Lecture 1 : Fundamentals of Nursing

Nursing process : (Nursing Care Plans)

The concept of nursing process:

The nursing process is the framework for providing professional, quality nursing care. It directs nursing activities for health promotion, health protection, and disease prevention and is used by nurses in every practice setting and different branches. "The nursing process provides the basis for critical thinking in nursing.

Nursing process ; is a systematic , patient – centered , goal – oriented method of caring to provide a frame work for nursing practice .

Components of the nursing process:

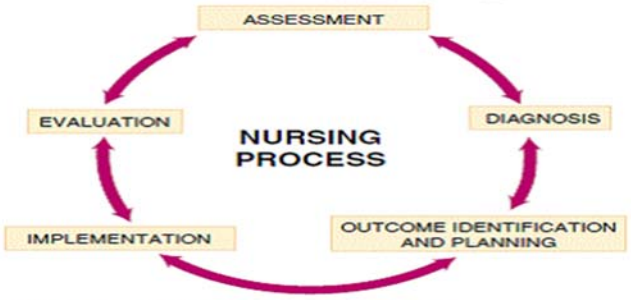


Figure 5-1 Components of the Nursing Process

Purpose of Nursing Process:(Objectives of N P)

1. Identify needs of the patient.
2. To establish priorities of care.
3. To identify a client's health status.
4. To resolve actual & or potential patient problem.
5. To apply health promotion to possible for each patient.
6. To provide an individualized, holistic, effective and efficient nursing care.

Nursing Assessment :Definition

Nursing Assessment is the first phase of the nursing process, it is systematic , continuously collect, and communication of patient's data. Nursing Assessment is the gathering of information about a patient physiological, psychological, sociological and spiritual status.

Information is collected by using the skills observation, interviewing, physical examination, including clients, their family members or significant others, health records, other health team members.

5 Activities Needed to Perform a Systematic Assessment:

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

Purpose of Assessment

1. Establish a baseline of information on the client and develop a data base.
2. Determine client's normal function.
3. Determine client's risk for dysfunction.
4. Determine presence or absence of dysfunction.
5. Determine client's strengths .
6. Provide data for diagnostic phase.

Gather Information/Collect Data:

Source of Information:

- **Primary Source** : Client / Family
- **Secondary Source** - physical exam, nursing history, team members, lab reports, diagnostic tests…..

Types of Data collection:

- **Subjective** : from the client (symptom)
  - I have a headache , I feel colic pain in right side.
- **Objective** : observable data (sign)
  - Blood Pressure 130/80 ,increase temperature , pale .

Assessment skills collect data by :

1- Observation

Observation includes looking, watching, examining.Observation begins the moment the nurse meets the client. If he a conscious or not.

2- Interviewing

Is a planned communication or a conversation with a purpose, for example to get or give information, identify problems.

3- Physical examination techniques

Is a systematic data collection method that uses the senses of sight, hearing, smell, and touch to detect health problems. Four techniques are used: **inspection, palpation, percussion, and auscultation.**

Inspection

Is visual examination of the client . The client is observed first from a general point of view and then with specific attention to detail from head to toe.

Palpation

Uses the sense of touch to assess mass, temperature, moisture, organ location and size, vibrations and pulsations, swelling, and tenderness.

Percussion

Uses short, tapping strokes on the surface of the skin to create vibrations of underlying organs.

Auscultation

Involves listening to sounds in the body that are created by movement of air or fluid. Areas most often auscultated include the lungs, heart, abdomen, and blood vessels.

Components of Data Collection:

- **Biographic data :** name, address, age, sex, marital status, occupation, religion.
- **Reason for visit/Chief complaint :** Reasons for seeking healthcare or hospitalization
- **Medical/Surgical Health history :** includes usual health status.
- **Past Health History :** includes all previous immunizations, Past illness.
- **Family History :** reveals risk factors for certain disease (Diabetes, hypertension, cancer, mental illness ,heart disease).

- **Review of systems :** review of all health problems by body systems (neurological/mental status, musculoskeletal, cardiovascular, respiratory, Gastro intestinal tract , skin and wounds…etc)
- **Lifestyle :** include personal habits, diets, sleep or rest patterns, activities of daily living, hobbies.
- **Social and Environmental history** include family relationships, ethnic and educational background, economic status, home and neighborhood conditions.
- **Psychological data :** information about the client's emotional status.

Nursing Diagnosis :

Definition of Nursing Diagnosis:

A clinical judgment about individual, family, or community responses to actual or potential health/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is responsible .Second step of the Nursing Process Interpret & analyze collected data Identify client's problems and strengths.

Purpose of a Nursing Diagnosis:

1. Identify how and individual, group or community responds to an actual or potential health and life processes.

2. Identify factors that contribute to or cause health problems (etiology).

3. Identify resources or strengths the individual, group or community can utilize(use) to prevent or resolve problems.

Nursing Diagnosis	Medical Diagnosis
Made by the nurse	Made by a physician
Describes clients response to a health problem	Identify and Describes the disease
Nurse treats problem within scope of independent nursing practice	Physician directs treatment
Nurse orders interventions	Physician orders interventions
May change from day to day as the patient's responses change for example Pain, difficult of breathing	Remains the same as long as the disease is present for example Myocardial infarction, asthma

For example the nursing diagnosis (NANDA : North American Nursing Diagnosis Association) :

1. Acute pain related to breast cancer .
2. Risk for Infection related to break in skin integrity (surgical incision, wound drainage devices).
3. Risk for falls related to age, narcotic use, generalized weakness.
4. Acute pain related to osteoarthritis aggravated by movement.
5. Imbalanced nutrition; less than body requirements related to chronic diarrhea, nausea.

Nursing Planning:

Third step of the Nursing Process ,this is when the nurse organizes a nursing care plan based on the nursing diagnoses. Nurse and client formulate goals to help the client with their problems.

Planning requires decision-making and problem-solving skills to design nursing care. In this phase, the nurse should: establish priorities determine goals and expected outcomes formulate a plan of nursing care.

Types of Planning goals:

1-Short term goals: Short term goal can be achieved (few hours to few days) (less than a week) for example reduce fever.

2-Long term goals: Long term goals may take weeks/months to be achieved, For example: "Patient's pressure ulcer will Heal.

Goals must be centered :

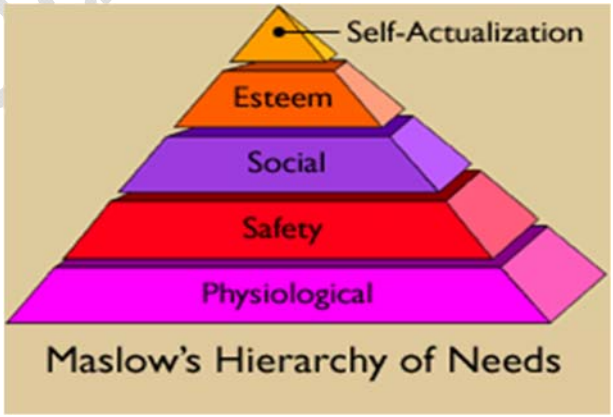
1. Specific
2. Measurable
3. Attainable
4. Relevant
5. Time

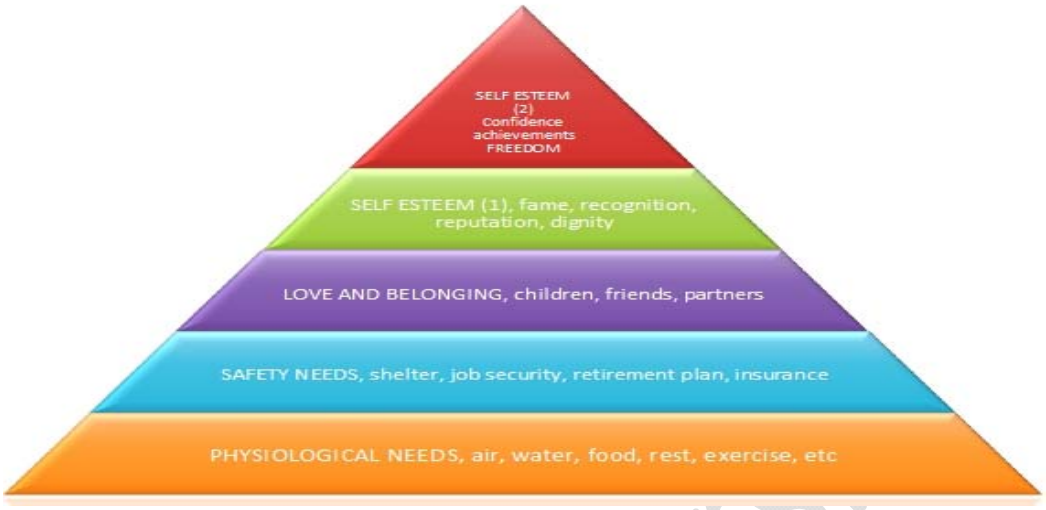
Establish Priorities:

Which problems require my immediate intervention?

Which problems are the most important to the patient?

Which problem has the highest level of need based on Maslow's Hierarchy? Physiologic, Safety, Love , Self-esteem ,Self-actualization.





Nursing Implementation:

The fourth step in the Nursing Process .Nursing actions planned in the previous step are carried out. Implementation includes interventions for performing, assisting, counseling and teaching; providing direct care, supervising, and recording and exchanging information relevant to client care.

Nursing Implementation actions performed by the nurse to:

1. Monitor health status
2. Reduce risks
3. Resolve, prevent, or manage a problem
4. Promote optimal sense of physical, psychological and spiritual well being

Three types of Interventions :

1-Independent (Nurse initiated): any action the nurse can initiate without direct supervision.

2-Dependent (Physician initiated):nursing actions requiring MD orders.

3-Interdependent (Collaborative): nursing actions performed with other health care team members.

Implementation Skills:

1. Cognitive skills: involve application of nursing knowledge.
2. Interpersonal skills: these are essential for nursing practice. They are built on confidence relationship and clear communication.
3. Psychomotor skills: require the integration of cognitive and motor activities, such as learning to give an injection, the nurse must understand anatomy and pharmacology (cognitive) and the mechanics of preparing and giving an injection (motor).

Nursing Evaluation:

Fifth step during this phase, the nurse and the patient together measure how well the patient has achieved the outcomes specified in the plan of care. Final step of the Nursing Process ,Also it is the step that measures the client's response to nursing actions and the client's progress toward achieving goals, also involves measurement of Quality of Care.

Purpose of Evaluation:

1. Collect data to evaluate nursing care.
2. Examine patient’s response to nursing interventions.
3. Compare client’s response with outcome criteria.
4. Determine involvement and collaboration of others in healthcare decision.
5. Provide basis for modifications of care plan.
6. Monitor quality of nursing care and its effect on client’s health status.