiple nsg diagnosis, but we need to prioritize based on the urgency of the problem.

Priorities are classified **as High, Intermediate**, or **Low.** Nursing diagnosis that if untreated could result in harm to client or others have highest priorities. High priorities can be both psychological and physiological. Avoid classifying only physiological diagnosis as priority.

- **Intermediate Priority**:- are non- emergent, non-life threatening needs of the client.
- Low priority :- In which the client needs are not directly related to a specific illness or prognosis, but may affect the clients future well-being.

Examples

High priority :- Ineffective coping Rt anxiety about unknown medical diagnosis.

Ineffective airway clearance Rt pooling of secretions in the bronchial tree.

Rationale:- Prompt interventions for anxiety will help client prepare for and cope with diagnostic test, treatment and diagnosis.

- **Intermediate** priority :- Alteration in nutrition less than body requirements RT chronic diahorrea for 3 weeks.
- Low priority :- Knowledge deficit regarding smoking cessation programs rt lack of opportunity to attend the programs.

- IMPLLEMENTATION
- Implements the intervention identified in the plan of care. It is the action phase of the NP. Nsg actions are behavior that serves to help the patent to achieve the expected out come.

- **Independent actions** – These activities are performed by the nurse using her own judgment. These activities do not require guidelines or others from other health professionals. (sponge bath, nail care, tepid sponge etc)

- **Collaborative actions** – are activities that involves mutual decisions with the doctors and other health care professionals Eg. administering medications, ryles tube, catheterization Etc.

- **Nsg. Interventions** are specific nsg. activities or actions that a nurse must perform to **prevent complications**, **provide comfort** (physical, psychological and spiritual) to **promote**, maintain and restore heath.

- The activities and interventions that to be undertaken by nurses are –
- 1. Nsg assessment
- 2. patient teaching
- 3. Patient counseling
- 4. Consulting/referring to other health professionals.
- 5. Carrying specific procedures to remove/reduce/resolve health problems.

- 6. Assisting the patient to perform activities themselves.
- Patient teaching and discharge planning should be done on the day of admission.

- **Putting the plan into action-** We need to follow activities given below –
- Continuing data collection and assessment
- Setting daily priorities
- Performing nsg interventions
- Documenting nsg care
- Giving verbal nsg reports
- Maintaining a current care plan

- **Expected outcomes**:- They are specific statement of client behavior or responses that we aim to achieve as a result of nursing care. After assessing , diagnosing and establishing priorities about the clients health care needs, formulate goals and expected outcomes.

- **Purpose of goals and outcomes:-**
- Provide direction for the selection and use of Nsg intervention.
- Provide focus for evaluation of the effectiveness of the intervention.
- Goals and expected out come indicate anticipated client responses.

Each goal and expected outcome statement must have a time frame for evaluation. The time frame depends on the nature of the problem, etiology and over all condition of the patient.

Planning Nursing Care:-

After establishing goals and expected outcomes, select appropriate nsg. interventions/ actions. Selecting a suitable Nsg. interventions is a decision making.

To select the interventions we must have :-

- Knowledge about the scientific rationale for the interventions
- Posses the necessary psychomotor and interpersonal skills to perform the interventions.
- Able to function within a particular setting to use the available health care resources effectively.

- **Nursing care plans**

They include :- Subjective/objective data.

Nursing diagnostic statement

Objectives/ goals, expected outcomes, and time limit.

Specific nursing activities.

Rationale

Interventions

Evaluations.

- **Implementation**:- Means providing a patient with planned care. It is carried out by the nurse, patient, family, care givers and health professionals.
- Process of Implementation:-
- Reassess the client
- Review and revise the care plan
- Organize resources and care delivery
- Anticipate and prevent complications
- Implement Nsg. interventions

- Implementation skills:-
- Cognitive (head)
- Interpersonal (heart)
- Psychomotor (hands)

- Cognitive skills:- involves application of nsg knowledge. This allows to anticipate and recognize client needs and know the best nsg approaches. We should also know the rationale for therapeutic interventions, understand normal and abnormal physiological, psychological responses, know nsg sciences to be able to identify client learning and discharge needs and recognize the clients health promotion and illness prevention needs.

- Interpersonal skills:- One must develop a trusting relationship and communicate early with the client, family, and other members of the health care team.
- Psychomotor skills:- require the integration of cognitive and motor activities such as learning to give an injection, you must understand anatomy and pharmacology and the mechanics of preparing and giving injections.

EVALUATION

- Ask the following questions while evaluating:-
- Was the therapy effective in improving the clients level of health or functional status
- Did the patient benefit
- It is important to evaluate whether each client reaches a level of wellness or recovery that the health care team and client established in the goals of care.
- Goal fully met, partially met, not met.