Hammoud Hospital
University Medical Center
Staff Development Department

Nursing Process

Presented by
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Staff Development Coordinator
Agenda

- History of Nursing Process
- Definition of Nursing Process
- Advantages of Nursing Process
- Steps of the Nursing Process
- Difference between Nursing Diagnosis and Medical Diagnosis
- Nursing Process and Critical thinking
- Recommendations
Nursing care comes in many forms. Sometimes it is the ability to make someone feel physically comfortable by various means. Other times it is the ability to improve the body's ability to achieve or maintain health. But often it is an uncanny yet well honed knack to see beyond the obvious and address, in some way, the deeper needs of the human soul.

Donna Wilk Cardillo, RN
Florence Nightingale

1859, She linked health with 5 environmental factors:
1. Pure or fresh air
2. Pure water
3. Efficient drainage
4. Cleanliness
5. Light (especially direct sunlight)

Deficiencies in these five factors produced lack of health or illness.
Virginia Henderson

1922 She conceptualized the role of the nurses as assisting sick or healthy individuals to gain independence in meeting the fourteen fundamental needs.
The 14 Fundamentals or Basic Needs

1. Breathe normally
2. Eat and drink adequately
3. Eliminate body wastes
4. Move and maintain desirable positions
5. Sleep and rest
6. Select suitable clothes, dress, and undress
7. Maintain body temperature within normal range by adjusting clothing and modifying environment
8. Keep the body clean and well groomed and protect the integument
9. Avoid dangers in the environment and avoid injuring others
10. Communicate with others in expressing emotions, needs, fears, or opinions
11. Worship according to one’s faith
12. Work in such a way that there is a sense of accomplishment
13. Play or participate in various forms of recreation
14. Learn, discover, or satisfy the curiosity that leads to normal development and health and use the available health facilities
The term nursing process was first used/mentioned by Lydia Hall, a nursing theorist, in 1955 wherein she introduced 3 STEPs:

- Observation
- Administration of care
- Validation

Care, Core, and Cure Model
The Nursing Process continue to evolve

APIE 1967
- ASSESSMENT
- PLANNING
- IMPLEMENTATION
- EVALUATION

ADPIE 1980
- ASSESSMENT
- DIAGNOSIS
- PLANNING
- IMPLEMENTATION
- EVALUATION

ADPIE 1991
- ASSESSMENT
- DIAGNOSIS
- OUTCOME
- PLANNING
- IMPLEMENTATION
- EVALUATION
NURSING PROCESS

THE CORNERSTONE OF THE NURSING PROFESSION
The Nursing Process

Is a process by which nurses deliver care to individuals, families, and/or communities and is supported by nursing theories. The nursing process was originally an adapted form of problem-solving and is classified as a deductive theory.

Wikipedia, 2009
Purpose of Nursing process

- Defines patient goals
- Determines the Nurses' Role
- Provides consistency of care
- Customizes Care Interventions
- Promotes holistic treatment
- Provides quality patient care
Benefits of the Nursing process for the Nurse

- Job satisfaction
- Professional growth
- Avoidance of legal action
- Meeting professional nursing standards
- Meeting standards of accredited hospitals
Characteristics of the Nursing Process

Cyclic

G O S H approach

Dynamic
Phases of the nursing process include:

ADOPIE

Assessment of the patient's need

Diagnosis of human response needs

Planning of patient's care

Outcome identification

Nursing Process & Critical Thinking

Implementation of care

Evaluation of the success of the implemented care
All the Components of the Nursing process are considered and conducted using the Nursing Care Plan
The Nursing Care Plan

A **set of actions** that the nurse will **implement** to **resolve existing and potential health problems** identified through **nursing assessment**

Wikipedia 2011
**Assessment (what is the situation)?**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Purpose</th>
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</thead>
<tbody>
<tr>
<td>Is the first and most critical step of <a href="#">nursing process</a> in which the <a href="#">nurse</a> carries out a complete and <a href="#">holistic</a> nursing assessment of every patient's needs, regardless of the reason for the encounter.</td>
<td>★ To establish baseline information on the client</td>
</tr>
<tr>
<td>★ To identify the patient's nursing <a href="#">problems</a></td>
<td>★ To identify the patient's nursing <a href="#">problems</a></td>
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</table>

Usually, an assessment framework, based on a [nursing model](#) is used.
Types of Assessment

Initial
Ex: nursing admission assessment

Problem-focused
Ex: problem on urination-assess on fluid intake & urine output hourly

Emergency
Ex: assessment of a client’s airway, breathing status & circulation after a cardiac arrest

Time-lapsed reassessment
Ex: Reassessment of a client’s bed sore after 2 weeks of admission in the units
## Assessing

<table>
<thead>
<tr>
<th>Sources of Data</th>
<th>Data collection</th>
<th>Types of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Primary source</td>
<td>• Observation</td>
<td>• Subjective data</td>
</tr>
<tr>
<td>• Secondary source</td>
<td>• Interview</td>
<td>• Objective data</td>
</tr>
<tr>
<td></td>
<td>• Examination</td>
<td></td>
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</tbody>
</table>
Assessment

- Collect Data
- Organized Data
- Validate Data
- Documenting Data
Diagnosing (what is the problem?)

Data Analysis + Problem Identification + Formulation of Nursing Diagnosis = DIAGNOSING
A Nursing Diagnosis is defined as “a clinical judgment about an individual, family or community responses to actual and potential health problems/life processes. Nursing diagnosis provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.” (NANDA, 2009)
Classification of Nursing Diagnosis

- NANDA (the North American Nursing Diagnosis Association)*
- 14 needs VERGINIA HENDERSON
- 11 modes of MARJORY GORDON
- LYNDÁ JUALL CARPENITO,
- OTHERS........

*is a professional organization of nurses standardized nursing terminology that develops, researches, disseminates and refines the nomenclature, criteria, and taxonomy of nursing diagnoses.
Purpose of Nursing Diagnosis

- Promotes use of standardized language and process.
- Demonstrates professional judgment.
- Organizes decision making.
- Promotes accountability.
- Provides communication among nurses and other health care personnel.
- A means to individualize care.
Characteristics of Nursing Diagnosis

✓ states a clear and concise health problem.
✓ is derived from existing evidences about the client.
✓ is potentially amenable to nursing therapy.
✓ is the basis for planning and carrying out nursing care
Components of a Nursing Diagnosis

Problem statement/diagnostic label/definition = P
Etiology/related factors/causes = E
Defining characteristics/signs and symptoms = S

Related to
As evidenced by/secondary to

Composed of 3 parts: PES or 2 parts: PE
Components of a Nursing Diagnosis

Therefore may be written as:

- Nursing Diagnosis
  - Two-part statement
    - Problem statement or diagnostic label
    - Etiology
  - Three-part statement
    - Etiology
    - Diagnostic Label
    - Defining Characteristics
<table>
<thead>
<tr>
<th>Nursing Diagnosis</th>
<th>Two-Part Statement</th>
<th>Three-Part Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeding Self-Care Deficit</td>
<td>Feeding Self-Care Deficit RT decreased strength and endurance</td>
<td>Feeding Self-Care Deficit RT decreased strength and endurance AEB inability to maintain fork in hand from plate to mouth</td>
</tr>
<tr>
<td>Ineffective Airway Clearance</td>
<td>Ineffective Airway Clearance RT fatigue</td>
<td>Ineffective Airway Clearance RT fatigue AEB dyspnea at rest</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Anxiety RT change in role functioning</td>
<td>Anxiety RT change in role functioning AEB insomnia, poor eye contact, and quivering voice</td>
</tr>
<tr>
<td>Deficient Knowledge</td>
<td>Deficient Knowledge RT misinterpretation of information</td>
<td>Deficient Knowledge RT misinterpretation of information AEB inaccurate return demonstration of self-injection</td>
</tr>
<tr>
<td>Spiritual Distress</td>
<td>Spiritual Distress RT separation from religious ties</td>
<td>Spiritual Distress RT separation from religious ties AEB crying and withdrawal</td>
</tr>
</tbody>
</table>

Structure of Nursing Diagnosis

- Actual Nursing Diagnosis
  - Problem presents at the time of the assessment
  - Presence of associated signs and symptoms

- Potential Nursing Diagnosis
  - Problem does not exist
  - Presence of risk factors

- Health-Promotion Nursing Diagnosis
  - Problem related to healthcare

- Syndrome Diagnosis
  - Cluster of nursing diagnoses

Examples Potential
- Risk for Constipation R/ To inactivity and insufficient fluid intake
- Risk for infection R/ To compromised immune system.
- Risk for injury R/ To decreased vision after cataract surgery.

Examples Actual
- Impaired skin integrity R/ To prolonged immobility.
- Ineffective airway clearance R/ To retained secretions.
Process of Diagnosis

1. Compare data against standards
2. Cluster or group data
3. Data analysis after comparing with standards
4. Identify gaps in data
5. Determine the client’s health problems, health risks,..
6. Formulate Nursing Diagnosis
Classification of Nursing Diagnosis

- High – priority life threatening and requires immediate attention.
- Medium – priority resulting to unhealthy consequences.
- Low – priority can be resolve with minimal interventions.
**Guidelines for writing a Nursing Diagnosis statement**

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Incorrect Statement</th>
<th>Correct Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. State in terms of a problem, not a need.</td>
<td>Fluid Replacement (need) related to fever</td>
<td>Deficient Fluid Volume (problem) related to fever</td>
</tr>
<tr>
<td>2. Word the statement so that it is legally advisable.</td>
<td>Impaired Skin Integrity related to improper positioning (implies legal liability)</td>
<td>Impaired Skin Integrity related to immobility (legally acceptable)</td>
</tr>
<tr>
<td>3. Use nonjudgmental statements.</td>
<td>Spiritual Distress related to strict rules necessitating church attendance (judgmental)</td>
<td>Spiritual Distress related to inability to attend church services secondary to immobility (nonjudgmental)</td>
</tr>
<tr>
<td>4. Make sure that both elements of the statement do not say the same thing.</td>
<td>Impaired Skin Integrity related to ulceration of sacral area (response and probable cause are the same)</td>
<td>Risk for Impaired Skin Integrity related to immobility</td>
</tr>
<tr>
<td>5. Be sure that cause and effect are correctly stated (i.e., the etiology causes the problem or puts the client at risk for the problem).</td>
<td>Pain related to severe headache</td>
<td>Pain: Severe Headache related to fear of addiction to narcotics</td>
</tr>
<tr>
<td>6. Word the diagnosis specifically and precisely to provide direction for planning nursing intervention.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Use nursing terminology rather than medical terminology to describe the client’s response.</td>
<td>Impaired Oral Mucous Membrane related to noxious agent (vague)</td>
<td>Impaired Oral Mucous Membrane related to decreased salivation secondary to radiation of neck (specific)</td>
</tr>
<tr>
<td>8. Use nursing terminology rather than medical terminology to describe the probable cause of the client’s response.</td>
<td>Risk for Pneumonia (medical terminology)</td>
<td>Risk for Ineffective Airway Clearance related to accumulation of secretions in lungs (nursing terminology)</td>
</tr>
<tr>
<td></td>
<td>Risk for Ineffective Airway Clearance related to emphysema (medical terminology)</td>
<td>Risk for Ineffective Airway Clearance related to accumulation of secretions in lungs (nursing terminology)</td>
</tr>
</tbody>
</table>
### Difference between Nursing Diagnosis & Medical Diagnosis

<table>
<thead>
<tr>
<th>Nursing Diagnosis</th>
<th>Medical Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the scope of <strong>nursing</strong> practice</td>
<td>Within the scope of <strong>medical</strong> practice</td>
</tr>
<tr>
<td>Identify <strong>responses</strong> to health and illness</td>
<td>Focuses on <strong>curing</strong> pathology</td>
</tr>
<tr>
<td>Can <strong>change</strong> from day to day</td>
<td>Stays the <strong>same</strong> as long as the disease is present</td>
</tr>
<tr>
<td>Nursing Diagnosis</td>
<td>Medical Diagnosis</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Breathing patterns, ineffective</td>
<td>Chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>Activity intolerance</td>
<td>Cerebrovascular accident</td>
</tr>
<tr>
<td>Impaired sense of comfort (Pain)</td>
<td>Appendectomy</td>
</tr>
<tr>
<td>Body image disturbance</td>
<td>Amputation</td>
</tr>
<tr>
<td>Body temperature, risk for altered</td>
<td>Strep throat</td>
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</table>
## Outcome

<table>
<thead>
<tr>
<th>Definition</th>
<th>Purpose</th>
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</thead>
<tbody>
<tr>
<td>• It is <strong>the third step</strong> in the Nursing Process</td>
<td>✨ To promote client participation</td>
</tr>
<tr>
<td>• Refers to formulating and documenting measurable, realistic and client-focused goals</td>
<td>✨ To plan care that is realistic and measurable</td>
</tr>
<tr>
<td>• Nursing outcome Classification “NOC”</td>
<td>✨ To evaluate the effects of nursing care as a part of health care</td>
</tr>
</tbody>
</table>
Components of Outcomes

😊 **Subject**: who is the person expected to achieve the outcome?

😊 **Verb**: what actions must the person take to achieve the outcome?

😊 **Condition**: under what circumstances is the person to perform the actions?

😊 **Performance criteria**: how well is the person to perform the actions?

😊 **Target time**: by when is the person expected to be able to perform the actions?
Example of verbs used in client goals:

- Calculate
- Classify
- Communicate
- Compare
- Define
- Demonstrate
- Describe
- Construct
- Contrast
- Distinguish
- Draw
- Explain
- Express
- Identify
- List
- Name
- Maintain
- Perform
- Particular
- Practice
- Recall
- Recite
- Record
- State
- Use
- Verbalize
- Ambulates
Outcome criteria are: **SMART**

- **S** – Specific
- **M** – Measurable
- **A** – Attainable
- **R** – Realistic
- **T** – Time frame

**Example:**
- After teaching session, the client will demonstrate proper coughing techniques.
- The client will drink at least 6 glasses of water per day while in the hospital.
Types of goals

★ Short-term goal – can be met in a short period
★ Long term goal – requires more time

Example: Nursing Diagnosis
Impaired Tissue Integrity R/T destruction of tissue 2° pressure and friction AEB stage II pressure ulcer on coccyx
• Long term goal: “Patient’s pressure ulcer will heal before discharge
• Short term goal: “Patient will demonstrate 3 measures that she can do to prevent pressure ulcers during my shift”
Guideline for setting priorities:

- Use the principle of ABC’s (airway, breathing, circulation)
- Use 14 needs of Virginia Henderson.
- Consider something that is very important to the client.
- Actual problems take precedence over potential concerns.
## Planning( How to fix the problem)

### Definition
- It is **the forth step** in the Nursing Process
- Involve the client and his family
- Begins with the first client contact until client is discharged from the hospital

### Purpose
- To determine the goals of care and the course of actions to be undertaken during the implementation phase.
- To promote continuity of care.
Types of planning

- Initial planning
- Ongoing planning
- Discharge planning
### Implementation (putting plan into action)

<table>
<thead>
<tr>
<th>Definition</th>
<th>Purpose</th>
</tr>
</thead>
</table>
| • It is the fifth in the Nursing Process  
• is putting the nursing care plan into action.  
• Nursing Interventions Classification “NIC” | • To carry out planned nursing interventions to help the client attain goals and achieve optimal level of health.  
• To describe the activities that nurses perform |

**Definition**

- It is the fifth in the Nursing Process
- is putting the nursing care plan into action.
- Nursing Interventions Classification “NIC”
Activities during implementation

**Reassessing**
- To ensure prompt attention to emerging problems.

**Set priorities**
- to determine the order in which nursing interventions are carried out

**Perform nursing interventions**
- These may be independent. Dependent or collaborative measures

**Record actions**
- To complete nursing interventions, relevant documentation should be done.
Requirements of Implementation:

- **Knowledge** – include intellectual skills like problem-solving, decision-making and teaching.
- **Technical skills** – to carry out treatment and procedures.
- **Communication skills** – use of verbal and non-verbal communication to carry out planned nursing interventions.
- **Therapeutic use of self** – is being willing and being able to care.
### Evaluation (did the plan work?)

<table>
<thead>
<tr>
<th>Definition</th>
<th>Purpose</th>
</tr>
</thead>
</table>
| • It is **the final step** in the Nursing Process  
• is **assessing** the client’s response to **nursing interventions** and then comparing that response to predetermined standards or outcome **criteria**. | To appraise the extent to which goals and outcome criteria of nursing care have been achieved |
Activities during Evaluation

- Collect data about the client’s response
- Compare response to goals and outcome criteria
- Assess whether goals are met (partially/completely met or unmet)
- Analyze reasons for outcomes
- Modify care plan as needed
Critical thinking

Nurse as Critical Thinker

No action is performed without critical thinking”

(Rubenfeld & Scheffer, 1999)

- Analyze complex data about clients
- Make decisions about the client's problems and alternate possibilities
- Evaluate each problem to decide which applies
- Decide on the most appropriate interventions for the situation

Oermann, 1999 as cited in Jarvis, 2004
When do Nurses Use Critical Thinking?

☆ To prioritize nursing actions
☆ To resolve conflict
☆ To implement change
☆ To analyze situations
☆ To solve problems
☆ To make decisions
<table>
<thead>
<tr>
<th>Assessment data related to Nursing diagnosis</th>
<th>Nursing Diagnosis</th>
<th>Outcomes</th>
<th>Nursing Interventions</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective data: 1. CVA left sided paralysis 2. Diminished gag reflex 3. Difficulty swallowing liquids</td>
<td><strong>Potential For aspiration related to diminished gag reflex and impaired swallowing ability</strong></td>
<td>Patient will maintain patent air way (23/03/2011 at 2 pm) <strong>Outcome criteria:</strong> 1. Patient will have no choking episodes while eating 2. Patients color will not remain cyanotic 3. Patient lung sounds will remain clear 4. Patient CXR will shows no signs of aspiration</td>
<td>1. Place patient one semi setting position to avoid aspiration of mucous. 2. Feed patient liquids which have been thickened, as thin liquids are more likely to cause aspiration. 3. Monitor lung sounds and skin color for signs of aspiration. 4. Monitor lab and X-rays data for signs of aspiration.</td>
<td>-Patient didn’t have problems with shocking during my shift 1. Patient color was pink. 1. Patient lung sounds remain clear. 2. Patient has lab/X-rays didn’t show no signs of aspiration</td>
</tr>
</tbody>
</table>
Finally

• DO IT
• DO IT RIGHT
• DO IT RIGHT NOW!
References

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Thank You