



Nursing sciences

Nursing Process

Learning Objectives:

After completing this lecture, the students will be able to:

- Identify the purposes and characteristics of the nursing process.
- Describe the five phases of the nursing process.
- Differentiate objective and subjective data, primary and secondary sources of data.
- Identify the components of a nursing diagnosis.
- Describe various forms for writing nursing diagnosis statements.
- Identify steps in the planning, implementation, and evaluation process.

Nursing Process:

Nursing process: is a systematic, client-centered, rational method of planning and providing individualized nursing care. **Its purposes are:**

- To identify a client's health status and actual or potential healthcare 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

- Cyclic and
- Dynamic nature,
- Client-centeredness,
- Focus on problem-solving and decision-making,
- Interpersonal and collaborative style,
- universal applicability,
- Use of critical thinking and clinical research

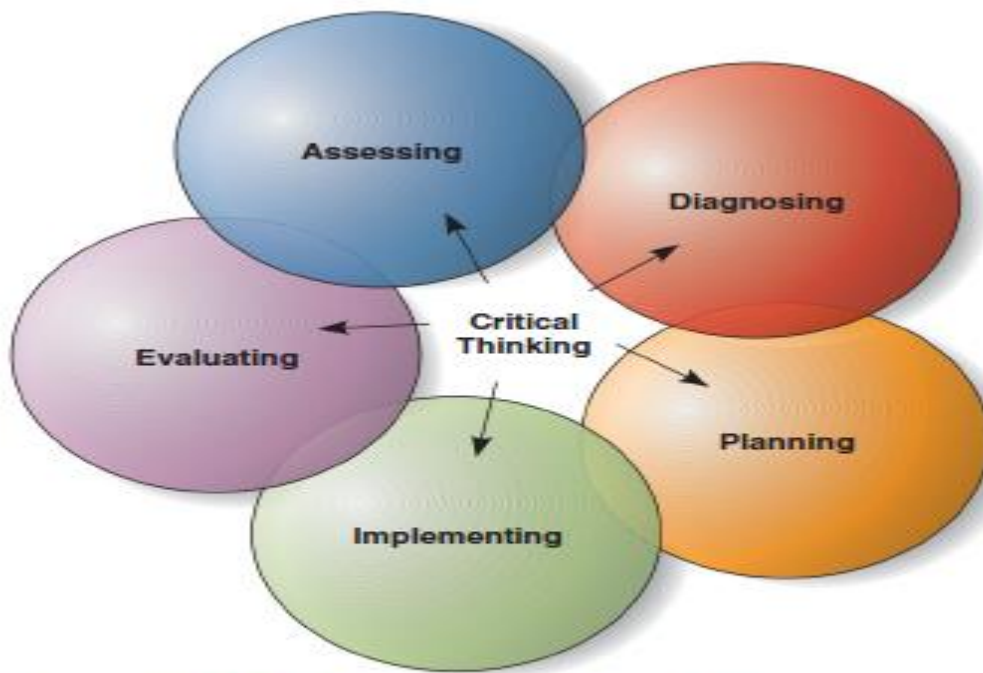


Figure 11–2 ■ The five overlapping phases of the nursing process. Each phase depends on the accuracy of the other phases. Each phase involves critical thinking.



Phases of the Nursing Process

1. Assessment phase:

Is the systematic and continuous collection, organization, validation, and documentation of data (information).

❖ Type of assessment:

TABLE 11–3 Types of Assessment

TYPE	TIME PERFORMED	PURPOSE	EXAMPLE
Initial assessment	Performed within specified time after admission to a health care agency	To establish a complete database for problem identification, reference, and future comparison	Nursing admission assessment
Problem-focused assessment	Ongoing process integrated with nursing care	To determine the status of a specific problem identified in an earlier assessment	Hourly assessment of client's fluid intake and urinary output in an ICU Assessment of client's ability to perform self-care while assisting a client to bathe
Emergency assessment	During any physiological or psychological crisis of the client	To identify life-threatening problems To identify new or overlooked problems	Rapid assessment of a person's airway, breathing status, and circulation during a cardiac arrest Assessment of suicidal tendencies or potential for violence
Time-lapsed reassessment	Several months after initial assessment	To compare the client's current status to baseline data previously obtained	Reassessment of a client's functional health patterns in a home care or outpatient setting or, in a hospital, at shift change

❖ Collecting Data:

- Is the process of gathering information about a client's health status.
- It must be both systematic and continuous to prevent the omission of significant data
- Past history as well as current problems.
- Data can be subjective or objective
- From a primary or secondary source

✓ **Database:** contains all the information about a client including the health history, physical assessment, and examination, results of laboratory and diagnostic tests.



❖ Types of Data:

1. **Subjective data, also referred to as (symptoms):** (Interview)

- ✓ Or covert data, are apparent only to the person affected and can be described or verified only by that person
- ✓ Subjective data include the client's sensations, feelings, values, beliefs, attitudes, and perception of personal health status and life situation
- ✓ ***For example:***
 - "I have had pain in my lower abdomen for the last two days".
 - "I feelings of worry"

2. **Objective data, also referred to as signs:** (Observation)

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.

- ✓ ***For example:***
 - Discoloration of skin
 - Blood pressure readings, pulse measure
 - Sputum contains blood, vomiting.



Sources of Data

- **Primary source:**
 - Client: the best data source is usually the client unless the client is too ill, young, or confused to communicate clearly.
- **Secondary source:**
 - Family members and caregivers can supplement information provided by the client, etc.
- **Client Records:**
 - Medical records, Records of therapies, Laboratory records



Data Collection Methods

The methods used to collect data are:

- **Observation:** gathering data using the five senses such as vision, hearing ...etc.
- **Interview:** is a planned communication or conversation with a purpose involving (closed and open-ended questions).
- **Physical examination:** using four techniques of inspection, palpation, and percussion, auscultation.

❖ Organizing Data

The nurse uses a written (or electronic) format that organizes the assessment data systematically. This is often referred to as a nursing health history, or nursing assessment.

❖ Validating Data:

The information gathered during the assessment phase must be complete and accurate for the nurse to analyze the data and determine appropriate interventions. Validation is the act of “double-checking” or verifying data (cues) to confirm that they are accurate and factual. The client’s perceptions of “feeling hot” need to be compared with the measurement of the body temperature.

❖ Documenting Data

- To complete the assessment phase, the nurse records client data. Accurate documentation is essential and should include all data collected about the client’s health status. Data are recorded factually and not interpreted by the nurse.

- **For example**, the nurse records the client's breakfast intake as "coffee 240 mL, juice 120 mL, 1 egg, and 1 slice of toast," rather than as "appetite good" (a judgment).



2. Diagnosis Phase:

- Diagnosing is the second phase of the nursing process. In this phase, nurses use critical thinking skills to interpret assessment data and identify client strengths and problems. **Focus on analyzing data, identifying health problems, risks, and strengths, and formulating diagnostic statements.**
- The official NANDA definition of a nursing diagnosis:
"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"

Status of the Nursing Diagnoses

1. An Actual Nursing Diagnosis/Problem Statement

- Problem present at the time of the nursing assessment
- Based on the presence of associated signs and symptoms.
- Consist of a **diagnosis label, etiology, and defining characteristics.**
- **E.g.:** Impaired skin integrity related to prolonged immobility as evidenced by a 2 cm sacral lesion

2. A Risk Nursing Diagnosis

- Clinical judgment that a problem does not exist
- The presence of risk factors indicates that a problem is likely to develop unless nurses intervene.
- Consists of a **Diagnostic label and related Risk factors.**
- **E.g.:** all people admitted to a hospital have some possibility of acquiring an infection

3. A Health Promotion Diagnoses

- Clients' preparedness to implement behaviors to improve their health condition.
- Readiness for enhanced nutrition.

Differentiating Nursing Diagnoses from Medical Diagnoses

Nursing Diagnosis	Medical Diagnosis
Clinical judgment about individuals, Family, or community responses to actual or potential health problems/life processes	Clinical judgment by the physician determines a specific disease, condition, or pathological state. Only a physician can treat.
Focus on care & prevention	Focus on treatment
E.g.: ineffective breathing pattern	E.g.; Asthma



3. Planning phase

- The phase of the nursing process that involves decision-making and problem-solving
- Formulating client goals and designing the nursing interventions required to prevent, reduce, or eliminate the client's health problems.

Types of Planning

The planning phase consists of three types:

1. Initial Planning
2. Ongoing Planning
3. Discharge Planning

Planning Process

In the process of developing client care plans, the nurse engages in the following activities:

1. **Setting priorities**: is the process of establishing a preferential sequence for addressing nursing diagnoses and interventions.
 - **High-priority** (Life-threatening problems, such as impaired respiratory or cardiac function)
 - **Medium priority** (Health-threatening problems, such as acute illness)
 - **low-priority problem** (developmental needs)

Note: *Nurses use Maslow's hierarchy of needs when setting priorities (physiological needs).*

2. Establishing client goals/desired outcomes: describe, in terms of observable client responses, what the nurse through the implementation of nursing interventions, hopes the client will achieve.

- **Goals** as broad statements about the client's status (e.g., Improve nutritional status)
- **Desired health outcomes**, observable criteria used to evaluate whether the goals have been met. (e.g., Gain 2.5 kg by April 25).

Note: *The plan of care must include both goals and desired outcomes. Sometimes they are combined.*

Example of desired outcomes	
Nursing Diagnosis	Goal Statements/Desired Outcomes
<i>Ineffective Airway Clearance</i> related to viscous secretions and shallow chest expansion secondary to fluid volume deficit, pain, and fatigue	Gas exchange, as evidenced by the following: ▪ Absence of pallor and cyanosis (skin and mucous membranes) ▪ Use of correct breathing/coughing technique after instruction ▪ Productive cough ▪ Symmetrical chest excursion ▪ Lungs clear to auscultation ▪ Respirations 12–22/min, pulse less than 100 beats/min

3. Selecting nursing interventions and activities: Actions that a nurse performs to achieve client goals/desired outcomes. focus on **eliminating or reducing the health problem** or the **factors contributing** to it and **treating the signs and symptoms**, **interventions for risk reduction** should focus on measures to reduce the client's risk factors.

4. Writing individualized nursing interventions on care plans



4. Implementation phase

Implementing is the phase in which the nurse puts the nursing care plan into action. Consists of doing and documenting the activities that are the specific nursing actions needed to carry out the interventions. To implement the care plan successfully, nurses need cognitive skills (intellectual skills), interpersonal skills, and technical skills that are purposeful “hands-on”.



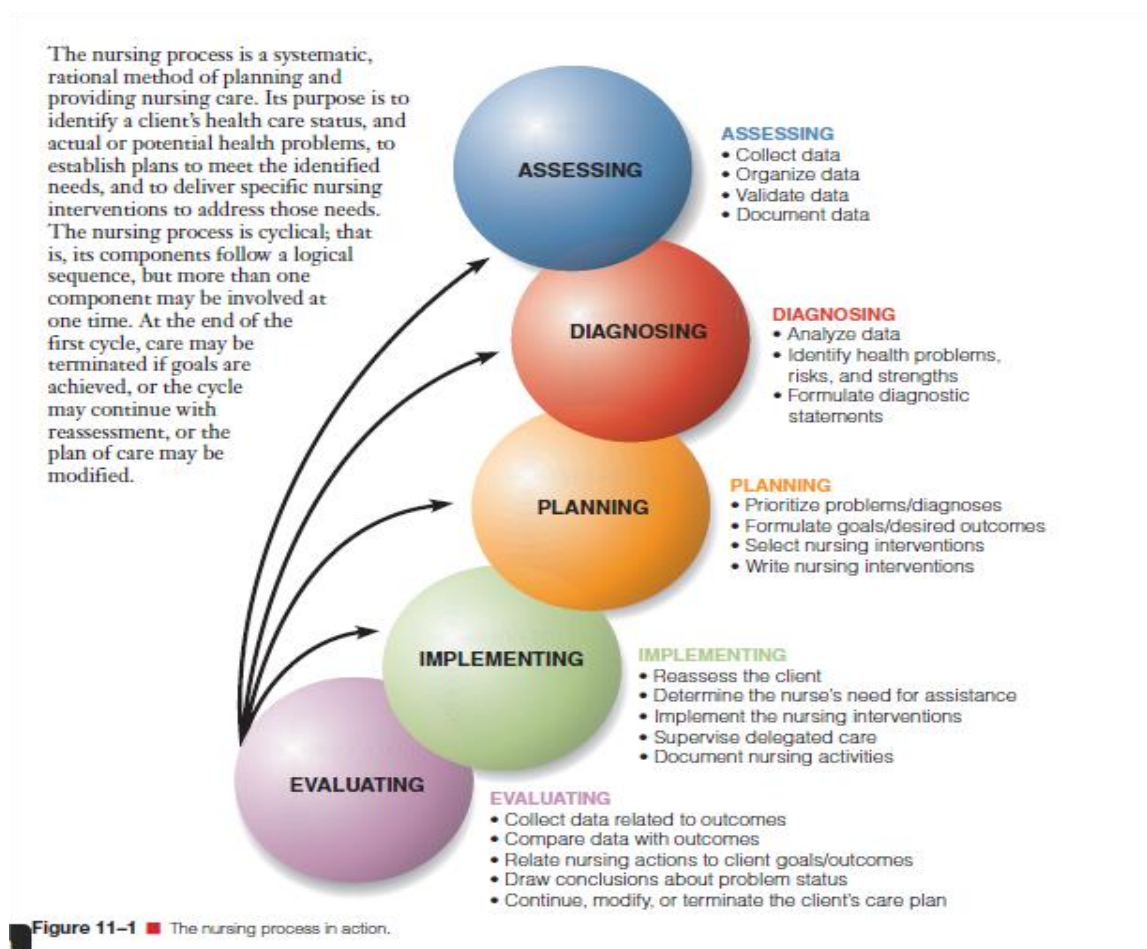
5. Evaluation phase

Evaluation is a planned, ongoing, purposeful activity in which clients and healthcare professionals determine:

- The client's progress toward achievement of goals/outcomes
- The effectiveness of the nursing care plan
- ✓ It is a continuous process, done while or immediately after implementing a nursing order.
- ✓ Before evaluation, we should identify desired outcomes that will be used to measure client goal achievement.

Process of Evaluating

- Collecting data related to the desired outcomes
- Comparing the data with desired outcomes
- Relating nursing activities to outcomes
- Drawing conclusions about the problem status
- Continuing, modifying, or terminating the nursing care plan.



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