**Concept of Nursing Process Outline**

**Objectives**

* Identify the stages of illness and its effects.
* Elucidate the concept of nursing process.
* Relate the purpose of the nursing process and it’s benefits.
* Understand the characteristics of the nursing process.
* Identify the steps of the nursing process.

**Nursing:**

Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, facilitation of healing, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations. (ANA, 2018)

**Nurse Responsibilities:**

* Perform physical exams and health histories
* Provide health promotion, counseling and education
* Administer medications, wound care, and numerous other personalized interventions
* Interpret patient information and make critical decisions about needed actions
* Coordinate care, in collaboration with a wide array of healthcare professionals
* Direct and supervise care delivered by other healthcare personnel like LPNs and nurse aides
* Conduct research in support of improved practice and patient outcomes

**Definition of Nursing Process:**

It is a systematic, rational method of planning and providing individualized nursing care.

* Hall ( 1955) originated the term nursing process.
* Johnson (1959), Orlando ( 1961), Wiedenbach ( 1963) were among the first to use this term with this description.

**Purposes of Nursing Process:**

* To identify a client’s health status and actual or potential health care problems or needs.
* To establish plans to meet the identified needs.
* To deliver specific nursing interventions to meet those needs.

**Characteristics of the Nursing Process:**

**a) Cyclical and dynamic**

* Data from each phase provide input to the next phase. Findings from the evaluation phase feedback into assessment.

**b)Client-centered**

* Plan of care is according to the client problems rather than nursing goals.

**c) Focused on problem solving and decision making**

* An adaptation of problem solving
* Problem directed towards a client’s responses to real or potential disease and illness.
* Decision making is involved in every phase.

**d)** **Interpersonal and Collaborative**

* + Requires the nurse to communicate directly and consistently with clients and families to meet their needs.
	+ Requires the nurse to collaborate as members of the health care team, to provide quality of client care.

**e) Universal applicability**

* + It is used as a framework for nursing care in all types of health care settings with clients of all age groups.

**f) Utilizes critical thinking and clinical reasoning**

* + The nurse determines whether the outcome of care was appropriate.
	+ By reflecting, the nurse asks questions during evaluation of care and while providing care in view of the nursing process.

**Benefits of Nursing Process**

* Provides an orderly & systematic method for planning & care.
* Enhances nursing efficiency by standardizing nursing practice.
* Facilitates documentation of care.
* Provides a unity of language for the nursing profession.
* Stresses the independent function of nurses.
* Increases care quality through the use of deliberate actions.

**Steps of the Nursing Process**

1. Assessment
2. Diagnosis
3. Planning
4. Implementation
5. Evaluation

**1. Assessment**

It is the systematic and continuous collection, organization, validation and documentation of data ( information)

**Type of data ( information)**

* **Objective** data-observable and measurable facts **(Signs)**
* **Subjective** data-information that only the client feels and can describe **(Symptoms)**

**Sources of Data**

* **Primary source**: Client (the best source of data)
* **Secondary source**: Client’s family, reports, test results, information in current and past medical records, and discussions with other health care workers.

**Four Types of Assessment**

1. **Initial Assessment**
* Performed within specified time after admission to a health care agency.
* Establish a complete database for problem identification, reference, and future comparison.

1. **Problem-focused assessment**
* Ongoing process integrated with nursing care
* Determine the status of a specific problem identified in an earlier assessment.
1. **Emergency Assessment**
* During any physiological or psychological crisis of the client.
* Identify life-threatening problems.
* Identify new or overlooked problems.
1. **Time-lapsed reassessment**
* Several months after initial assessment.
* Compare the client’s current status to baseline data previously obtained.

**Data Collection Methods**

* **Observation**: Occurs whenever the nurse is in contact with the client or support persons.
* **Interview**: Used mainly while taking the nursing health history.
* **Examination**: Used through physical health assessment.

**2. Nursing Diagnosing**

It is referred as a statement or conclusion regarding the nature of a phenomenon./ to identify the patient's nursing problem

**North American Nursing Diagnosis Association (NANDA) definition:**

“ Nursing diagnosis is a clinical judgment concerning a human response to health conditions/life processes or a vulnerability for that response, by an individual, family, group or community.” Herdman & Kamitsuru (2018)

**Types of nursing diagnoses**

1. **Actual Diagnosis**
	* A client problem that is present at the time of the nursing assessment.
	* Based on the presence of associated signs and symptoms
2. **Health Promotion Diagnosis**
	* Relates to the client’s preparedness to implement behaviors to improve their health condition.
3. **Risk Nursing Diagnosis**
	* A clinical judgment that a problem does not exist, but the presence of risk factors indicated that problem is likely to develop unless nurses intervene.
4. **Syndrome Diagnosis**
	* Assigned by a nurse’s clinical judgment to describe a cluster of nursing diagnoses that have a similar interventions.

**Write Nursing diagnoses (activity)**

Labels to give meaning to the statement:

* + - * Deficient ( inadequate in amount, quality, or degree, not sufficient, incomplete)
			* Impaired ( made worse, weakened, damage, reduced, deteriorated)
			* Decreased ( lesser in size, amount, or degree)
			* Ineffective ( not producing the desired effect)
			* Compromised ( to make vulnerable to threat )

**Nursing Diagnosis vs. Medical Diagnoses**

**Nursing Diagnoses**

* + Is a statement of nursing judgement.
	+ Refers to a condition that nurses, by virtue of their education, experience and expertise are licensed to treat.
	+ Describe human response, a client’s physical, sociocultural, psychological, and spiritual responses to an illness or a health problem.

**Medical Diagnoses**

* Is made by a physician and refers to a condition that only a physician can treat.
* Refers to disease processes ( pathophysiologic responses)

**3.Planning**

It is a deliberative, systematic phase of the nursing process which involves decision making and problem solving.

Nursing interventions are identified and required to prevent, reduce or eliminate the client’s health problems.

* **Nursing interventions:** is any treatment, based upon clinical judgment and knowledge that a nurse performs to enhance patient/client outcomes

**Type of planning**

**Initial Planning**

Developed by the nurse performing the admission assessment.

**Ongoing Planning**

Performed by all nurses who worked with the client.

Occurs at the beginning of a shift as the nurse plans the care to be given that day.

**Discharge Planning**

The process of anticipating and planning for needs after discharge.

**Planing Process**

1. Setting Priorities
2. Establishing client goals/desired outcomes
3. Selecting nursing interventions and activities
4. Writing individualized nursing interventions on care plans.

**a) Setting Priorites**

* It is the process of establishing a preferential sequence for addressing nursing diagnoses and interventions.
* Nurse frequently use **the Maslow’s hierarchy of needs** ( Figure .1).
* Priorities change as the client’s responses, problems, and therapies change.

**Classification of priorities**

* **High**: nursing diagnosis that if untreated, could result in harm to the client or others have the highest priority
* **Intermediate**: nursing diagnosis involves the non-emergency, non-life threatening needs of the clients
* **Low**: nursing diagnosis are client’s needs that may not be directly to a specific illness or prognosis

**b) Establishing Client Goals/ Desired Outcomes**

Describes in terms of observable client responses what the nurse hopes to achieve by implementing the nursing interventions.

* **(Class Exercise)**

Goal statement (long or short term) = patient behavior + criteria + time + conditions (if needed)

1. Subject -patient

2. Verb -action/behavior which pt performs

3. Criteria -acceptable performance

4. Within specified time period

5. Condition (if needed) circumstances under which behavior performed

Example:

* The patient (1) will walk (2) the length of the hall (3) with a walker (5) by the end of the shift (4).

**b) Selecting Nursing Interventions and Activities**

Nursing interventions and activities are the actions that a nurse performs to achieve client goals.

**Type of Nursing interventions:**

1. **Independent interventions**
2. **Dependent interventions**
3. **Collaborative interventions**

**c) Writing individualized nursing interventions on care plans.**

* Format for written interventions is similar to that of outcomes: verb, conditions, and modifiers plus a time element.
* (**Class Exercise**)
	+ Action verb – starts the intervention and must be precise ( explain, teach, measure, record, assess)
	+ Time element – answers when, how long, or how often the nursing action is to occur ( Assist client with tub bath at 0700 daily)

**4. Implemntation**

It is the action phase in which the nurse performs the nursing interventions.

It consists of doing and documenting the activities that are the specific nursing actions needed to carry out the interventions.

**Process of Implementation:**

* Reassessing the client.
* Determining the nurses need for assistance.
* Implementing the nursing interventions.
* Supervising the delegated care.
* Documenting nursing activities.
* Selecting Nursing Implementation
* Planning the measures that the client and nurse will use to accomplish identified goals involves critical thinking.
* Nursing interventions are directed at eliminating the etiologies.
* The nurse selects strategies based on the knowledge that certain nursing actions produce desired effects.

**5. Evaluating**

It is a planned, ongoing, purposeful activity in which clients and health care **Professionals determine:**

 a. The client’s progress toward achievement of goals/outcomes.

 b. the effectiveness of the nursing care plan

**Process of evaluating client response**

1. Identify the desired outcomes.
2. Collecting data related to desire outcomes.
3. Compare the data with desired outcomes
4. Relate nursing actions to client goals/desired outcomes.
5. Draw conclusions about problem status.
6. Continue to modify or terminate the clients care plan.



Figure1: The Maslow’s hierarchy of needs