SNS COLLEGE OF NURSING

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NURSING PROCESS

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THE NURSING PROCESS

A systematic problem-solving approach used to identify, prevent and treat actual or potential health problems and promote wellness.

Nursing process

A systematic way to plan, implement and evaluate care for individuals, families, groups and communities.

PURPOSES OF NURSING PROCESS

- To help the patient in maintaining health
- To protect client from illness
- To identify client's health status
- To identify client's actual and potential health problems
- To determine priorities
- To initiate/establish plan for meeting the identified needs
- To deliver the specific nursing intervention

PURPOSES OF NURSING PROCESS

- To evaluate effectiveness of care provided
- To promote recovery from illness
- To promote return to a state of maximum functioning
- During terminal illness, help the client have a peaceful death

CHARACTERISTICS OF NURSING PROCESS

- Problem oriented
- Universally applicable
- Dynamic
- Cyclic
- Interpersonal and collaborative approach(Health team)
- Involves creativity in designing ways
- Goal oriented
- Open & flexible

CHARACTERISTICS OF NURSING PROCESS

- Client oriented & individualized approach
- Systemic & planned
- Emphasis on feedback
- Can focus on problems or strengths

PROBLEM ORIENTED

- Nursing process is always focusing on client's problem. Problem may be actual/current or potential problems.

Actual problem means the need/problem from which the client is already suffering. E.g. loss of appetite, loss of sleep in whole night, constipation, pain, vomiting and dyspnea

Potential problem means which are not presently, client have, but in future, there are chances/probability for their occurrence, e.g. in case client is bed ridden, obese- development of bedsore, muscle wastage, constipation etc.,

UNIVERSALLY APPLICABLE

- In nursing process, we are following standardized steps as well as NANDA diagnosis. Regardless of location worldwide, same terminology will be applied.

DYNAMIC

- It is a dynamic activity that begins when the nurse collects subjective data and objective data. Dynamic means changeable. New data is added if the patient's condition changes or patient reveals more information.

CYCLIC

- Nursing process involves inter-related steps. Nurse can't process by omitting one step. If the problem is not solved, nurse has to follow the assessment step or the planning step or have to change the nursing strategic.
- Just like a wheel, the nursing process continuously proceed until the problem is solves or goal is achieved.

INTERPERSONAL AND COLLABORATIVE APPROACH

- The nurse can't give independent care to client in hospital.
- In the assessment phase of nursing process, she verifies/collects information from laboratory investigation as well as medical records.
- Similarly in the planning phase, also she consults the doctor/physiotherapist, dietitian in solving the client's problem.

GOAL ORIENTED

- Nursing process is always goal oriented. While approaching the client, nurse keeps in mind her professional goal i.e.
  - To promote health
  - To prevent the occurrence of disease
  - To protect client from complication
  - To enhance early recovery from disease condition

OPEN & FLEXIBLE

- Open means information is gathered through client's cooperation. It is discussed with the client. As nursing process is dynamic, it changes as the client's needs change or problem is resolved. By keeping in mind the client's nature, values, feelings, beliefs, nursing care is provided.

CLIENT ORIENTED

- Nursing process involves identifying and solving the client's problem not the nurse's. It does not means that nurse will do the work/care as per her desires.

SYSTEMATIC & PLANNED

- Nursing process always follows series of action/5steps. Nurse can’t proceed to 3rd step until she follows first two steps in sequence. Nursing process is always a planned activity.

FEEDBACK

- Nursing process gives much weightage to the feedback i.e client reaction to the identified/potential problem. If the feedback is positive, means problem is solved, gives satisfaction to nurse for her activities. If the feedback is negative, she again follows the nursing steps to resolve the problem.

NURSING STEPS ARE INTER-RELATED

- Every step of nursing process is closely related. Each step is dependent on other step. E.g. Nurse can't frame nursing diagnosis until the assessment step is completed.

IMPORTANCE OF NURSING PROCESS

- Helps in ensuring quality care.
- Hospital team have a access to the systematic and scientific plan of care.
- Nursing activities performed for a client, family or society are available in written form.
- It avoids duplication and omissions.
- It enhance communication as well as cooperation among nursing personnel.
- It helps in meeting the patient's individualized preferences and needs.

IMPORTANCE OF NURSING PROCESS

- As nursing process is client centered participation of patient in care is encouraged. It enhances his dependence.
- Nursing process is a legal document.
- It can be used for medical student's learning purpose.
- It provides an organized method of giving nursing care.
- It helps nurses to gain satisfaction by getting results.
- It helps to improve continuity of care.
- It promotes flexibility in giving individualized nursing care.

STEPS IN NURSING PROCESS

- Assessment
- Nursing Diagnosis
- Planning
- Implementation
- Evaluation


Assessment
Evaluation
Nursing Diagnosis
Nursing Process
Implementation
Planning

ASSESSMENT

Assessment

- Assessing is a continuous process carried out during all phases of nursing process. All phases of the nursing process depend on the accurate and complete collection of data.

- Assessing is the systematic and continuous collection, organization, validation and documentation of data.

- Potter and Perry(2006)

Assessment is the deliberate and systematic collection of data to determine a clients current and past health status and to determine the clients present and past coping patterns

- Carpenito 2000

- Assessment is the systematic and continuous collection, validation and communication of patient data.

- Carol Taylor

1. COLLECTION OF DATA

Figure 12-4 In the interview, both the seating arrangement and the distance from the patient are important in establishing a relaxed and comfortable environment for data collection. (Photo © B. Proud)

Figure 25-23 Examination of the nasal passages using an otoscope with a wide speculum. (Photo © B. Proud.)

Data Collection is the process of gathering information about a clients health status.

Collection of Data:

- **Data base**: A data base is all information about a client. It includes the nursing health history, physical assessment, the physician's history, physical examination, results of laboratory and diagnostic tests and material contributed by other health personnel.

Types of Data:

SUBJECTIVE DATA: Also referred to as symptoms or covert data are apparent only to the person affected and can be described or verified only by that person

Eg. Itching, Pain, Feelings of worry

OBJECTIVE DATA: Also referred to as signs or overt data. These are detectable by an observer or can be measured or tested against an accepted standard.

They can be seen, heard, felt or smelled and they are obtained by observation or physical examination

Eg. A Blood Pressure Data
Discolouration of the Skin

Sources of Data:

- **Primary Source (Direct Source**

client: Usually BEST source

Secondary Sources (Indirect Sources)

- Family Members
- Client's records

1. Medical Records

Eg. Medical History, Physical Examination, Operation notes, Progress notes, Consultation done by Physicians

2. Records of therapies done by other health professionals

Eg. Social Workers, Dieticians, Physical Therapist

3. Laboratory Records

- Other health care professionals Verbal reports

- Literature

NURSING DIAGNOSIS

Components of a NANDA Nursing Diagnosis

A nursing diagnosis has three components:

(1) The problem and its definition

(2) The etiology

(3) The defining characteristics.

1. The **problem statement** describes the client's health problem.
2. The **etiology** component of a nursing diagnosis identifies causes of the health problem.
3. **Defining characteristics** are the cluster of signs and symptoms that indicate the presence of health problem.

Formulating Diagnostic Statements

The basic three-part nursing diagnosis statement is called the PES format and includes the following:

1. ***Problem (P):*** statement of the client's health problem (NANDA label)
2. ***Etiology (E):*** causes of the health problem
3. ***Signs and symptoms (S):*** defining characteristics manifested by the client.

Acute pain related to **abdominal surgery** as evidenced by **patient discomfort and pain scale.**

Problem	Etiology	Signs and symptoms
Pain	Surgery of abdomen	Pain scale and discomfort of patient

PLANNING

PLANNING

- Planning is the process of thinking before doing. It involves determination of goals as well as nursing activities required to be undertaken to achieve the desired/set goals.

IMPLEMENTATION

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- Implementation follows the planning phase of nursing process. It puts the nursing care plan into action.

EVALUATION

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- Evaluation is the consequences/results, outcome of the nursing intervention. It may be positive or negative. It is a formal and systematic procedure of determining the effectiveness of the nursing care given.


Thank
you