

Lecture (2) 4th Stage Nursing

Assist. L zainab Hassan

Concept of Nursing process and stages

Nursing process: is a systemic method for providing care to clients. The purpose is to provide individualized , holistic, effective client care efficiently. Although the steps of nursing process build on each other, each step overlaps with the previous and subsequent steps.

Purposes of nursing process

1. Providing professional, quality nursing care.

2. Directs nursing activities for health promotion, health protection, and disease prevention and is used by nurses in every practice setting and specialty

3. Provides the basis for critical thinking in nursing

Phases of the nursing process:

1. Assessment (of patient's needs).

2. Diagnosis (of human response needs that nurses can deal with).

3. Planning (of patient's care).

4. Implementation (of care).

5. Evaluation (of the implemented care)

Steps (Phases) of nursing process:

1. Assessment: Is the first step in the nursing process and includes systemic collection, verification, organization, interpretation (analysis), and documentation of data. The completeness and correctness of the information obtained during assessment are directly related to the accuracy of the steps that follow. Assessment involves several steps

   a. Data collection from a variety of sources.

   b. Data validation

   c. Organizing the data.

   d. Data interpretation (Data analysis).

   e. Making initial inferences or imprecision

Type of assessment

1. Comprehensive assessment:

Provide baseline of client data including a complete health history and current needs assessment

Usually completed upon admission to health care agency.

includes of clients physical and psychological health, perception of health, presence of health risk factors, and coping patterns

2. Focused assessment

Is limited to potential health care risks, a particular need, or health care concern.

Often used when short stays are anticipated (e.g., outpatient surgery and emergency departments).

Used in specialty areas such as mental health settings and delivery.

Used in screening for specific problems or risk factors

3. Ongoing assessment:

Follow up , or monitoring of specific problems.

Systematic monitoring allows the nurse to determine the clients response to nursing interventions and to identify any other problems.

Types of Data collection by assessment methods:

- A. Subjective data (also called symptoms): are data from the client's point of view (provided verbally by the patient) and include feelings, perceptions, and concerns. Interview is the primarily method of collecting subjective information. Steps of collecting subjective data

Examples of subjective information :

- a. I have had pains in my legs for three days ago.
- b. I have had headache, nausea, vomiting, dizziness for three hours ago.
- c. I have had anxiety from surgery

B. Objective data (also called signs): are observable and measurable data that are obtained through both physical examination and the result of laboratory and diagnostic tests. The primary method of collecting objective information is the physical examination, which provides information about the function of body systems. Inspection, palpation, percussion, and auscultation techniques are used to collect objective data

Examples of objective information include:

a. Temperature (37.3°C), Pulse rate (100 b/m), Respiration (18 T/m), 16 Blood pressure (130/76 mm/hg).

b. Positive bowel sounds.

c. Flushed face

2. Nursing Diagnosis phase:

involves further analysis and synthesis of the data that have been collected. According to the North American Nursing Diagnosis Association (NANDA) a nursing diagnosis: Is a clinical judgment about individual, family, or community responses to actual or potential health problems / life.

Comparison of Medical Diagnoses and Nursing Diagnoses

Medical Diagnosis	Nursing Diagnosis
Focuses on illness, injury, or disease process.	Focuses on clients responses to actual or potential health problems or life processes.
Recognizes conditions the physician is licensed and qualified to treat.]	. Recognizes situations that the nurse is licensed and qualified to intervene
Example: (Lung cancer, Congestive heart Brain tumor, Exploratory surgery, Appendectomy, Bronchial asthma).).	Example: (Nausea, Acute pain, Anxiety, Impaired physical mobility, Ineffective breathing pattern, Risk for imbalanced fluid volume.

Types of Nursing Diagnoses:

1. Actual nursing diagnosis (Actual problems)

Indicates that a problem exists.

Composed of (diagnostic label, related factors, and signs and symptoms).

Example (Impaired Skin Integrity related to prolonged pressure on bony prominence as manifested by stage II pressure ulcer over coccyx, 3 cm 13 in diameter).

2.Risk nursing diagnosis (Potential problems)

Indicates that a problem does not yet exist, but special risk factors are present.

A risk diagnosis is composed of the diagnostic label preceded by the phrase “risk for” with the specific risk factors listed.

An example of a risk diagnosis is: (Risk for Impaired Skin Integrity

3. Wellness nursing diagnosis (Wellness conditions):

Composed of the diagnostic label preceded by the phrase “potential for enhanced.”

For example a client who is neither overweight nor underweight tells the nurse that she knows she could improve her diet in some ways. She expresses a desire to know more about how to improve her diet. The nurse would make a wellness diagnosis of Potential for Enhanced Nutrition.

3 Planning phase:

The planning of nursing care occurs in three phases:

a. Initial planning: Developed by the nurse who performs the admission assessment and gathers the comprehensive admission assessment data
b. Ongoing planning: Updating of the client’s plan of care.
c. Discharge planning: Critical anticipation and planning for the client’s
d. needs after discharge.

The planning phase involves several tasks

a. Establishing priorities of nursing diagnoses.

c. Planning nursing interventions (with collaboration and consultation as needed).

4. Implementation phase: Involves the execution of the nursing care plan derived during planning phase. It consists of performing nursing activities that have been planned to meet the goals set with the client. The implementation phase of the nursing process requires cognitive (intellectual), psychomotor (technical), and interpersonal skills. The

nurse must continue to assess the client's condition before, during, and after the nursing intervention.

Nursing implementation activities include:

a. Establishment of priorities.

b. Allocation of resources.

c. Initiation of nursing interventions.

d. Documentation of interventions and client response.

5. Evaluation phase

Involves determining whether the goals have been met, partially met, or not met.

1. If the goal has been met, the nurse must then decide whether nursing activities will stop or continue in order for status to be maintained.

2. If the goal has been partially met or not been met, the nurse must reassess the situation and change the plan of care accordingly. New problems may be identified at this stage, and thus the process will start all over again.

Best wishes