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Author(s): Jeremy Lapham, 2014 (University of Michigan)

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THE NURSING PROCESS

Jeremy Lapham, RN

Nursing Process

Definition:

A systematic, rational method of planning and providing individualized nursing care.

Purpose of Nursing Process:

1-Identify a client health status and actual or potential health care problems and needs.

2-Establish plans to meet the identifying needs.

3-Deliver specific nursing intervention to meet needs.

NURSING PROCESS:

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

Benefits of Nursing Process

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

The Nursing Process consist of a series of five component or phases:

1- Assessing.

2- Diagnosis.

3- Planning.

4- Implementing.

5- Evaluating.

- The five phases of the nursing process are not discrete entities but overlapping, continuing sub process.

Nursing Process:

- **characteristic of nursing process:**
  - It is cyclic and dynamic.
  - It is client centered.
  - It is planned.
  - It is goal directed.
  - It is universally applicable.

Assessment:

1-Assessing:

Is a systematic and continuous collection, organization, validation and documentation of data.

- Nursing assessment focus upon client's responses to a health problem.

The assessment process involve four closely activities:

I- Collecting data.

II- Organizing data.

III- Validating data.

IV- Documenting data.

Assessment:

Collecting Data:

Is the process of gathering information about clients, and health status.

*** Types of data:**

I- subjective data (symptoms):

these data that can be described or verified only by that person.

e.g itching, pain, feelings, stress.

II- Objective data(signs):

that can be seen heard,felt,or smelled,by observation and physical examination. e.g discoloration, vital organ, lungs sounds, vomited 100ml.

*** Source of data:**

a- client.

b- Health care professionals.

c- Support people

d- lecture.

f- Client records.

Assessment:

Data collection methods:

I- Observing:

it is gather data by using the five senses.

II- Interviewing.

Nursing Diagnosis:

Nursing Diagnosis:

is a clinical judgment about individual, family or community responses to actual and potential health problems/life processes.

Types of nursing diagnosis:

1- An actual diagnosis: is a client problem that is present at the time of nursing assessment, and is based on the presence of associated signs and symptoms.

e.g. risk for infection.

2- **A risk nursing diagnosis**: is a clinical judgment that a problem does not exit, but the presence of risk factors indicate that a problem is likely to develop unless nurses intervention.

Nursing Diagnosis:

Component of NANDA nursing diagnosis:

I- Basic two or three-part statement:

1- Problem: (diagnostic lable)

There are words that have been added to some NANDA label to give additional meaning. e.g. altered , impaired , decrease, ineffective, acute , chronic, Knowledge deficit. Ineffective breathing pattern

2-Etiology :(related factor and risk factor):

identifies one or more probable causes of the health problem.

3- Defining characteristics:

- Are cluster of sign and symptoms that indicate the presence of a particular diagnostic label.

Nursing Diagnosis:

Nursing Diagnosis process:

1- Analyzing data.

2- Identifying health problem, risks and strengths.

3- Formulating diagnostic statement.

APPENDIX C 2007–2008 NANDA-Approved Nursing Diagnoses

- Activity Intolerance
- Activity Intolerance, Risk for
- Airway Clearance, Ineffective
- Anxiety
- Anxiety, Death
- Aspiration, Risk for
- Attachment, Parent/Infant/Child, Risk for
- Impaired
- Autonomic Dysreflexia
- Autonomic Dysreflexia, Risk for
- Blood Glucose, Risk for Unstable
- Body Image, Disturbed
- Body Temperature: Imbalanced, Risk for
- Bowel Incontinence
- Breastfeeding, Effective
- Breastfeeding, Ineffective
- Breastfeeding, Interrupted
- Breathing Pattern, Ineffective
- Cardiac Output, Decreased
- Caregiver Role Strain
- Caregiver Role Strain, Risk for
- Comfort, Readiness for Enhanced
- Communication: Impaired, Verbal
- Communication, Readiness for Enhanced
- Confusion, Acute
- Confusion, Acute, Risk for
- Confusion, Chronic
- Constipation
- Constipation, Perceived
- Constipation, Risk for
- Contamination
- Contamination, Risk for
- Coping: Community, Ineffective
- Coping: Community, Readiness for Enhanced
- Coping, Defensive

APPENDIX C 2007–2008 NANDA-Approved Nursing Diagnoses

- Coping: Family, Compromised
- Coping: Family, Disabled
- Coping: Family, Readiness for Enhanced
- Coping (Individual), Readiness for Enhanced
- Coping, Ineffective
- Decisional Conflict
- Decision Making, Readiness for Enhanced
- Denial, Ineffective
- Dentition, Impaired
- Development: Delayed, Risk for
- Diarrhea
- Disuse Syndrome, Risk for
- Diversional Activity, Deficient
- Energy Field, Disturbed
- Environmental Interpretation Syndrome, Impaired
- Failure to Thrive, Adult
- Falls, Risk for
- Family Processes, Dysfunctional: Alcoholism
- Family Processes, Interrupted
- Family Processes, Readiness for Enhanced
- Fatigue
- Fear
- Fluid Balance, Readiness for Enhanced
- Fluid Volume, Deficient
- Fluid Volume, Deficient, Risk for
- Fluid Volume, Excess
- Fluid Volume, Imbalanced, Risk for
- Gas Exchange, Impaired

APPENDIX C 2007–2008 NANDA-Approved Nursing Diagnoses

- Grieving
- Grieving, Complicated
- Grieving, Risk for Complicated
- Growth, Disproportionate, Risk for
- Growth and Development, Delayed
- Health Behavior, Risk-Prone
- Health Maintenance, Ineffective
- Health-Seeking Behaviors (Specify)
- Home Maintenance, Impaired
- Hope, Readiness for Enhanced
- Hopelessness
- Human Dignity, Risk for Compromised
- Hyperthermia
- Hypothermia
- Immunization Status, Readiness for Enhanced
- Infant Behavior, Disorganized
- Infant Behavior: Disorganized, Risk for
- Infant Behavior: Organized, Readiness for
- Enhanced
- Infant Feeding Pattern, Ineffective
- Infection, Risk for
- Injury, Risk for
- Insomnia
- Intracranial Adaptive Capacity, Decreased
- Knowledge, Deficient (Specify)
- Knowledge (Specify), Readiness for Enhanced
- Latex Allergy Response
- Latex Allergy Response, Risk for
- Liver Function, Impaired, Risk for
- Loneliness, Risk for

APPENDIX C 2007–2008 NANDA-Approved Nursing Diagnoses

- Memory, Impaired
- Mobility: Bed, Impaired
- Mobility: Physical, Impaired
- Mobility: Wheelchair, Impaired
- Moral Distress
- Nausea
- Neurovascular Dysfunction: Peripheral, Risk for
- Noncompliance (Specify)
- Nutrition, Imbalanced: Less than Body
- Requirements
- Nutrition, Imbalanced: More than Body
- Requirements
- Nutrition, Imbalanced: More than Body
- Requirements, Risk for
- Nutrition, Readiness for Enhanced
- Oral Mucous Membrane, Impaired
- Pain, Acute
- Pain, Chronic
- Parenting, Impaired
- Parenting, Readiness for Enhanced
- Parenting, Risk for Impaired
- Perioperative Positioning Injury, Risk for
- Personal Identity, Disturbed
- Poisoning, Risk for
- Post-Trauma Syndrome
- Post-Trauma Syndrome, Risk for
- Power, Readiness for Enhanced
- Powerlessness

APPENDIX C 2007–2008 NANDA-Approved Nursing Diagnoses

- Powerlessness, Risk for
- Role Conflict, Parental
- Role Performance, Ineffective
- Sedentary Lifestyle
- Self-Care, Readiness for Enhanced
- Self-Care Deficit: Bathing/Hygiene
- Self-Care Deficit: Dressing/Grooming
- Self-Care Deficit: Feeding
- Self-Care Deficit: Toileting
- Self-Concept, Readiness for Enhanced
- Self-Esteem, Chronic Low
- Self-Esteem, Situational Low
- Self-Esteem, Risk for Situational Low
- Sexual Dysfunction
- Sexuality Pattern, Ineffective
- Skin Integrity, Impaired
- Skin Integrity, Risk for Impaired
- Sleep Deprivation
- Sleep, Readiness for Enhanced
- Social Interaction, Impaired
- Social Isolation

APPENDIX C 2007–2008 NANDA-Approved Nursing Diagnoses

- Spiritual Distress
- Spiritual Distress, Risk for
- Spiritual Well-Being, Readiness for Enhanced
- Spontaneous Ventilation, Impaired
- Stress, Overload
- Sudden Infant Death Syndrome, Risk for
- Suffocation, Risk for
- Suicide, Risk for
- Surgical Recovery, Delayed
- Swallowing, Impaired
- Therapeutic Regimen Management: Community,
- Ineffective
- Therapeutic Regimen Management, Effective
- Therapeutic Regimen Management: Family,
- Ineffective
- Therapeutic Regimen Management,
  Ineffective
- Therapeutic Regimen Management, Readiness for
- Enhanced
- Thermoregulation, Ineffective
- Thought Processes, Disturbed
- Tissue Integrity, Impaired
- Tissue Perfusion, Ineffective (Specify: Cerebral,
- Cardiopulmonary, Gastrointestinal, Renal)

APPENDIX C 2007–2008 NANDA-Approved Nursing Diagnoses

- APPENDIX C **1531**
- Tissue Perfusion, Ineffective, Peripheral
- Transfer Ability, Impaired
- Trauma, Risk for
- Unilateral Neglect
- Urinary Elimination, Impaired
- Urinary Elimination, Readiness for Enhanced
- Urinary Incontinence, Functional
- Urinary Retention
- Ventilatory Weaning Response, Dysfunctional
- Violence: Other-Directed, Risk for
- Violence: Self-Directed, Risk for
- Walking, Impaired
- Wandering
- Urinary Incontinence, Overflow
- Urinary Incontinence, Reflex
- Urinary Incontinence, Stress
- Urinary Incontinence, Total
- Urinary Incontinence, Urge
- Urinary Incontinence, Risk for Urge
- *Source: NANDA Nursing Diagnoses: Definitions and Classification, 2007–2008.* Philadelphia: North American Nursing Diagnosis Association. Used with permission

III- PLANNING

Planning:

: is a deliberative, systematic phase of nursing process that involve decision making and problem solving .

Types of planning:

1- Initial planning: the nurse who performs the admission assessment usually develops the initial comprehensive plan of care.

2- Ongoing planning:

- Is done by all nurses who work with the client.
- It is the beginning of shift as the nurse plans the care to be given that day.

3- Discharge planning:

The process of anticipating and planning for needs after discharge.

Planning:

Planning Process:

1- Setting priorities.

2- Establishing client goals/desired out comes.

3- Selecting nursing strategies.

4- Writing nursing orders.

Planning Process:

1-Setting priorities:

Is the process of establishing a preferential order for nursing diagnosis and interventions.

- The nurse and client begin planning by deciding which nursing diagnosis requires attention first, which second, and so on.

- Instead of rank-ordering diagnosis, nurses can group them as having high, medium, low priority.

e.g.- high priority------ loss of respiratory and cardiac function.

- Medium priority----- acute illness, coping ability.
- Low priority------- normal development need or requires minimal nursing support.

Planning Process:

2- Establishing client goal/desired out comes:

The nurse client set goals for each nursing diagnosis.

*** Purpose of Goals:**

a- provide direction for planning nursing interventions

b- Serve as criteria for evaluating client progress.

c- Enable the client and the nurse to determine when the problem has been resolved.

Types of Goals:

a- Short Term Goals:

For a client who require health care for a short time.

For those who are frustrated by long-term goals that seem difficult to attain and who need satisfaction of achieving ashort-term goal.

b- Long Term Goals:

Are often used for clients who live at home and have a chronic health problem.

Planning Process:

- Selecting nursing intervention and activities are actions that nurse performs to a achieve client goals.

- The specific strategies chosen should focus on eliminating or reducing the etiology.

Types of Nursing Intervention:

1- Independent intervention: are those activities that nurses are licensed to initiate on the basis of their knowledge and skills.

2- Dependent intervention: are activities carried out under the physician orders.

3- Collaborative intervention: are actions the nurse carries out in collaboration with other health team member.

Planning Process:

3- Choosing nursing strategies:

*__criteria for choosing nursing strategies:__

1- Safe and appropriate for patient.

2- An achievable with the resources available.

3- Congruent with other strategies.

4- Determined by state law.

4- Writing Nursing Orders:

*** The component of nursing order:**

1- Date.

2- Action verb.

3- Content area.

4- Time element.

5- Signature.

IV-Implementing:

Is the phase in which the nurse puts the nursing care plan into action.

*** Process of implementing:**

1- Reassessing the client.

2- Determining the nurse need for assistance.

3- Implementing the nursing orders(strategies).

4- Delegating and Supervising.

5- Communicating the nursing actions.

V- Evaluating:

Evaluating:

Is to judge or to appraise.

- evaluating is a planned, ongoing, purposeful activity in which clients and health care professionals determine:
  - The clients progress toward goals an achievement.
  - The effectiveness of the nursing care plan.

*** Process of evaluating client responses:**

1- Identify the desired out comes.

2- Collecting data related to desired out comes.

3- Compare the data with desired out comes

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.