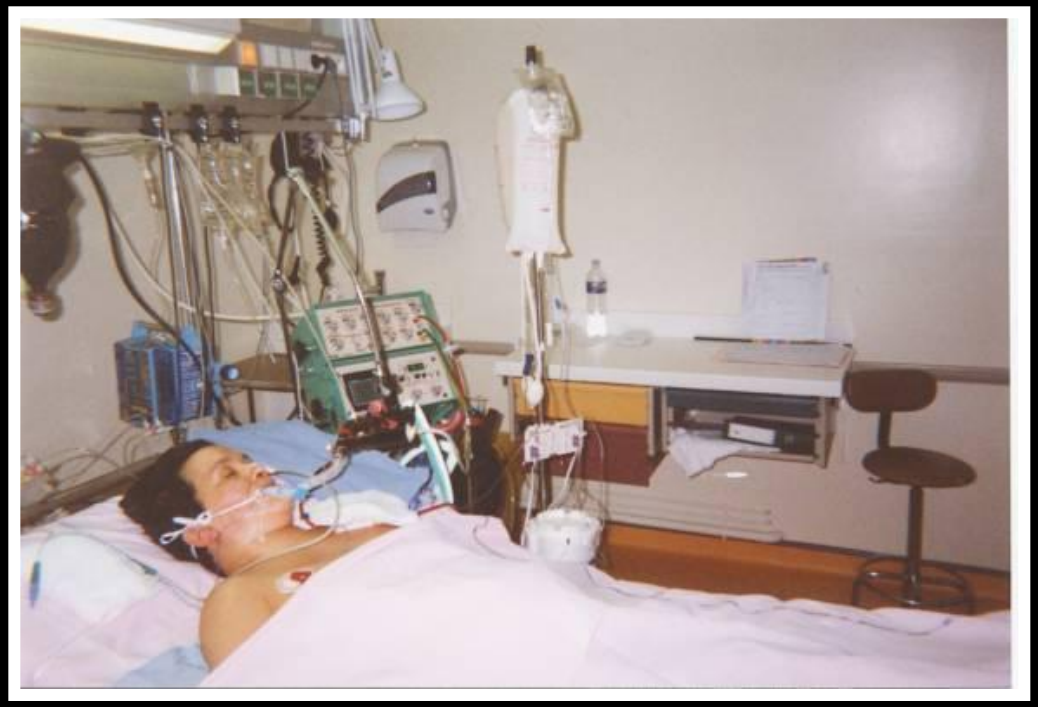
Nursing Process



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The Nursing Process is a Systematic Five Step Process

- Assessment
- Diagnosis
- Planning
- Implementation
- Evaluation

5 Activities Needed to Perform a Systematic Assessment

- Collect data
- Verify data
- Organize data
- Identify Patterns
- Report & Record data

What's Important Data?

- Name, age, gender, admitting diagnosis
- Medical/surgical history, chronic illnesses
- Laboratory Data/Diagnostic tests
- Medications
- Allergies
- Psychosocial/Cultural Assessment
- Emotional state
- Comprehensive Physical Assessment

Comprehensive Physical Assessment

- Vital signs
- Height & weight
- Review of systems (neurological/mental status, musculoskeletal, cardiovascular, respiratory, GI, GU, skin and wounds.
- Standardized risk assessments: Pressure ulcers, falls, DVT

Identifying Nursing Diagnosis

- Common language for nurses
- A clinical judgment about an individual, family or community response to an actual or potential health problem or life process,
- Nursing diagnosis provide a basis for selection of nursing interventions so that goals and outcomes can be achieved

Diagnostic Reasoning

- Apply critical thinking to problem identification
- Requires knowledge, skill, and experience
- Big Picture

Planning

- Set your priorities of care, what needs to be done first, what can wait.
- Apply Nursing Standards, Nurse Practice Act, National practice guidelines, hospital policy and procedure manuals.
- Identify your goals & outcomes, derive them from nursing diagnosis/problem.
- Determine interventions, based on goals.
- Record the plan (care plan/concept map)

Determining Interventions

- Nursing interventions are actions performed by nurse to reach goal or outcome
- Monitor health status
- Minimize client risks
- Direct Care Intervention: Direct action performed to client (inserting foley catheter)
- Indirect Care Intervention: actions performed away from client (looking at lab results)

Types of Nursing Interventions

- Protocols: Written plan specifying the procedures to be followed during care of a client with a select clinical condition or situation
- Standing Orders: Document containing orders for the conduct of routine therapies, monitoring guidelines, and/or diagnostic procedure for specific condition

Evaluation

- Evaluation of individual plan of care includes determining outcome achievement
- Identify variables/factors affecting outcome achievement
- Decide where to continue/modify/terminate plan
- Continue/modify/terminate plan based on whether outcome has been met (partially or completely)
- Ongoing assessment

Comparison of Medical and Nursing Diagnoses

- *Medical diagnosis* is the terminology used for a clinical judgment by the physician that identifies or determines a specific disease, condition, or pathologic state.

Nursing Diagnosis

- Terminology used for a clinical judgment by the professional nurse that identifies the client's actual, risk, wellness, or syndrome responses to a health state, problem, or condition.

Components of a Nursing Diagnosis

- The two-part statement
  - Problem statement or diagnostic label
  - Etiology
- The diagnostic label and etiology are linked by the term related to (RT).

Components of a Nursing Diagnosis

- The three-part statement
  - Diagnostic Label
  - Etiology
  - Defining Characteristics
- Defining characteristics are the signs and symptoms, subjective and objective data, or clinical manifestations.
- The phrase, "as evidenced by ..." (AEB), is joined to the first two components.

Example of nursing diagnosis

Ineffective Airway Clearance	*Ineffective Airway Clearance* RT fatigue	*Ineffective Airway Clearance* RT fatigue AEB dyspnea at rest
Anxiety	*Anxiety* RT change in role functioning	*Anxiety* RT change in role functioning AEB insomnia, poor eye contact, and quivering voice
Deficient Knowledge	*Deficient Knowledge* RT misinterpretation of information	*Deficient Knowledge* RT misinterpretation of information AEB inaccurate return demonstration of self-injection
Spiritual Distress	*Spiritual Distress* RT separation from religious ties	*Spiritual Distress* RT separation from religious ties AEB crying and withdrawal

(Data from American Nurses Association. [1997]. *Standards of clinical nursing practice* [pp. 7–9]. Washington, DC: Author.)

V).Types of Nursing Diagnosis

1. Actual Nursing Diagnosis
2. Risk Nursing Diagnosis
3. Health-Promotion Nursing Diagnosis
4. Possible Nursing Diagnosis
5. Syndrome Diagnosis

1. Actual Nursing Diagnosis

- Actual Nursing Diagnosis is a client problem that is present at the time of Nursing Assessment
- It is based on the presence of associated signs & symptoms
- Firm diagnosis supported by nurses findings (validated)

DEFINITION OF ACTUAL NURSING DIAGNOSIS

- "A clinical judgment about human experience/responses to health conditions/life processes that exist in an individual, family, or community".

EXAMPLES OF ACTUAL NURSING DIAGNOSIS

- Ineffective breathing pattern related to bacterial / viral inflammatory Process.
- Ineffective breathing pattern related to Tracheo-bronchial obstruction
- Anxiety related to changes in the environment and routines, threat to socio economic status.
- Anxiety related to change in health status and situational crisis.
- Body image disturbance related to temporary presence of a visible drain/ tube.

2.Risk nursing diagnosis

- It is a clinical judgment that a problem doesn't exist, but the presence of risk factors indicates that a problem is likely to develop unless nurses intervene.
- Describes human responses to health conditions / life processes that may develop in a vulnerable individual / family / community.

2.RISK NURSING DIAGNOSIS

- It is supported by risk factors that contribute to increased vulnerability.
- Eg. A client with Diabetes Mellitus or a compromised immune system is at high risk than others.
- Therefore the nurse would appropriately use the label risk for infection to describe the client's health status.

EXAMPLES OF RISK NURSING DIAGNOSIS

- Eg. Admission in hospital prone for acquiring infection- compromised immune system

1. Risk for infection related to compromised immune system.
2. Risk for injury related to altered mobility and disorientation.
3. Risk for aspiration related to decreased cough and gag reflex

EXAMPLES OF RISK NURSING DIAGNOSIS

1. Risk for impaired skin integrity related to immobility.
2. Risk for impaired skin integrity related to edema and neuropathy
3. Risk for injury related to generalized weakness
4. Risk for Impaired skin integrity (left ankle) related to decrease peripheral circulation in diabetes.
5. Risk for Impaired skin integrity related to loss of pain perception

3. HEALTH-PROMOTION NURSING DIAGNOSIS

- A clinical judgment about a person's, family's or community's motivation and desire to increase wellbeing and actualize human health potential as expressed in the readiness to enhance specific health behaviors, and can be used in any health state.

3. HEALTH-PROMOTION NURSING DIAGNOSIS

- Describes human responses to levels of wellness in an individual, family or community that have a readiness for enhancement.
- Health-promotion nursing diagnosis are one part statement includes diagnostic label.

EXAMPLES OF HEALTH-PROMOTION NURSING DIAGNOSIS

- Readiness for Enhanced Self-Esteem.
- Readiness for enhanced spiritual well being
- Readiness for enhanced family coping.

4. POSSIBLE NURSING DIAGNOSIS

- A possible nursing diagnosis is one in which evidence about a health problem is incomplete or unclear.
- A possible diagnosis requires more data either to support or to refuse it.
- Possible nursing diagnosis are suspected because of the prescence of certain factors.
- Tentative-additional data needed to confirm or rule out problem.

EXAMPLES SITUATION FOR FORMULATING POSSIBLE NURSING DIAGNOSIS

- Eg. Elderly widow who lives alone admitted in hospital no visitors and she is pleased with attention and conversation from the nursing staff. Until more data are collected, the nurse may write a nursing diagnosis of
- **Possible social isolation R/T unknown etiology**

EXAMPLES OF POSSIBLE NURSING DIAGNOSIS

- Potential risk of constipation as a result of enforced bed rest.

-Potential risk of pressure sore development from enforced bed rest.

5. A SYNDROME DIAGNOSIS

- A clinical judgment describing a specific cluster of nursing diagnoses that occur together, and are best addressed together and through similar interventions.

Elements of Effective Documentation

To ensure effective documentation, nurses should:

- Use a common vocabulary.
- Write legibly and neatly.
- Use only authorized abbreviations and symbols.
- Employ factual and time-sequenced organization.
- Document accurately and completely, including any errors.

Nursing Care Plans in MI

1. **Acute Pain,**

May be related to Tissue ischemia

Possibly evidenced by

Reports of chest pain with/without radiation
Facial grimacing
Restlessness, changes in level of consciousness
Changes in pulse, BP

Nursing Care Plans in MI

2. Activity Intolerance May be related to
Imbalance between myocardial oxygen supply and demand
Presence of ischemic/necrotic myocardial tissues
Cardiac depressant effects of certain drugs (beta-blockers, antiarrhythmics)

Possibly evidenced by
Alterations in heart rate and BP with activity
Development of dysrhythmias
Changes in skin color/moisture
Exertional angina
Generalized weakness

Nursing Care Plans in MI

3. Fear/Anxiety May be related to
Threat to or change in health and socioeconomic status
Threat of loss/death
Unconscious conflict about essential values, beliefs, and goals of life
Interpersonal transmission/contagion

Possibly evidenced by
Fearful attitude
Apprehension, increased tension, restlessness, facial tension
Uncertainty, feelings of inadequacy
Somatic complaints/sympathetic stimulation
Focus on self, expressions of concern about current and future events
Fight (e.g., belligerent attitude) or flight behavior

Nursing Care Plans in MI

4. Risk for Decreased Cardiac Output

Risk factors may include

Changes in rate, rhythm, electrical conduction

Reduced preload/increased SVR

Infarcted/dyskinetic muscle, structural defects, e.g., ventricular aneurysm, septal defects

Possibly evidenced by

Not applicable. A risk diagnosis is not evidenced by signs and symptoms, as the problem has not occurred and nursing interventions are directed at prevention.

Nursing Care Plans in MI

5. Ineffective Tissue Perfusion

Risk factors may include

Reduction/interruption of blood flow, e.g., vasoconstriction, hypovolemia/shunting, and thromboembolic formation

Possibly evidenced by

Not applicable. A risk diagnosis is not evidenced by signs and symptoms, as the problem has not occurred and nursing interventions are directed at prevention.

Nursing Care Plans in MI

6. Risk for Excess Fluid Volume

Risk factors may include

Decreased organ perfusion (renal)
Increased sodium/water retention
Increased hydrostatic pressure or decreased plasma proteins.

Possibly evidenced by

Not applicable. A risk diagnosis is not evidenced by signs and symptoms, as the problem has not occurred and nursing interventions are directed at prevention.

Nursing Care Plans in MI

7. Deficient Knowledge May be related to
Lack of information/misunderstanding of medical condition/therapy needs
Unfamiliarity with information resources
Lack of recall

Possibly evidenced by
Questions; statement of misconception
Failure to improve on previous regimen
Development of preventable complications