The Nursing Process

The Nursing Process

- An organizational framework for the practice of nursing
- Orderly, systematic
- Central to all nursing care
- Encompasses all steps taken by the nurse in caring for a patient

Definition of the Nursing Process

- An organized sequence of problem-solving steps used to identify and to manage the health problems of clients

The Nursing Process

- Assessment
- Planning
- Implementation
- Evaluation

Characteristics of the Nursing Process

- Within the legal scope of nursing
- Based on knowledge-requiring critical thinking
- Planned-organized and systematic
- Client-centered
- Goal-directed
- Prioritized
- Dynamic

What Are the nurses' Responsibilities?

- Recognize health problems.
- Anticipate complications.
- Initiate actions to ensure appropriate and timely treatment.

Begin to think CRITICALLY !!!!!!

Assessment of Well-Being

- According to the World Health Organization well-being includes the following:
  - Emotional
  - Physical
  - Social
  - Spiritual

Lets Get Started :

- Nurse collects background info from previous charts
- Ensure environment is conducive
- Arrange seating
- Allow adequate time
- Nurse introduces self
- Identifies purpose of interview
- Ensure confidentiality of information
- Provide for patient needs before starting

ASSESSMENT

- Observation
- Interview
  - Types of questions
  - Environment
- Examination

Types of Data To Collect:

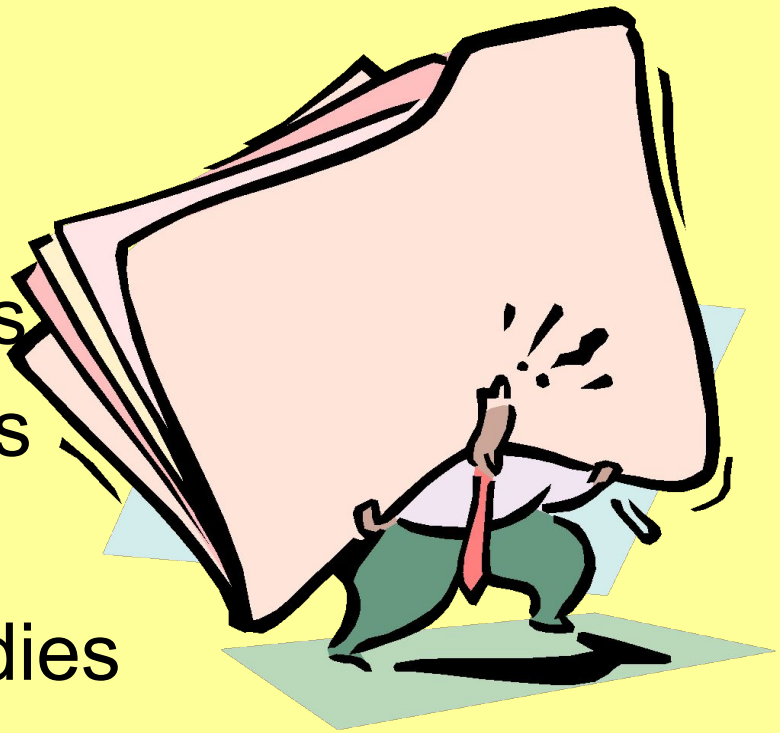
- Objective data-observable and measurable facts **(Signs)**
- Subjective data-information that only the client feels and can describe **(Symptoms)**

CULTURAL DIVERSITY

- **Respect INDIVIDUAL'S DIFFERENCES, What is the significance of the problem or illness to the client?**
- **What does it mean in the family/community?**

Resources

- Client
- Other individuals
- Previous records
- Consultations
- Diagnostics studies
- Relevant literature



Assessment

- Data base assessment – comprehensive information you gather on initial contact with the person to assess all aspects of health status.

Sources of Data

- Primary source: Client
- Secondary source: Client's family, reports, test results, information in current and past medical records, and discussions with other health care workers

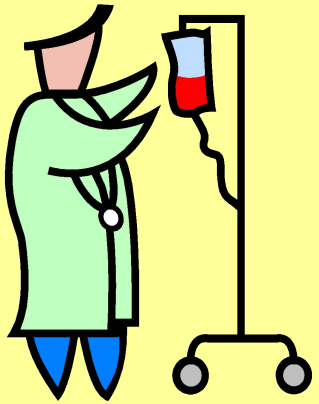
Disease Prevention

- Primary prevention – protection from a disease while still in a healthy state.
- Secondary prevention – early detection and treatment of disease.
- Tertiary prevention – prevent complications and to maintain health once the disease process has occurred.

Planning

- Establish the goals, interventions and outcomes

General Guidelines for Setting Priorities



1. Take care of immediate life-threatening issues.
2. Safety issues.
3. Patient-identified issues.
4. Nurse-identified priorities based on the overall picture, the patient as a whole person, and availability of time and resources.

Nursing Interventions

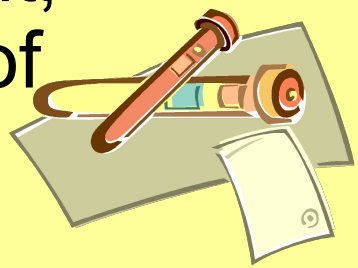
- Outlining the best ways to provide nursing care.
- Evidence based nursing.

1. Monitor health status.
2. Minimize risks.
3. Resolve or control a problem.
4. Assist with ADLs.
5. Promote optimum health and independence.

Interventions

- ***Direct interventions***: actions performed through interaction with clients.

- ***Indirect interventions***: actions performed away from the client, on behalf of a client or group of clients.



Documenting the Plan of Care

- To ensure continuity of care, the plan must be written and shared with all health care personnel caring for the client.
- Consists of:

1. Prioritized nursing diagnostic statements.
2. Outcomes.
3. Interventions.

Documentation

- Clear and concise
- Appropriate terminology
  - Usually on a designated form
- Physical assessment
  - Usually by Review of Systems
    - Overview of symptoms
    - Diet

Documentation

- Use patient's own words in subjective data – enclose in " ___" (quotation marks)
- Avoid generalizations – be specific

Evaluation

1. Determining outcome achievement
2. Identifying the variables affecting outcome achievement
3. Deciding whether to continue, modify, or terminate the plan

Determining Outcome Achievement

- Must be aware of outcomes set for the client.
- Is patient able to meet outcome criteria?
- Is it:

  Completely met?

  Partially met?

  Not met at all?
- Record in progress in notes.
- Update care plan.

- Maintain individuality of care plan:
  1. Is the plan realistic for the client?
  2. Is the plan appropriate at the time for this particular client?
  3. Were changes made in the plan when needed?
  4. How does the client feel about the plan?

Planning

- The process of prioritizing nursing diagnoses and collaborative problems, identifying measurable goals or outcomes, selecting appropriate interventions, and documenting the plan of care.
- The nurse consults with the client while developing and revising the plan.

Setting Priorities

- Determine problems that require immediate action
- Maslow's Hierarchy of Human Needs

Short-Term Goals

- Outcomes achievable in a few days or 1 week
- Developed form the problem portion of the diagnostic statement
- Client-centered
- Measurable
- Realistic
- Accompanied by a target date

Long-Term Goals

- Desirable outcomes that take weeks or months to accomplish for client's with chronic health problems

The Nursing Process

Planning

- Identification of goals and outcome criteria
- Prioritization
- Time frame

Communicating The Plan

- The nurse shares the plan of care with nursing team members, the client, and client's family.
- The plan is a permanent part of the record.

Evaluation

- The way nurses determine whether a client has reached a goal.
- It is the analysis of the client's response, evaluation helps to determine the effectiveness of nursing care.

The Nursing Process

Evaluation

- Ongoing part of the nursing process
- Determining the status of the goals and outcomes of care
- Monitoring the patient's response to drug therapy

Documentation

- Clear and concise
- Appropriate terminology
  - Usually on a designated form
- Physical assessment
  - Usually by Review of Systems
    - Overview of symptoms
    - Diet
    - Each body system