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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 all 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:

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 label)
      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
- 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
- Power, Readiness for Enhanced
- Powerlessness
- Post-Trauma Syndrome, Risk for
- 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,
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

III- PLANNING

Planning:

: is a deliberative, systematic phase of nursing process that involves 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 outcomes.
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 outcomes:
   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 a short-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 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 members.
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.