

Nursing Process

The **nursing process** is the framework for providing professional, quality nursing care. It used by nurses in every practice setting and specialty & throughout the nursing practice.



Steps of Nursing Process

1. Nursing assessment:

Assessment includes: collection, verification, organization, interpretation, and documentation of data.

It should be a systematic & continuous collection of data .

Sources of the data

a. The primary source :

The information collected from the client using both interview techniques and physical examination skills.

a. The secondary sources:

Includes family members, other health care providers, and medical records.

There are two types of information:

a. Subjective data: Are data from the client's point include feelings, perceptions & concerns.

b. Objective data: Are observable and measurable data(physical examination & diagnostic tests).

Assessment skills

1- Observation

- ❖ The nurses use the senses of smell, hearing, touch.
- ❖ Observation includes looking, watching, examining.
- ❖ Observation begins the moment the nurse meets the client.

2- Interviewing

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

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:

- a. Inspection,
- b. Palpation,
- c. Percussion,
- d. Auscultation
- e. **Inspection**

Is visual examination of the client that is done in a methodical and deliberate manner. The client is observed first from a general point of view and then with specific attention to detail.

inspection requires:

adequate lighting and exposure of the body parts being observed.

b. Palpation : Uses the sense of touch to assess a. texture b. temperature c. moisture d. organ location and size,

Palpation requires : a calm, gentle approach and is used systematically, with light palpation

c. Percussion

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

It is used for assessing the density of structures or determining the location and the size of organs in the body.

d. 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.

2. Nursing diagnosis:

It involves further analysis and synthesis of the data that have been collected.

Types of Nursing Diagnoses

- a. **An actual nursing diagnosis:** indicates that a problem exists.
- b. **A risk nursing diagnosis:** (potential problem) indicates that a problem does not yet exist, but special risk factors are present.
- c. **A wellness nursing diagnosis:** indicates the client's expression of a desire to attain a higher level of wellness in some area of function.
- d. **Collaborative problems** are defined as physiologic complications monitored by nurses to assess changes in client status.

3. Planning:

Planning includes the formulation of guidelines that establish the proposed course of nursing action in the resolution of nursing diagnoses and the development of the client's plan of care.

The planning phase involves several tasks:

- a. Prioritization of nursing diagnoses .
- b. Identification and writing of long- and short-term goals & outcomes (are used to evaluate the nursing interventions which must be measurable, have a time limit, & be realistic).
- c. Development of specific interventions

4. Implementation:

It consists of performing nursing activities that have been planned to meet the goals.

5. **Evaluation:**

Involves determining whether the client goals have been met & measurement of the effectiveness of nursing care.

Characteristic of the Nursing Process

1. Systematic (known as prioritization). Logic, orderly, steps based on the most important vital needs.
2. Client oriented.
3. Goal oriented.
4. Continuous.
5. Dynamic .

