Introduction to nursing process

Definition of nursing process:

Nursing process is a treatment management process engaged in by nurse and client as a primary means of achieving specific heath goals. Health goals can relate to wellness promotion, disease and illness prevention, health restoration and coping and altered functioning.

Or

Nursing process is a critical thinking process that professional nurses use to apply the best available evidence to care giving and promoting human functions and responses to heath and illness (American Nurses Association, 2010).

Or

The nursing process is a systemic method of planning and providing individualized nursing care.

Purpose of nursing process:

1. To identify a clients heath status and actual or potential health care problems or needs.
2. To establish plans to meet the identified needs.
3. To deliver specific nursing interventions to meet those needs.
4. It helps to ensure continuity of care.
5. The nursing process goes into details of patients care and leaves no chance of negligence.
6. It ensures complete record of the patient's condition throughout the stay of the patient.
7. It helps to keep a complete record of nursing care provided to the patient.
8. Nursing process provides greater emphasis on social and psychological needs of the patient.

Components of nursing process

- It involves assessment data collection, nursing diagnosis, planning, implementation and evaluation.

Characteristics of nursing process:

- Dynamic and cyclic.
- Goal directed.
- Purposeful.
- Interactive.
- Flexible.
- Theoretically based.

- Client centered, using the clients strengths.
- Planned.
- Interpersonal and collaborative.
- Universally applicable.
- Systematic.
- Interdependent.
- Can focus on problems.
- Appropriate for use throughout the lifespan.
- It can be used in all settings.

Benefits of nursing process:

1. It helps to ensure continuity of care.
2. The nursing process goes into details of patients care and leaves no chance of negligence.
3. It ensures complete record of nursing care provided to the patient.
4. It helps to keep a complete record of nursing care provided to the patient.
5. Nursing process provides greater emphasis on social and psychological needs of the patient.

Steps of nursing process:

The nursing process includes five steps. These steps are overlapping and interrelated-

A—Assessment (The systemic collection of data).

D—Diagnosis (Interpretation of data for problem identification).

P—Planning (Goals and selected interventions).

I—Implementation/interventions (Putting the plan into action)

E—Evaluation (Assess the achievement of goals and changing the plan as indicated by current needs)

1. Assessment

Definition of assessment:

It is the 1st step of nursing process. It is defined as a systematic and continuous collection of data on the health status of the patient to determine the patient's health status and to identify any actual or potential health problem.

Types of assessment:

The four different types of assessments are-

1. **Initial nursing assessment**-Performed within specified time after admission. To establish a complete data base for problem identification. E.g nursing admission assessment.
2. **Problem-focused assessment**-To determine the status of a specific problem identified in an earlier assessment.eg hourly checking of vital signs of fever patient.
3. **Emergency assessment**-During emergency situation to identify any life threatening situation.eg Rapid assessment of an individual's airway, breathing status and circulation during a cardiac arrest.
4. **Time-lapsed reassessment**-Several months after initial assessment. To compare the clients current health status with the data previously obtained.

Purposes of assessment:

1. To obtain health history.
2. Perform physical assessment.
3. Review records-laboratory records, other health care records.
4. Interview supports persons.
5. Review literature.
6. Validate assessment data.
7. To identify the nursing needs of the patient.
8. To establish a nursing diagnosis.
9. To prepare a nursing care plan.
10. To give complete nursing intervention.
11. To evaluate the effectiveness of nursing interventions.
12. To reviewing the collected information.

Element of assessment process-

The essential elements of the assessment process are-

1. Data collection.
2. Data verification.
3. Data organization.
4. Data interpretation.
5. Data documentation.

2. Diagnosis

Definition of diagnosis:

The official NANDA definition of a nursing diagnosis is:

‘’a clinical judgment concerning a human response to health conditions/life processes, or a vulnerability for the response, by an individual, family, group or community.’’

Diagnosis is the second phase of the nursing process. In this phase, nurses use critical thinking skills to interpret assessment data to identify client problems.

Aims of nursing diagnosis:

1. Identifying actual and potential health problem of the problem.
2. Organize, analyze, synthesize and summarize the assessment data.
3. Improves communication between nurses and other member of the heath team.
4. Nursing diagnosis helps the patient to reach the highest level of the health.
5. Facilitates the evaluation of nursing practice.
6. Lead to more comprehensive and individualized patient care.

Components of NANDA nursing diagnosis

A nursing diagnosis has three components;

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

Characteristics of nursing diagnosis:

1. They state a clear and concise health problem.
2. They are derived from existing evidence about the patient and from sound nursing therapy.
3. They are potential amenable to nursing therapy.
4. They are on the basis for planning and carrying out nursing care.
5. They are patient centered.

Different between nursing diagnosis and medical diagnosis:

Nursing diagnosis	Medical diagnosis
1. A nursing diagnosis is a statement of nursing judgment that made by nurse, by their education, experience and expertise, are licensed to treat.	1. A medical diagnosis is made by a physician.
2. Nursing diagnosis describe the human response to an illness or a health problem.	2. Medical diagnosis refers to disease processes.
3. Nursing diagnosis may change as the clients responses change.	3. A client's medical diagnosis remains the same for as long as the disease is present.
4. Ineffective breathing pattern.	4.Asthma
5. Activity intolerance.	5. Cerebrovascular accident.
6. Acute pain.	6. Appendicitis.

3. Planning

Planning involves decision making and problem solving.

It is the process of formulating client goals and designing the nursing interventions required to prevent, reduce or eliminate the clients' health problems.

Types of planning:

1. Initial planning- planning which is done after the initial assessment.
2. Ongoing planning- It is a continuous planning.
3. Discharge planning- Planning for needs after discharge.

Component of planning

1. Setting priority.
2. Establishing client goals and outcomes criteria or objectives.
3. Planning nursing strategies.
4. Writing nursing orders.
5. Writing nursing care plan.
6. Counseling.

4. Nursing implementation/intervention:

It is a series of actions for accomplishing the health care plan formulated. The purpose of implementation is to carry out the nursing care plan developed in the planning.

Types of nursing intervention:

1. **Independent interventions** are those activities that nurses are licensed to initiate on the basic of their knowledge and skills.
2. **Dependent interventions** are activities carried out under the orders or supervision of a licensed physician.
3. **Collaborative interventions** are action the nurse carries out in collaboration with other health team members.

Methods of implementation:

- Coordinate activities of patient, significant others, and other nursing team members.
- Delegate specific nursing interventions to other members, of the team.
- Supervise by other members of health team.
- Record the patient's responses to nursing intervention.

Component of intervention:

- Assisting with daily living activities.
- Counseling and teaching.
- Giving direct nursing care to achieve the goal.
- Care is given to facilitate attainment of patient's health goals.

5. Evaluation

The evaluation process determines the success of nursing care and the need to alter the care plan. The evaluation includes four steps-

1. Establishment of the criteria of evaluation.
2. Comparison of the patient's response to criteria.
3. Analysis of outcomes and conclusion.
4. Modification of nursing care plan.

Types of evaluation-

A. According to criteria (structure, process and outcomes): structure, process and outcomes all works together affect care. However each requires different criteria and methods of evaluation.

1. **Structure evaluation:** focuses on the setting in which care is provided. It explores the effect of organizational characteristics and the quality of care. It requires data about policies, procedures, fiscal resources, physical facilities and equipment and number and qualification and personnel.
2. **Process evaluation:** Focus on the manner in which care is given-the activities performed by nurse and other personnel. It explore whether the care was relevant to the patient needs, appropriate, complete and timely.
3. **Outcome evaluation:** Focuses on demonstrable or measureable changes in the patient health status than result from the care given.

B. According to frequency and time(ongoing, intermittent and terminal):
   1. **Ongoing evaluation:** It will be performed while implementing, immediately after an evaluation or at each patient contact.
   2. **Intermittent evaluation:** It is performed at specific time, which enables nurse to judge the progress towards goal achievement and to modify the care plan as needed.

Definition nursing care plan:

Nursing care plan is legal document, which contains information about patient's health. It is written for every patient in the ward. It is summary of all nursing care for the patient. It describes the nursing diagnosis, nursing goal, nursing activities and care for individual patient.

Purpose of nursing care plan:

1. Provide a detailed guide for patient care.
2. Put patient goals, objectives priorities, deadlines and nursing action to writing.
3. Individualize patient care.
4. Co-ordinate the efforts of all nursing team member.
5. Provide a source of information and a line of communication for nursing team members.
6. Assist the staff in meeting the patient's psychological needs.
7. Encourage patient and family participation in nursing programme.
8. Construct a programme for patient family health education.

Principles of nursing care plan:

1. Nursing care plans focus on nursing problems and have a nursing approach.
2. Nursing care plans are written in clear, specific and actionable team.
3. Nursing care plans are short and concise.

4. Nursing care plans show the patient needs and nursing problems that are receiving attentive as well as long and short terms objectives that the interventions are designed to accomplish.
5. Nursing care plans are written in a non-permanent fashion.

Component of nursing care plan:

1. Nursing diagnosis.
2. Goal/objective.
3. Planning.
4. Implementation/intervention.
5. Evaluation.

Nursing care plan;

Date	Nursing diagnosis	Objective	Care plan	Implementation	Evaluation

Introduction of Health Assessment

Health assessment is central to effective planning, implementation and evaluation of nursing care. All nurses are accountable for the care they provide and need to be able to accurately determine patient needs in order to plan and deliver evidence-based care. Vital notes for nurses: Health assessment provides students with the knowledge required to consider different factors which can influence patient's health, comfort, well-being and recovery and to confidently assess patient needs.

Definition of health:

The World Health Organization 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, so that each citizen can lead a socially and economically productive life.''

Definition health assessment:

A health assessment is a plan of care that identifies the specific needs of the client and how those needs will be addressed by the facility.

OR

Health assessment is the systematic and continuous collection, validation and communication of patient data; these data reflect how health functioning is enhanced by health promotion or compromised by illness and injury.

OR

Health assessment is the process by which estimate the health condition of clients. As a professional nurse, nurses are constantly observing situation and collect information to make judgments about health condition. Moreover, they ask question or examine a person to assess health status.

Purposes of health assessment:

1. To obtain health history.
2. Perform physical assessment.
3. Review records-laboratory records other health care records.
4. Interview supports persons.
5. Review literature.
6. Validate assessment data.
7. To identify the nursing needs of the patient.
8. To establish a nursing diagnosis.

9. To prepare a nursing care plan.
10. To give complete nursing intervention.
11. To evaluate the effectiveness of nursing interventions.

Benefits of health assessment:

- Early detection of the disease.
- Identification of the patient's individual actual problem.
- For nursing diagnosis.
- For nursing intervention.

Importance of health assessment:

1. Systematic and continuous collection of client data.
2. It focuses on client responses to health problems.
3. The nurse carefully examines the client's body parts to determine any abnormalities.
4. The nurse relies on data from different sources which can indicate significant clinical problems.
5. Health assessment provides a base line used to plan the client are.
6. Health assessment helps the nurse to diagnose client's problem and the intervention.
7. Complete health assessment involves a more detailed review of client's condition.
8. Health assessment influences the choice of therapies and clients responses.

General principles of health assessment:

1. The first step in caring for a patient and getting active cooperation is to gather a careful and complete history-
    - ✓ In all patient concerns and problems and accurate history is the foundation on which data collection and the process of assessment are based.
    - ✓ The comprehensiveness of the history elicited will depend on the information available in the patient's record and the reliability of the patient.
2. Time span early in the nurse patient relationship gathering detailed information about what the patient knows thinks and feels about the problems will prevent errors and misunderstanding later.
3. Skill in interviewing will affect both the accuracy of information elicited and the quality of relationship establish with the patient.

Technique of health assessment:

The nurse depends on his/her own sense and use them in four examination technique that enable her to collect a broad range of physical data about the patients. These are-

1. Inspection(using sight):
    - ✓ Vision.
    - ✓ Smell.
2. Palpation(using touch):
    - ✓ Light palpation.
    - ✓ Deep palpation.
3. Percussion(using hearing and touch):
    - ✓ Direct percussion.
    - ✓ Blunt percussion.
    - ✓ Indirect percussion.
4. Auscultation(using hearing):
    - ✓ Immediate or direct auscultation.
    - ✓ Medical or indirect auscultation.

Definition of data:

Data is a set value of qualitative or quantitative variables about one or more persons or objects while a datum (singular of data) is a single value of a single variable.

Definition of data collection