University of Basrah
College of Nursing
Fundamentals of Nursing Department
Second stage

Adult Nursing I- Lecture 2 (Theory)

Nursing Process

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Lecture contents:

1- Nursing process definition.

2- Benefits of the nursing process.

3- Steps.

4- Summary.

5- Lecture questions.

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Nursing Process

- **The nursing process is a deliberate, problem-solving approach to meeting the health care and nursing needs of patients.**
- **The process as a whole is cyclical, with the steps being interrelated, interdependent, and recurrent.**

Benefits of the nursing process

1- For the patient

When used well, the nursing process achieves for the patient scientifically based, holistic, individualized care, the opportunity to work collaboratively with nurses, and continuity of care.

2- For the nurse

Nurses who use nursing process in a thoughtful and systematic way achieve a clear, efficient, and cost-effective plan of action, self-confidence, job satisfaction and professional growth.

Steps of Nursing Process

- Assessment (data collection).
- nursing diagnosis.
- Planning.
- Implementation.
- Evaluation.

Types of data

There are two types of data subjective and objective:

1- Subjective data: also called symptoms: are data from the client's point of view and include feelings, perceptions, and concerns.

2- Objective data: also called signs which refers to observable and measurable data that can be seen, heard, or felt by someone other than the person experiencing them such as vital signs.

Types of data

Q// Your patient tells you that they are "very itchy". What kind of data is this?

A. Historical data

B. Subjective data

C. Secondary data

D. Objective data

Q// Client verbally reports pain at a level of 8 or 9 when it becomes sharp is an example of

A. Subjective data

B. Objective data

C. Data clustering

D. Data analysis and interpreting

Source of data

1- Patient: primary and usually the best source of information.

2- Family

3- Patient record

4- Other health care professionals

Components of data collection

1- Nursing history

2- Nursing physical assessment

Types of data collection techniques

- **1-Interview**
- **During this phase the nurse can ask multiple types of questions:**

A. Open-ended question
B. Closed-ended question
C. Back channeling
D. Problem seeking

2- Physical examination

Q// Which of these are considered open ended questions?

A. Have you ever had pain in the eye?
B. From a scale of 1 to 10, 1 being the weakest and 10 being the strongest, how much would you rate your pain?
C. Is it okay if I touch you?
D. How have you been getting along?

1- Assessment

1- Assessment: systematic collection of data to determine the patient's health status and to identify any actual or potential health problems.

Assessment

1. The nursing history.

Subjective data obtained by interviewing the patient, family members, or significant other and reviewing past medical records.

2. The physical examination.

Objective data obtained to determine the patient’s physical status.

**Should be done in a private, comfortable environment with efficiency and respect.

Types of nursing assessment

1- Initial assessment: is performed shortly after the patient is admitted to a health care agency.

2- Focused assessment: the nurse gathers data about a specific problem that has already been identified.

3- Emergency assessment: when a physiologic or psychological crises presents, the nurse performs an emergency assessment to identify life threatening problems.

4- Time-lapsed assessment: is scheduled to compare a patient's current status to baseline data obtained earlier.

Nursing assessment

Q// The nurse admitting Alice have leg fracture will want to include which assessments in the initial assessment?

a. Temperature of skin distal to the fracture

b. Capillary refill distal to the fracture

c. Pulses distal to the fracture

d. Question about numbness/tingling in affected limb

e. Pain character and intensity

f. Movement of toes on affected side

2- Nursing diagnosis

2- Nursing diagnosis: identification of actual or potential health problems that are amenable to resolution by nursing actions.

Types of nursing diagnosis

** There are currently 235 nursing diagnoses grouped in 13 domains

1- **Actual nursing diagnosis:** represent a problem that has been validated by the presence of major defining characteristics.

2- **Risk nursing diagnosis (potential)**: are clinical judgments that an individual, family, or community is more vulnerable to develop the problem than others in the same or similar situation.

Nursing diagnosis Versus Medical diagnosis

Nursing Diagnosis	Medical Diagnosis
1) Identify unhealthy response to health and illness	1) Identify disease
2) Described problems treated by nurses within the scope of independent nursing care	2) Describe problems for which the physician directs the primary treatment
3) Change from day to day as the patient's response change	3) Remain the same for as long as the disease is present

Components of nursing diagnosis

Component	Description
1- Problem	• Identify what is unhealthy about the patient
2- Etiology	• Identify the factors that are maintaining the unhealthy state or response
3- Defining characteristics	• Identify the subjective and objective data

Formulating nursing diagnosis

Problem → **Related to (Etiology)** → **Manifested by (Defining characteristics)**

Example:

Imbalance nutrition less than body requirement related to anemia manifested by weight loss

Formulating nursing diagnosis

Q// Which of the following is a complete and appropriate nursing diagnosis for a patient who was admitted with a high fever of unknown origin?

1.The client will be free of complications such as dehydration.
2.The nurse will monitor the patient's vital signs q 4 h.
3. Risk for impaired fluid balance related to dehydration
4. Risk for impaired fluid balance related to the febrile state

3- Planning: development of goals and a care plan designed to assist the patient in resolving the nursing diagnosis.

Stages of planning

1- Initial: is developed by nurse who performs the nursing history and physical assessment on admission.

2- Ongoing: is carried out by any nurse who interacts with the patient.

3- Discharge: is best carried out by the nurse who has worked most closely with the patient and family.

Types of planning

1. **Short-term plan**: done within minutes or hours.
2. **Long- term plan:** require a long period(usually more than week)

4- Implementation (intervention)

4- Implementation: actualization of the care plan through nursing interventions or supervision of others to do the same.

Types of nursing intervention

1) **Direct nursing intervention:** a treatment performed through interaction with the patient(s) which include both physiological and psychosocial nursing action.

2) **Indirect nursing intervention:** a treatment performed away from the patient but on behalf of a patient.

3) **Public health intervention:** is target to promote and preserve the health of populations.

Classification of nursing intervention according to degree of independencies:

a) **Nurse-initiated intervention(Independent):** is an autonomous action based on scientific rationale that a nurse execute to benefit the patient.

b) **Physician- initiated intervention(Dependent):** initiated by a physician in response to medical diagnosis but carried out by a nurse in response to a doctor's order.

c) **Collaborative intervention(Interdependent)**: nurses also carried out treatment initiated by other providers such as pharmacists, respiratory therapists.

5-Evaluation

Determines the success of nursing care and the need to alter the care plan.

1. Collect assessment data.
2. Compare patient’s actual outcomes to expected outcomes to determine to what extent goals have been achieved.
3. Include the patient, family, or significant other; nursing team members; and other health team members in the evaluation.
4. Identify alterations that need to be made in the goals and the nursing care plan.

Summary

1- The nursing process is a systematic method that directs the nurse and patient as together they accomplish the desired outcomes.

2- Nursing process consist of five steps: Assessment, Diagnosis, Planning, Implementation, and Evaluation.

3- The steps is patient-centered, outcome-oriented process and interrelated each step depends on the accuracy of the previous step.

Lecture questions:

1. You are performing a preschool examination on your patient.You have just taken his vital signs, height, and weight. Which phase of the nursing process do these activities describe?

a. Assessment
b. Planning
c. Implementation
d. Evaluation

2. What activities are performed during the assessment phase of the nursing process?

a. Identifying actual/potential health problems
b. Determining short- and long-term goals
c. Establishing patient outcomes
d. Collecting data

Reference

BRUNNER & SUDDARTH'S TEXTBOOK OF Medical-surgical Nursing 15TH EDITION, 2022,

As a nurse,
we have the
opportunity to heal
the mind, soul, heart,
and body of our
patients, their
families, and
ourselves.
They may forget
your name, but they
will never forget how
you made them feel.
– Maya Angelou