Hammoud Hospital
University Medical Center
Staff Development Department

Nursing Process

Presented by
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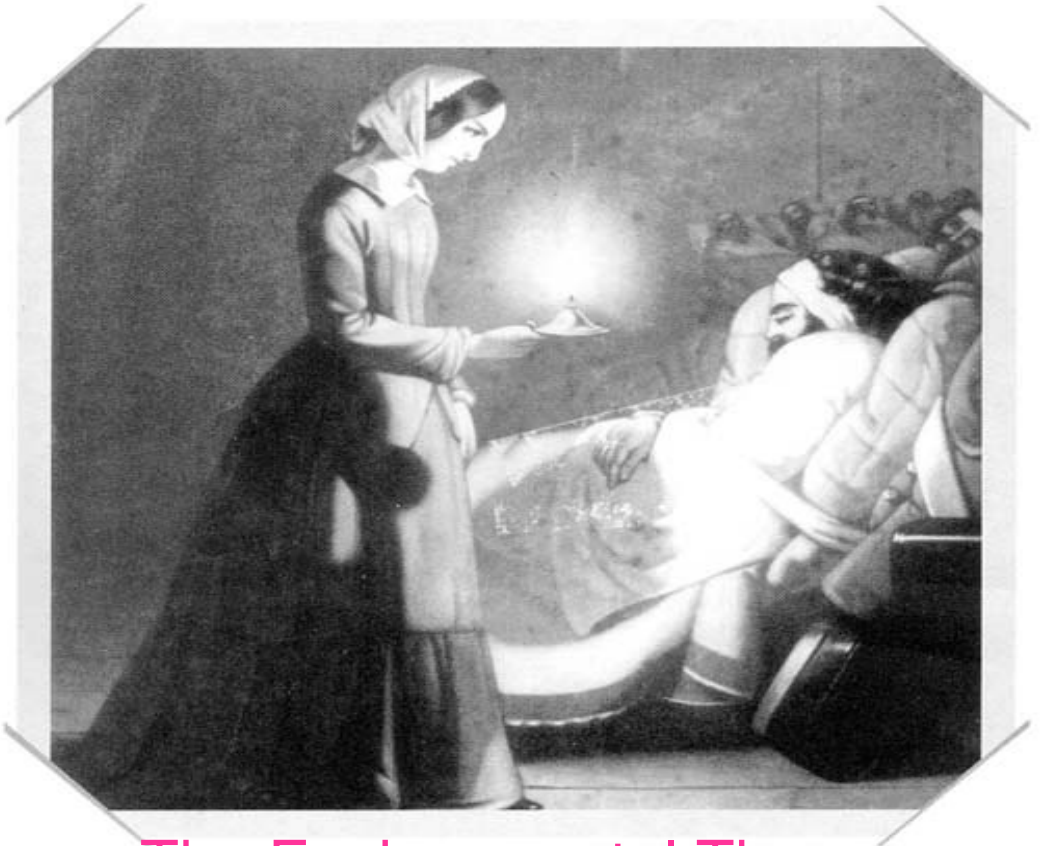
Agenda

- History of Nursing Process
- Definition of Nursing Process
- Advantages of Nursing Process
- Steps of the Nursing Process
- Difference between Nursing Diagnosis and Medical Diagnosis
- Nursing Process and Critical thinking
- Recommendations

Nursing care comes in many forms. Sometimes it is the ability to make someone feel physically comfortable by various means. Other times it is the ability to improve the body's ability to achieve or maintain health. But often it is an uncanny yet well honed knack to see beyond the obvious and address, in some way, the deeper needs of the human soul.

Donna Wilk Cardillo, *RN*

Florence Nightingale



The Environmental Theory

1859 ,She linked health with
5 environmental factors

1. Pure or fresh air
2. Pure water
3. Efficient drainage
4. Cleanliness
5. Light (especially direct sunlight)

Deficiencies in these five factors produced lack of health or illness.

Virginia Henderson

1922 She conceptualized the role of the nurses as assisting sick or healthy individuals to gain independence in meeting the fourteen fundamental needs

The Nature of Nursing Model

The 14 Fundamentals or Basic Needs

1.  Breathe normally

2.  Eat and drink adequately

3.  Eliminate body wastes

4.  Move and maintain desirable positions

5.  Sleep and rest

6.  Select suitable clothes-dress and undress

7.  Maintain body temperature withi normal range by adjusting clothing and modifying environment

8.  Keep the body clean and well groomed and protect the integument

9. 

Avoid dangers in the environment and avoid injuring others.

10.  Communicate with others in expressing emotions, needs, fears, or opinions.

11.  Worship accordin g to one's faith

12.  Work in such a way that there is a sense of accomplishment

13.  Play or participate in various forms of recreation

14.  Learn, discover, or satisfy the curiosity that leads to normal development and health and use the available health facilities

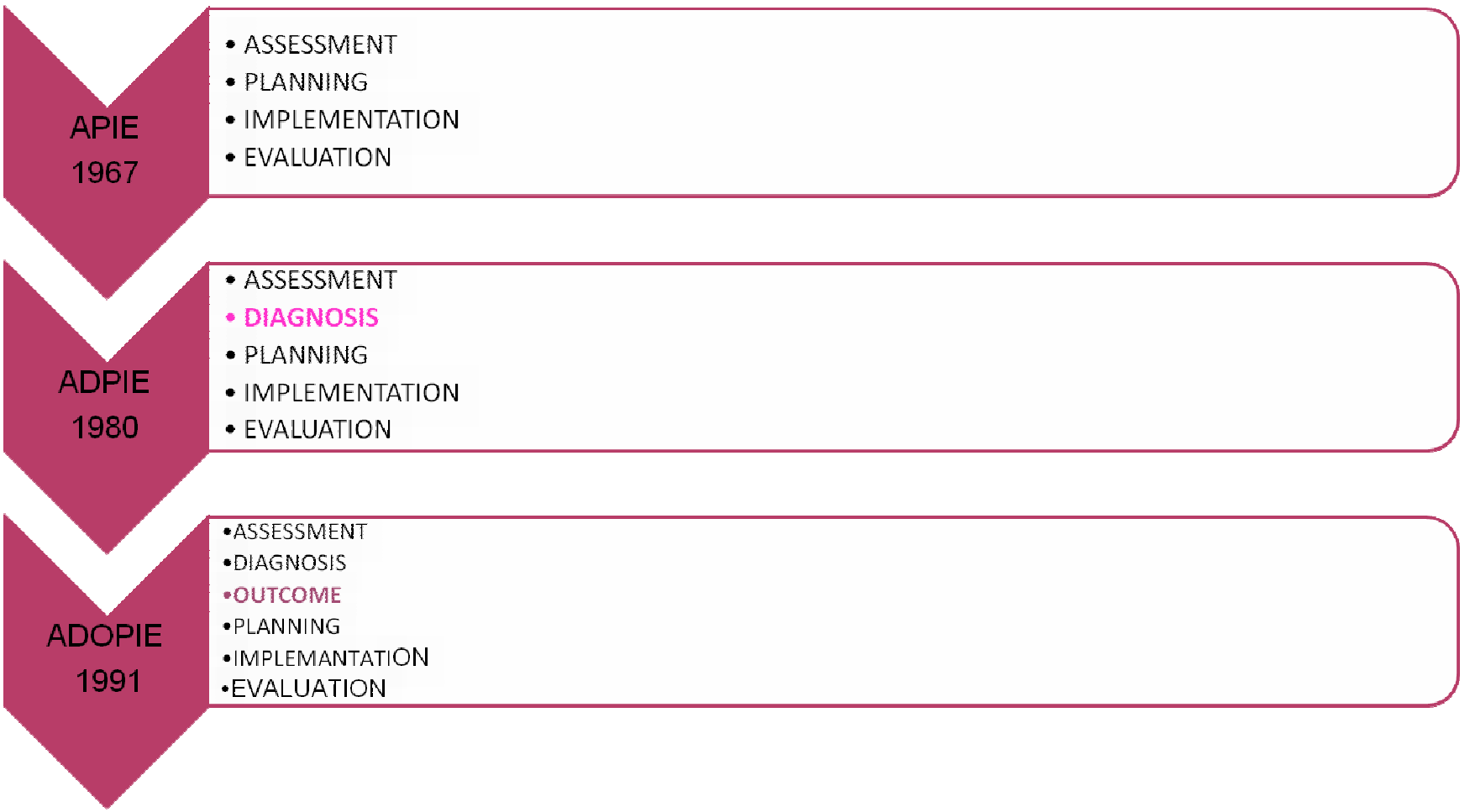
Then Lydia Hall…

The term nursing process was first used/mentioned by Lydia Hall, a nursing theorist, in 1955 wherein she introduced 3 STEPs:

- ✓Observation
- ✓Administration of care
- ✓Validation

Care ,Core and Cure Model

The Nursing Process continue to evolve



NURSING PROCESS

THE CORNERSTONE OF THE NURSING PROFESSION

The Nursing Process

Is a process by which nurses deliver care to individuals, families, and/or communities and is supported by nursing theories. The nursing process was originally an adapted form of problem-solving and is classified as a deductive theory.

Wikepedia ,2009

Purpose of Nursing process

- Defines patient goals
- **Determines the Nurses' Role**
- Provides consistency of care
- **Customizes Care Interventions**
- Promotes holistic treatment
- Provides quality patient care

Benefits of the Nursing process for the Nurse

- ★Job satisfaction
- ★Professional growth
- ★Avoidance of legal action
- ★Meeting professional nursing standards
- ★Meeting standards of accredited hospitals

Characteristics of the Nursing Process

Cyclic

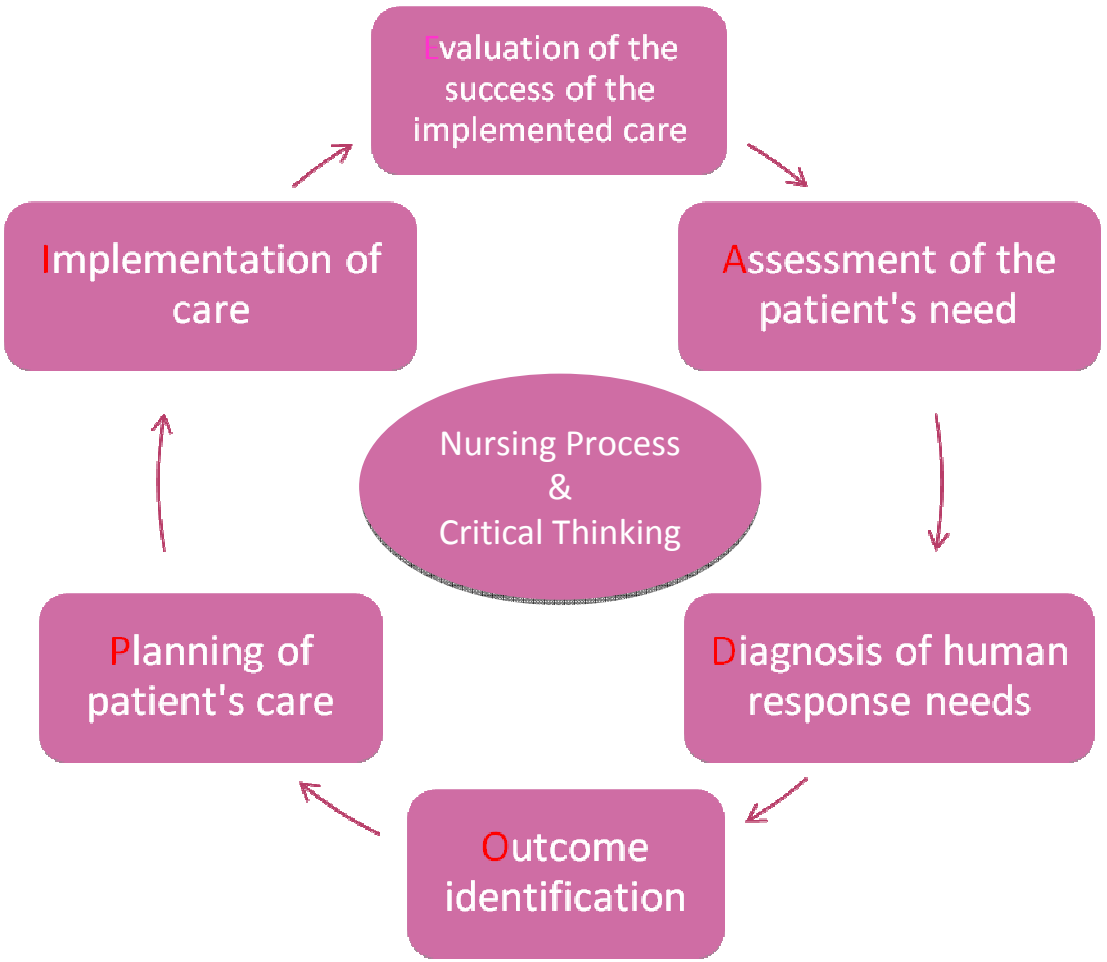
G O S H approach

Dynamic

Wikepedia

Phases of the nursing process include:

ADOPIE



All the Components of the Nursing process are considered and conducted using the

Nursing Care Plan

The Nursing Care Plan

A set of actions that the nurse will implement to resolve existing and potential health problems identified through nursing assessment

Wikepedia 2011

Assessment (what is the situation)?

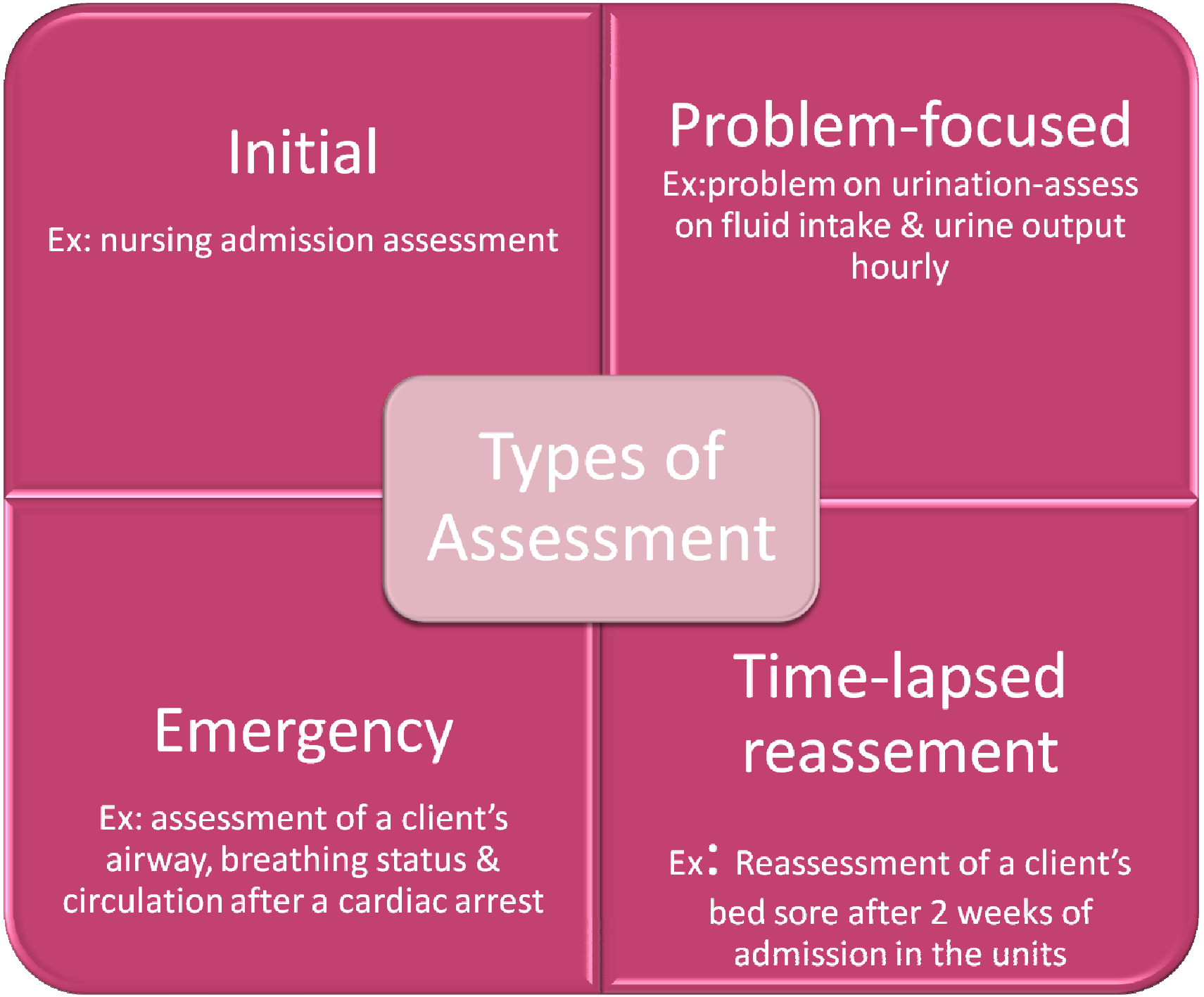
Definition

Is the first and most critical step of nursing process in which the nurse carries out a complete and holistic nursing assessment of every patient's needs, regardless of the reason for the encounter.

Usually, an assessment framework, based on a nursing model is used.

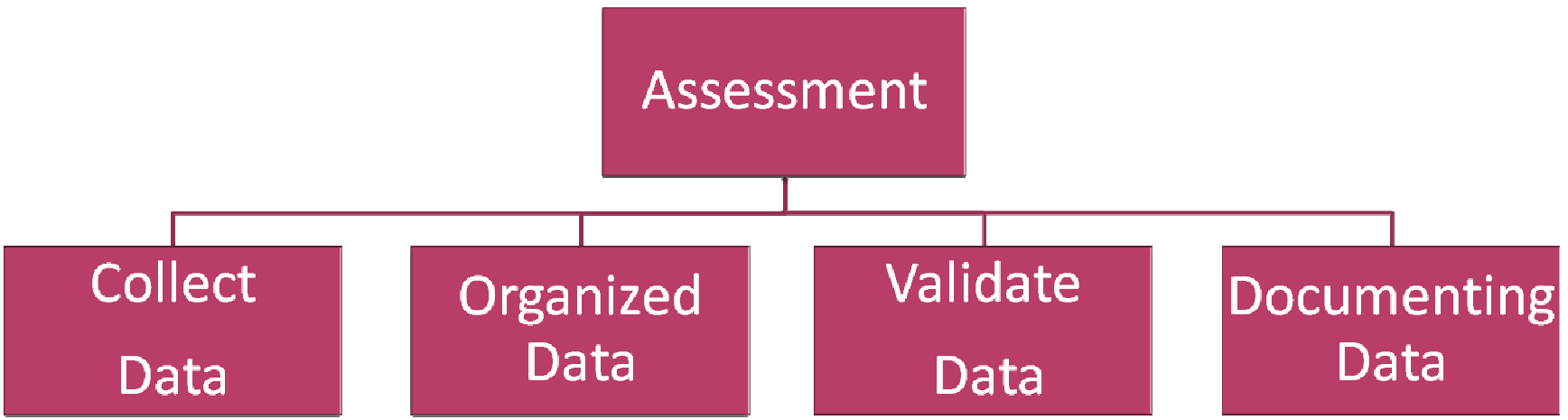
Purpose

- ☆ To establish baseline information on the client
- ☆ To identify the patient's nursing problems

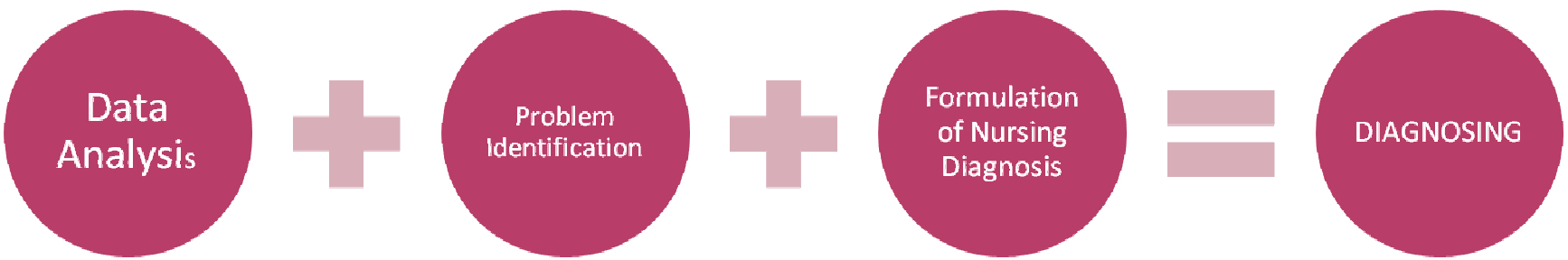

Initial
Ex: nursing admission assessment
Problem-focused
Ex:problem on urination-assess on fluid intake & urine output hourly
Types of Assessment
Emergency
Ex: assessment of a client's airway, breathing status & circulation after a cardiac arrest
Time-lapsed reassement
Ex: Reassessment of a client's bed sore after 2 weeks of admission in the units

Assessing

Sources of Data	Data collection	Types of Data
• Primary source • Secondary source	• Observation • Interview • Examination	• Subjective data • Objective data

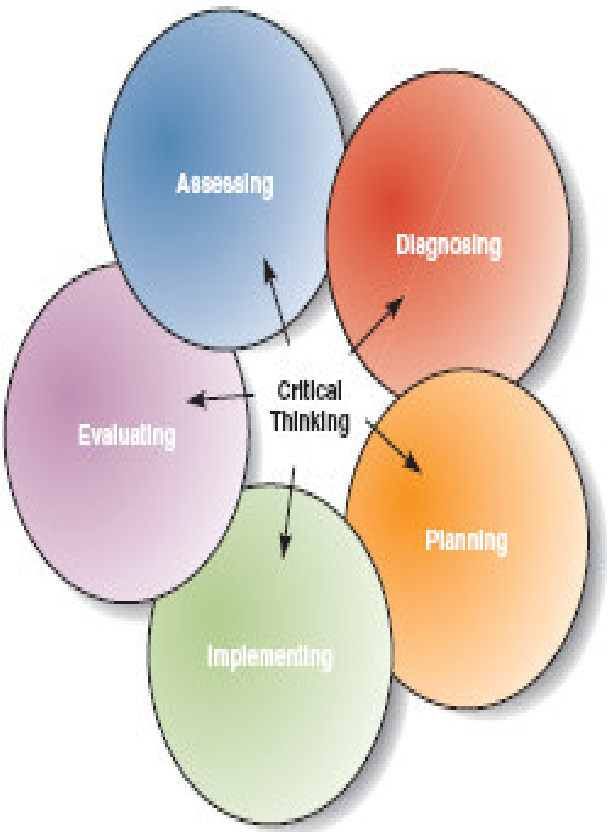

Assessment
Collect Data
Organized Data
Validate Data
Documenting Data

Diagnosing (what is the problem?)



Definition of Nursing Diagnosis

A Nursing Diagnosis is defined as " a clinical judgment about an individual, family or community responses to actual and potential health problems/life processes. Nursing diagnosis provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable."(NANDA, 2009)



Classification of Nursing Diagnosis

- NANDA (the North American Nursing Diagnosis Association)*
- 14 needs VERGINIA HENDERSON
- 11 modes of MARJORY GORDON
- LYNDA JUALL CARPENITO,
- OTHERS……..

*is a professional organization of nurses standardized nursing terminology that develops, researches, disseminates and refines the nomenclature, criteria, and taxonomy of nursing diagnoses.

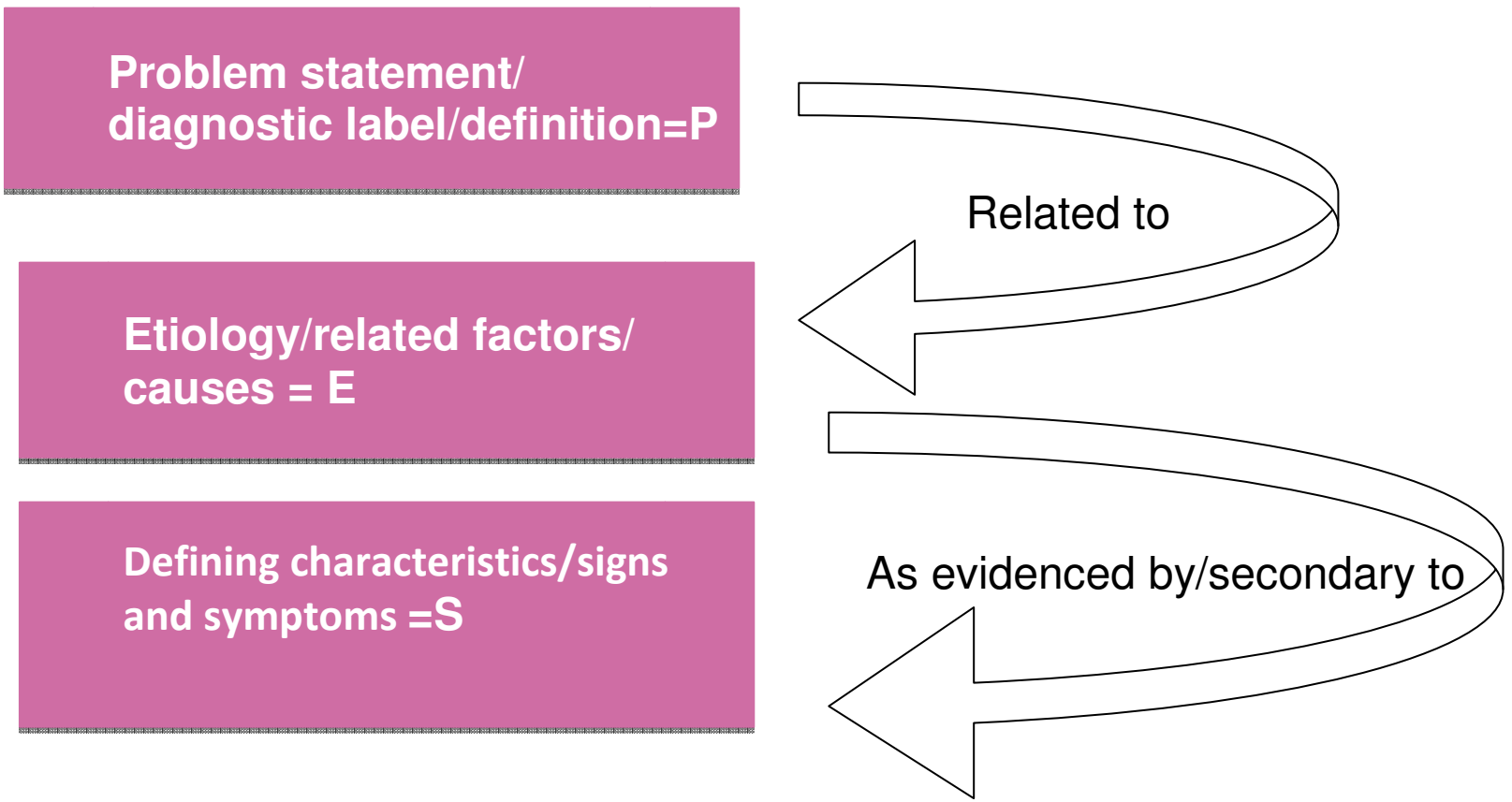
Purpose of Nursing Diagnosis

- ★ Promotes use of standardized language and process.
- ★ Demonstrates professional judgment.
- ★ Organizes decision making.
- ★ Promotes accountability.
- ★ Provides communication among nurses and other health care personnel.
- ★ A means to individualize care.

Characteristics of Nursing Diagnosis

- ✓ states a clear and concise health problem.
- ✓ is derived from existing evidences about the client.
- ✓ is potentially amenable to nursing therapy.
- ✓ is the basis for planning and carrying out nursing care

Components of a Nursing Diagnosis



Composed of 3 parts: PES or 2 parts:PE

Components of a Nursing Diagnosis

Therefore may be written as :

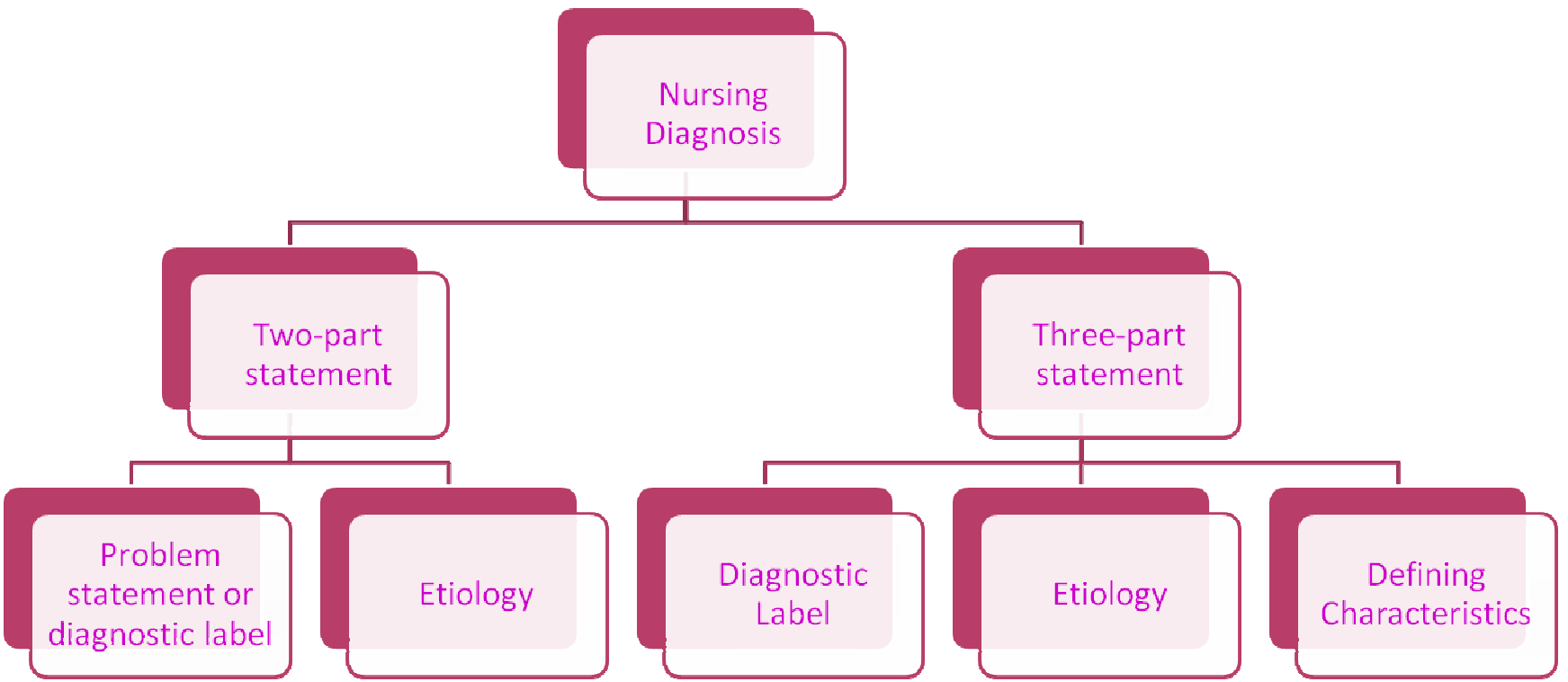
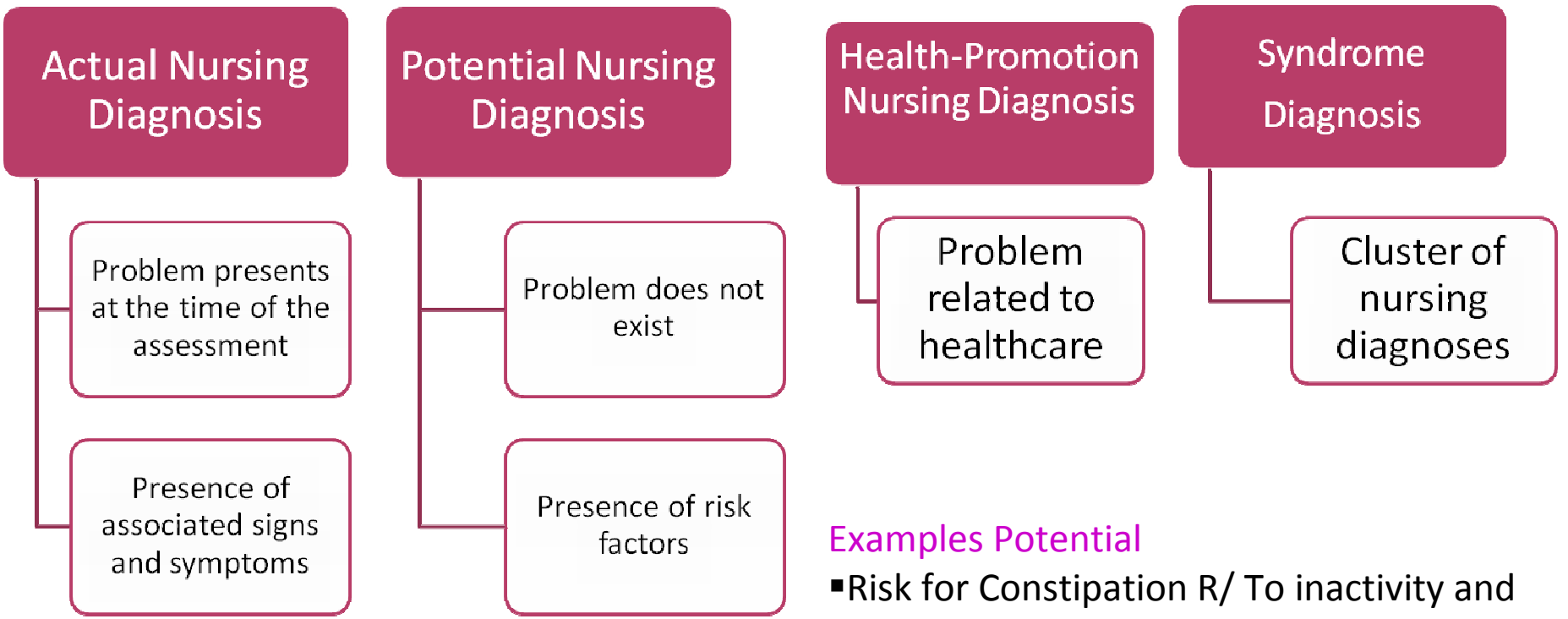


TABLE 12-3 EXAMPLES OF NURSING DIAGNOSES EXPRESSED IN TWO- AND THREE-PART STATEMENTS

Nursing Diagnosis	Two-Part Statement	Three-Part Statement
Feeding Self-Care Deficit	*Feeding Self-Care Deficit* RT decreased strength and endurance	*Feeding Self-Care Deficit* RT decreased strength and endurance AEB inability to maintain fork in hand from plate to mouth
Ineffective Airway Clearance	*Ineffective Airway Clearance* RT fatigue	*Ineffective Airway Clearance* RT fatigue AEB dyspnea at rest
Anxiety	*Anxiety* RT change in role functioning	*Anxiety* RT change in role functioning AEB insomnia, poor eye contact, and quivering voice
Deficient Knowledge	*Deficient Knowledge* RT misinterpretation of information	*Deficient Knowledge* RT misinterpretation of information AEB inaccurate return demonstration of self-injection
Spiritual Distress	*Spiritual Distress* RT separation from religious ties	*Spiritual Distress* RT separation from religious ties AEB crying and withdrawal

Data from North American Nursing Diagnosis Association (NANDA) (2003). *Nursing diagnoses: Definitions and classification 2003–2004.* Philadelphia: Author.

Structure of Nursing Diagnosis



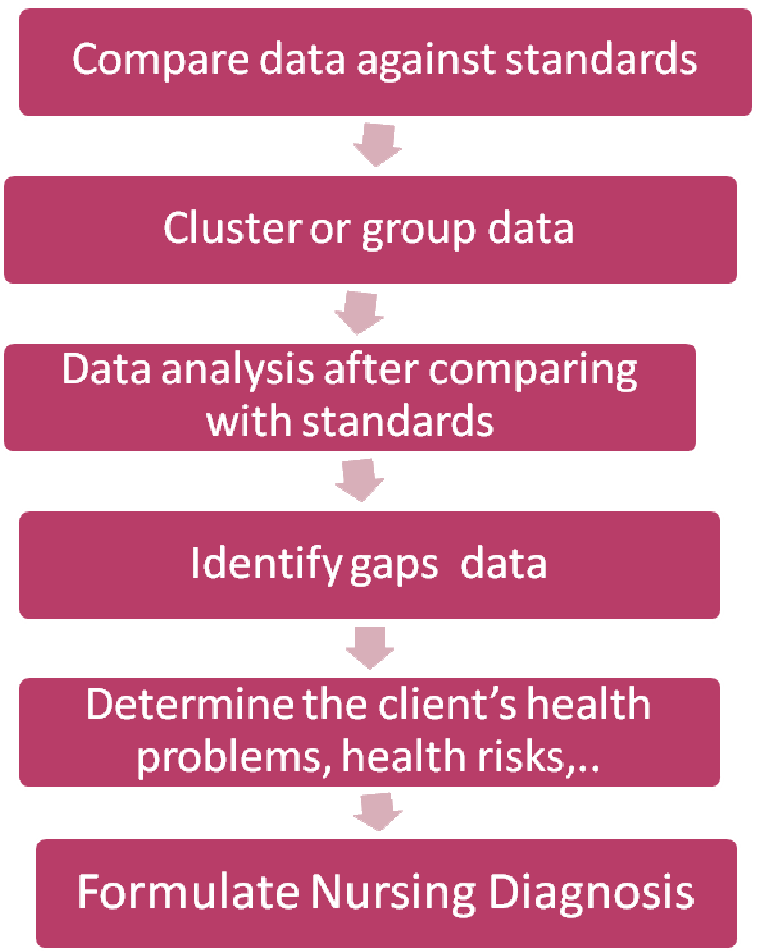
Examples Actual

- Impaired skin integrity R/ To prolonged immobility.
- Ineffective airway clearance R/ To retained secretions.

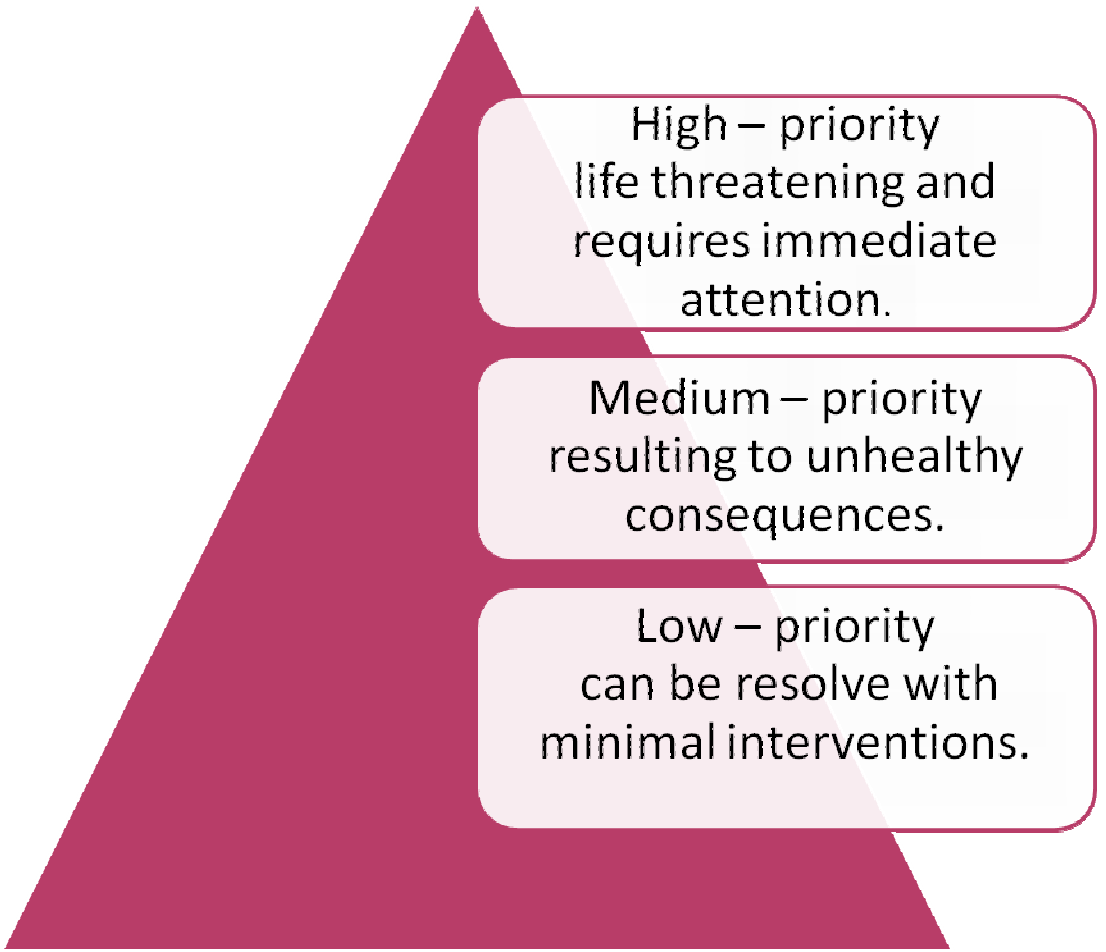
Examples Potential

- Risk for Constipation R/ To inactivity and insufficient fluid intake
- Risk for infection R/ To compromised immune system.
- Risk for injury R/ To decreased vision after cataract surgery.

Process of Diagnosis



Classification of Nursing Diagnosis



Guidelines for writing a Nursing Diagnosis statement

Guideline	Incorrect Statement	Correct Statement
1. State in terms of a problem, not a need.	*Fluid Replacement* (need) related to fever	*Deficient Fluid Volume* (problem) related to fever
2. Word the statement so that it is legally advisable.	*Impaired Skin Integrity* related to improper positioning (implies legal liability)	*Impaired Skin Integrity* related to immobility (legally acceptable)
3. Use nonjudgmental statements.	*Spiritual Distress* related to strict rules necessitating church attendance (judgmental)	*Spiritual Distress* related to inability to attend church services secondary to immobility (nonjudgmental)
4. Make sure that both elements of the statement do not say the same thing.	*Impaired Skin Integrity* related to ulceration of sacral area (response and probable cause are the same)	*Risk for Impaired Skin Integrity* related to immobility
5. Be sure that cause and effect are correctly stated (i.e., the etiology causes the problem or puts the client at risk for the problem).	*Pain* related to severe headache	*Pain: Severe Headache* related to fear of addiction to narcotics
6. Word the diagnosis specifically and precisely to provide direction for planning nursing intervention.	*Impaired Oral Mucous Membrane* related to noxious agent (vague)	*Impaired Oral Mucous Membrane* related to decreased salivation secondary to radiation of neck (specific)
7. Use nursing terminology rather than medical terminology to describe the client's response.	*Risk for Pneumonia* (medical terminology)	*Risk for Ineffective Airway Clearance* related to accumulation of secretions in lungs (nursing terminology)
8. Use nursing terminology rather than medical terminology to describe the probable cause of the client's response.	*Risk for Ineffective Airway Clearance* related to emphysema (medical terminology)	*Risk for Ineffective Airway Clearance* related to accumulation of secretions in lungs (nursing terminology)

Difference between Nursing Diagnosis &Medical Diagnosis

Nursing Diagnosis	Medical Diagnosis
Within the scope of **nursing** practice	Within the scope of **medical** practice
Identify **responses** to health and illness	Focuses on **curing** pathology
Can **change** from day to day	Stays the **same** as long as the disease is present

Nursing Diagnosis	Medical Diagnosis
Breathing patterns, ineffective	Chronic obstructive pulmonary disease
Activity intolerance	Cerebrovascular accident
Impaired sense of comfort (Pain)	Appendectomy
Body image disturbance	Amputation
Body temperature, risk for altered	Strep throat

Outcome

Definition

- It is the third step in the Nursing Process
- Refers to formulating and documenting measurable, realistic and client-focused goals
- Nursing outcome Classification “NOC”

Purpose

- To promote client participation
- To plan care that is realistic and measurable
- To evaluate the effects of nursing care as a part of health care

Components of Outcomes

- **Subject**: who is the person expected to achieve the outcome?
- **Verb**: what actions must the person take to achieve the outcome?
- **Condition**: under what circumstances is the person to perform the actions?
- **Performance criteria**: how well is the person to perform the actions?
- **Target time**: by when is the person expected to be able to perform the actions?

Example of verbs used in client goals:

- Calculate
- Classify
- Communicate
- Compare
- Define
- Demonstrate
- Describe
- Construct
- Contrast
- Distinguish
- Draw
- Explain
- Express
- Identify
- List
- Name
- Maintain
- Perform
- Particular
- Practice
- Recall
- Recite
- Record
- State
- Use
- Verbalize
- Ambulates

Outcome criteria are: **SMART**

- **S**
  - Specific
- **M**
  - Measurable
- **A**
  - Attainable
- **R**
  - Realistic
- **T**
  - Time frame

Example :

- After teaching session, the client will demonstrate proper coughing techniques.
- The client will drink at least 6 glasses of water per day while in the hospital.

Types of goals

★ Short-term goal – can be met in a short period
★ Long term goal – requires more time

Example :Nursing Diagnosis

Impaired Tissue Integrity R/T destruction of tissue 2° pressure and friction AEB stage II pressure ulcer on coccyx

- Long term goal: "Patient's pressure ulcer will heal before discharge
- Short term goal: "Patient will demonstrate 3 measures that she can do to prevent pressure ulcers during my shift"

Guideline for setting priorities:

- Use the principle of ABC's (airway, breathing, circulation)
- Use 14 needs of Virginia Henderson .
- Consider something that is very important to the client.
- Actual problems take precedence over potential concerns.

Planning(How to fix the problem)

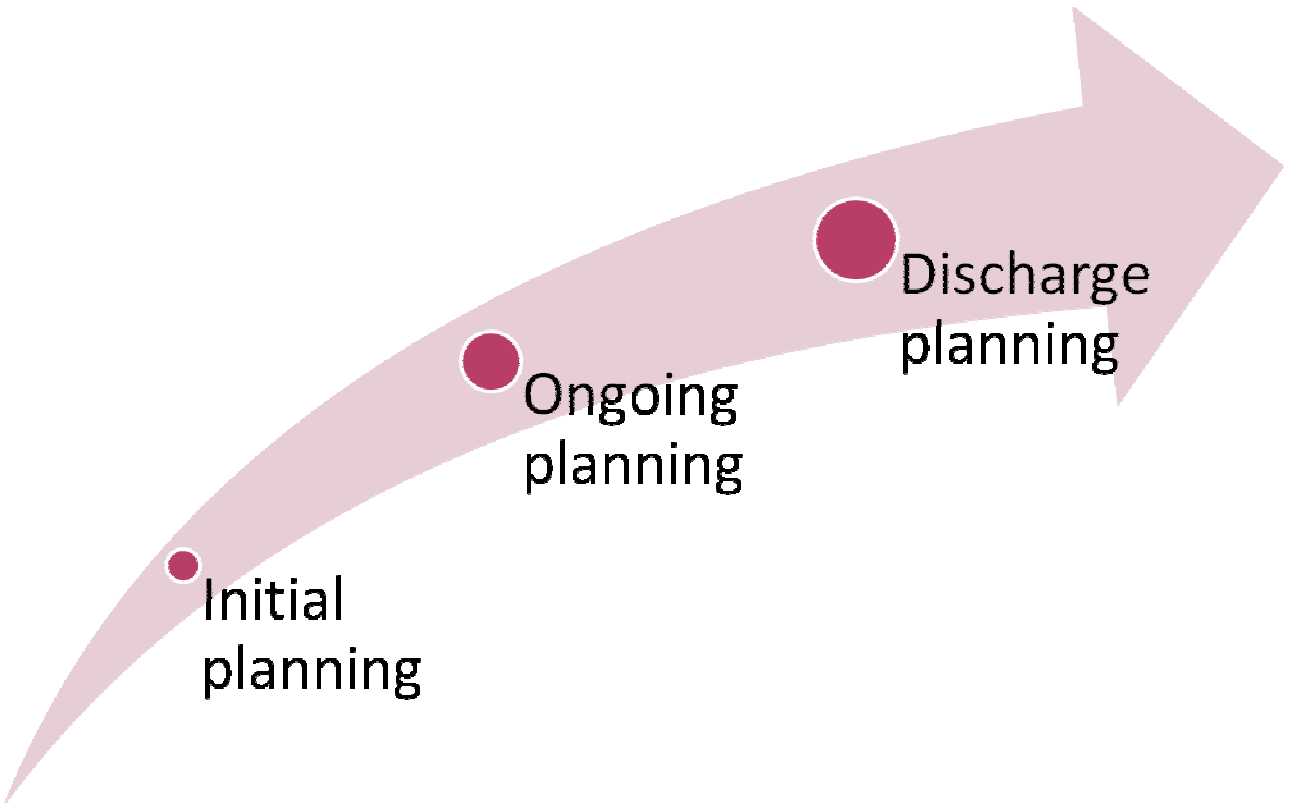
Definition

- It is the forth step in the Nursing Process
- Involve the client and his family
- Begins with the first client contact until client is discharged from the hospital

Purpose

- To determine the goals of care and the course of actions to be undertaken during the implementation phase.
- To promote continuity of care.

Types of planning



Implementation (putting plan into action)

Definition

- It is the fifth in the Nursing Process
- is putting the nursing care plan into action.
- Nursing Interventions Classification “NIC”

Purpose

- To carry out planned nursing interventions to help the client attain goals and achieve optimal level of health.
- To describe the activities that nurses perform

Activities during implementation

Reassessing	Set priorities	Perform nursing interventions	Record actions
• To ensure prompt attention to emerging problems.	• to determine the order in which nursing interventions are carried out	• These may be independent. Dependent or collaborative measures	• To complete nursing interventions, relevant documentation should be done.

Requirements of Implementation:

- Knowledge – include intellectual skills like problem-solving, decision-making and teaching.
- Technical skills – to carry out treatment and procedures.
- Communication skills – use of verbal and non-verbal communication to carry out planned nursing interventions.
- Therapeutic use of self – is being willing and being able to care.

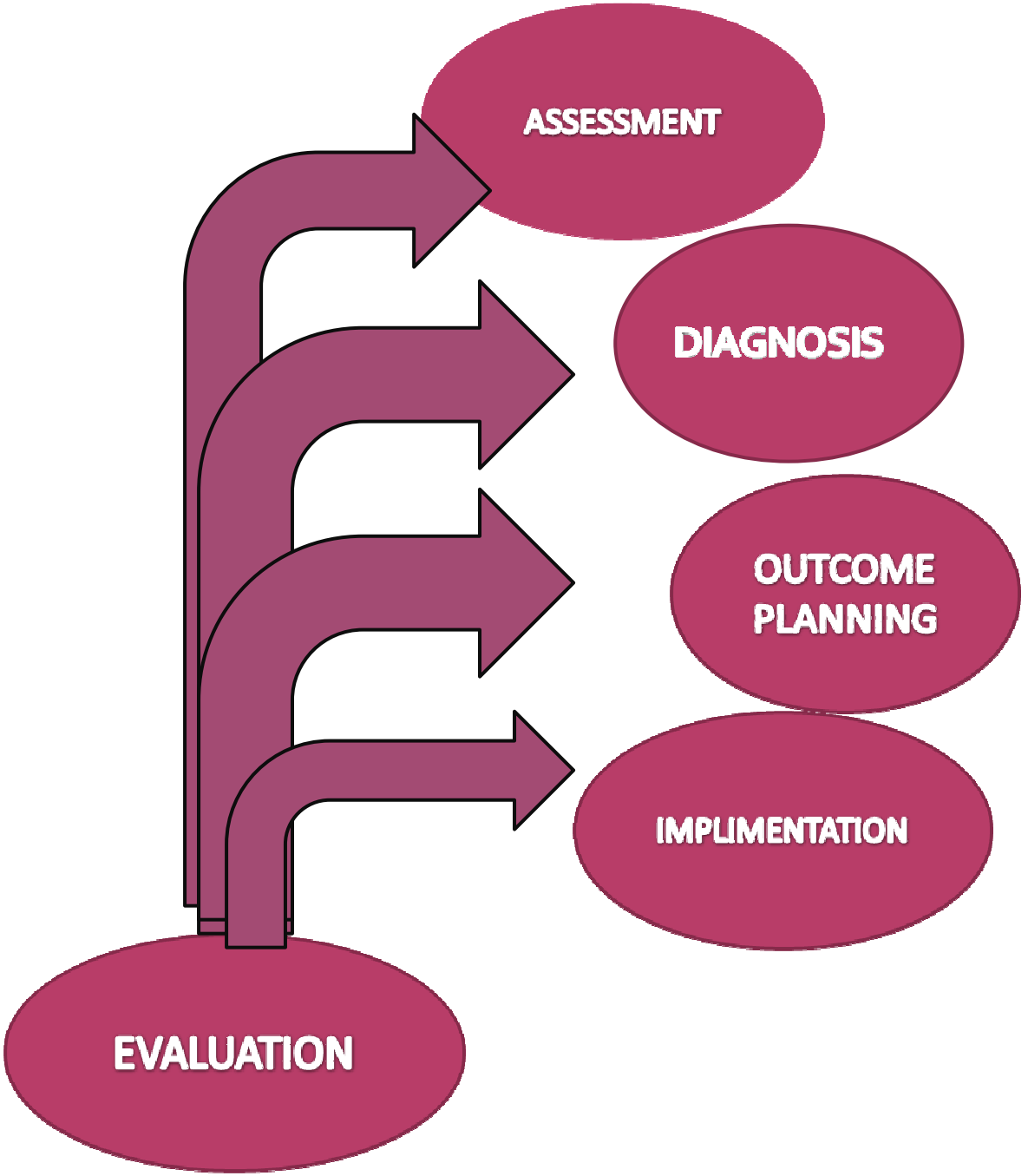
Evaluation(did the plan work?)

Definition

- It is the final step in the Nursing Process
- is assessing the client's response to nursing interventions and then comparing that response to predetermined standards or outcome criteria.

Purpose

To appraise the extent to which goals and outcome criteria of nursing care have been achieved


ASSESSMENT
DIAGNOSIS
OUTCOME PLANNING
IMPLIMENTATION
EVALUATION

Activities during Evaluation

Collect data about the client's response

Compare response to goals and outcome criteria

Assess whether goals are met (partially/completely met or unmet)

Analyze reasons for outcomes

Modify care plan as needed

HEART OF THE NURSING PROCESS

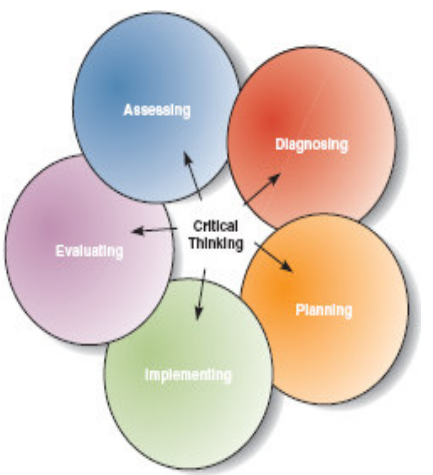
- Critical thinking

Nurse as Critical Thinker

No action is performed without critical thinking”

(Rubenfeled &Scheffer,1999)

- Analyze complex data about clients
- Make decisions about the client's problems and alternate possibilities
- Evaluate each problem to decide which applies
- Decide on the most appropriate interventions for the situation



Oermann, 1999 as cited in Jarvis, 2004

When do Nurses Use Critical Thinking?

- ☆To prioritize nursing actions
- ☆To resolve conflict
- ☆To implement change
- ☆To analyze situations
- ☆To solve problems
- ☆To make decisions

Nursing Care Plan

Assessment data related to Nursing diagnosis	Nursing Diagnosis	Outcomes	Nursing Interventions	Evaluation
Objective data: 1.CVA left sided paralysis 2.Diminished gag reflex 3.Difficulty swallowing liquids **Subjective data:** "Mom chokes every time she eats"	**Potential For aspiration** *related* to diminished gag reflex and impaired swallowing ability	Patient will maintain patent air way (23/03/2011 at 2 pm) **Outcome criteria:** 1.Patient will have no chocking episodes while eating 2.Patients color will not remain cyanotic 3.Patient lung sounds will remain clear 4.Patient CXR will shows no signs of aspiration	1. Place patient one semi setting position to avoid aspiration of mucous. 2. Feed patient liquids which have been thickened, as thin liquids are more likely to cause aspiration. 3. Monitor lung sounds and skin color for signs of aspiration. 4. Monitor lab and X-rays data for signs of aspiration.	-Patient **didn't have** problems with shocking during my shift 1. Patient color was **pink**. 1. Patient lung sounds remain **clear**. 2. Patient has lab/X-rays didn't show no signs of aspiration

Finally

- DO IT
- DO IT RIGHT
- DO IT RIGHT NOW!

References

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Thank You