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Nursing

Textbook of Advance Nursing Practice

2nd Edition

As per the Latest Syllabus for BSc Nursing



Samta Soni

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CHAPTER 1

Nursing Process

DEFINITIONS

- Nursing process is a specific method of organizing and delivering nursing care or action.
- The nursing process is used by nurses everyday to help patients improve their health and assist doctors in treating patients.
- It is a form of problem solving.
- The nursing process is made-up of a series of stages that are used to achieve the objectives.
- Nursing knowledge is used throughout the process to formulate changes in approach to the patients changing condition.
- Nursing process is a systematic problem-solving approach used to identify, prevent and treat actual or potential health problems and promote wellness.
- It is a systematic way to plan, implement and evaluate care for individuals, families, groups and communities.

Purpose

- To identify the clients health needs
- Determine priorities of care goals and expected outcomes
- Establish a nursing care plan to meet client centered needs
- Provide nursing intervention designed to meet these needs
- Evaluate the effectiveness of the nursing care in achieving client goal.

Characteristics of Nursing Process

- Dynamic
- Client-centered
- Planned Interpersonal and collaborative
- Universally applicable focus on problems or strengths
- Open, flexible
- Humanistic and Individualized
- Cyclical
- Outcome focused
- Emphasizes feedback and validation.

Nursing process is a deliberate, rational, systematic, goal directed method of planning and providing nursing care.

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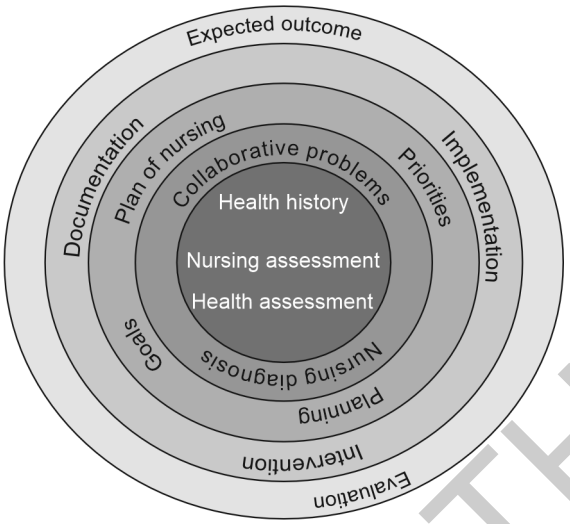

Fig. 1.1: Nursing process model.

Benefits of Using the Nursing Process

- ❖ Ensure continuity of care
- ❖ Prevention of duplication
- ❖ Individualized care
- ❖ Standards of care
- ❖ Increased client participation
- ❖ Collaboration of care.

Nursing Process is the Corner Stone of the Nursing Professions

It include ADOPIE
A—Assessment
D—Diagnosis
O—Outcome identification
P—Planning
I—Implementation
E—Evaluation

The nursing process is based on a nursing theory developed by Ida Jean Orlando. She developed this theory in late 1950's. Ms. Orlando had four steps in nursing process but through practical application over the past 40 years one step evolved and now there are five.

Steps are:

1. Assessment
2. Diagnosis
3. Planning
4. Implementation
5. Evaluation

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Practice Advantages of Nursing Process

- The nursing process provides a framework for meeting the individual needs of patients, family and community.
- The steps of the nursing process focus nurse's attention on the:

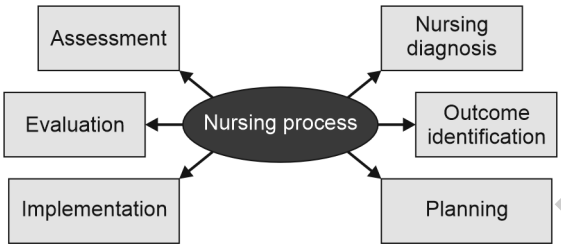

Fig. 1.2: Steps of nursing process.

- Individual or human responses of a patient or group to a given health situation, resulting in a holistic plan of care addressing their specific problem or needs.
  - The use of nursing process promotes active involvement of the patient in his own health care
  - The use of nursing process enable nurse to have more control over practice
  - The use of nursing process provides a common language for practice, unifying the nursing profession.
  - It provides a means of assessing nurses economic contribution to patient care.
  - It provides an organized systematic method of problem-solving, which may minimize dangerous errors or omissions in caregiving and avoid time consuming repetition in care and documentation.

Components of Nursing Process

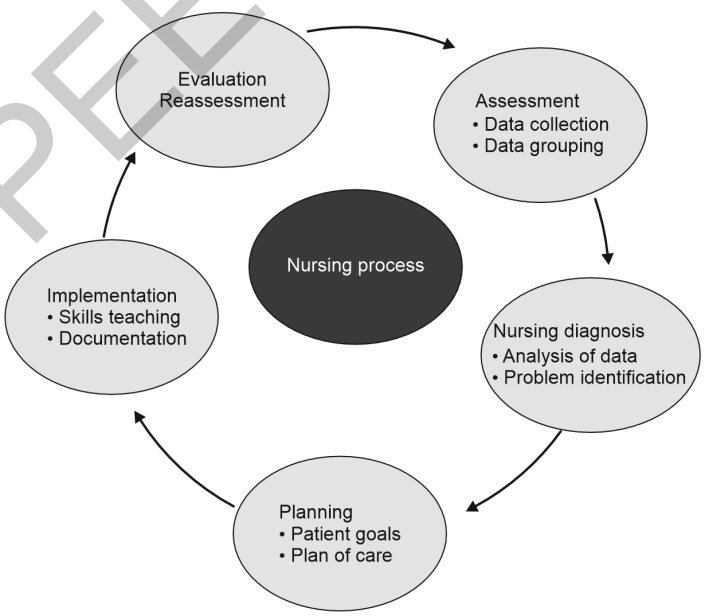

Fig. 1.3: Components of nursing process.

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Assessment

Assessment is the dynamic and continuous process of collecting, verifying and organizing information about a person or other entity.

Assessment obtaining information about a patient's response to health concerns/illness and their ability to manage these healthcare issues.

- Assessment step of the nursing process involve
  - Collection of data
  - Organization of data
  - Validation of data
  - Documentation of data

Assessing is a continuous process carried out during all phases of nursing process. All phases depend on the accurate and complete collection of data.

Purpose of Assessment

- To establish a database about the clients level of wellness health practices, past illness and related experiences and health care goals.
- Assessment is the deliberate and systematic collection of data to determine a client current and past health status and to determine the clients present and past coping patterns (*Carpenito 2000*).

Types of Assessment

- **Initial assessment:** Performed within specified time after admission to a healthcare agency, e.g., nursing admission assessment.
- **Problem-focused assessment:** Ongoing process integrated with nursing care to determine-specific problem identified in an earlier assessment and to identify new or over looked problems.
  Example: Assessment of patient's ability to perform self-care while assisting client to bathe.
- **Emergency assessment:** It is done during psychiatric and physiological crisis of the client to identify life-threatening problems.
  Example: Rapid assessment of ABC during cardiac arrest.
- **Time lapsed assessment:** It is done several months after initial assessment to compare the client's status to baseline data previously obtained.

Data Collection

- Data collection is the process of gathering information about a client's health status
- Data collection includes, nursing health history, physical examination, result of laboratory and diagnostic test and information from health care team members and the client's family.
- Data collected during assessment should be described, concise, complete and should not include interpretative statement.
- Several nursing models may be used to guide data collection. The use of a nursing model as a framework for data collection rather than a body system approach or the commonly known head to toe approach has the advantage of identifying and validating nursing diagnose as opposed to medical diagnoses.

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Types of Data

Subjective data (symptoms, covert data)

Subjective data are clients perception about their health problems. Only client can provide this kind of information subjective data usually include feeling of anxiety, physical discomfort or mental stress, pain, itching.

- Objective data—signs, overt data: These are observations and measurements made by data collectors. Objective data can be measured or tested against an accepted standard.
- They can be seen, heard, felt or smelled and they are obtained by observation or physical examination.
- Objective data include blood pressure data, skin color, assessment of client's wound, etc.

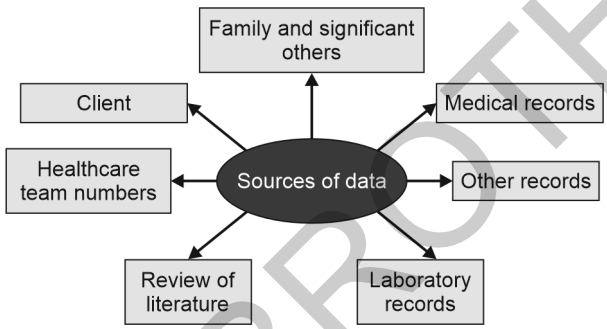

Fig. 1.4: Sources of data.

Primary (direct) source of data—client

Secondary source	– Family members – Clients's records – Medical records – Records of therapies – Laboratory records – Team members

Methods of Data Collection

- **Interview**
  - Problem-seeking behavior
  - Problem-solving technique
  - Direct questions
  - Open-ended questions
- **Nursing health history**
  - Biological information
  - Reason for seeking health care
  - Present illness

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- Past health history
- Family history
- Environmental history
- Psychological history
- Spiritual health
- Review of systems
- Client expectations

❖ **Physical examination**
- The physical examination is performed systemically in a manner similar to the review of system in the health history.
- Physical examination include various techniques
  - Inspection
  - Percussion
  - Palpation
  - Auscultation

❖ **Diagnostic and laboratory data:** The results of diagnostic and laboratory tests can identify or verify alterations questioned or identified during the nursing health history and physical examination.

The Interview Process

Information in the client data base is obtained primarily from the client and then from family members/significant others through conversation and by observation during a structured interview. The nursing interview may take place over several contact sessions, but each contact should yield information.

A well-conducted interview can be the first step in establishing a beneficial nurse-client relationship and the report needed for good communication.

Elements of Successful Interview

- Purpose
- Preliminary research
- Request to conduct interview
- Sound interview strategy
- Use of ice breakers
- Address the questions smoothly
- Good rapport
- Sensitivity to clients need
- Adequate time for recovery after discussion
- Closure with highlights of the interview.

Techniques of Data Collection

❖ Open-ended questions allow the client maximum freedom to respond in his own way.
Example: How do you feel?

❖ Hypothetical questions pose a situation and ask the client how it might be handled.
Example: What would you do if you feel lethargy?

❖ Reflecting or mirroring responses are useful techniques in getting an underlying meanings that might not be verbalized clearly.

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Example: You feel angry about having to use the nebulizer.

- ❖ Focusing shows the client that you are attending to what is being said and consists of eye contact, body posture and verbal responses.
  Example: Tell me more about that.
- ❖ Giving broad openings encourages the client to take the initiative about what is to be talked about
  Example: Where would you like to begin.
- ❖ **Offering general leads encourages** the client to continue and then
- ❖ Exploring pursues a topic in more detail.
  Example: Would you describe it completelly?
- ❖ Verbalizing the implied gives voice to what has been suggested.
  Example: Interviewer says it is no use taking this drug anymore.
  Nurse (Interviewer responds) you are concerned that it is not making a difference for you.
- ❖ Encouraging evaluation helps the client to consider the quality of his own experience.
  Example: How does that seem to you.

Do not use in Interview

- Close-ended questions
- Leading questions
- Probing questions
- Agreeing/disagreeings

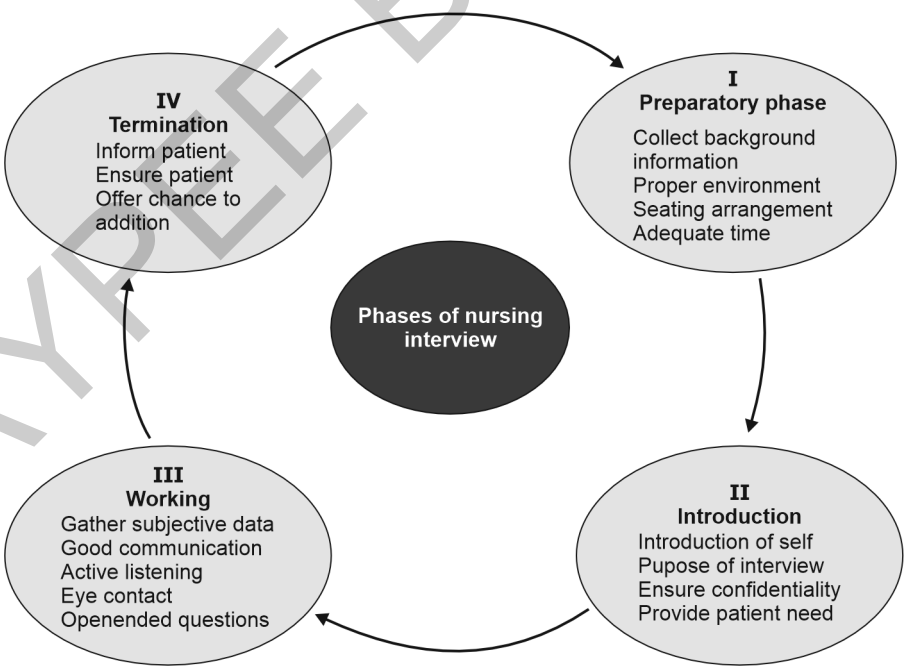

Fig. 1.5: Phases of nursing interview.

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Problems Related to Data Collection
- Inappropriate organization of the data base
- Omission of pertinent data
- Inclusion of irrelevant data
- Failure to establish rapport and partnership
- Recording an interpretation of data
- Failure to update the database

Principals of History Taking
- ❖ Listen carefully
- ❖ Active listening
- ❖ Objectivity
- ❖ Manageable detail
- ❖ Sequence information
- ❖ Document clearly
- ❖ Record data in time.

Data Clustering

Data gathered in the interview in the physical examinations and from other records are organized and recorded in a concise systematic way and clustered into similar categories.
- ❖ Cluster is a set of signs and symptoms that are grouped together in a logical order
- ❖ Clustering of data helps to focus on identification of the correct problem.

Reviewing and Validating Findings

Validation is an ongoing process that occurs during the data collection phase and on its completion, when the data are reviewed and compared. Validation is important particularly when the data are conflicting, when the source of data may not reliable.

Data that are grossly abnormal are rechecked. Objective and subjective data are compared for congruencies and inconsistencies.

Nursing Diagnosis
- ❖ The judgment or conclusion that occurs as a result of nursing assessment (Gebbie, Levin 1975)
- ❖ *Definition:* A clinical judgment about individual, family or community responses to actual or 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 1990)
- ❖ It is a statement of a client's potential or actual health problems resulting from analysis of data.
- ❖ It is a statement of clients potential or actual alteration in his health status.
- ❖ It is a problem statement that the nurse makes regarding a client condition which she uses to communicate professionally.

Nursing diagnosis is a term uses to classify health problems within the domain of nursing. Diagnosis means "to know" or "to distinguish".

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Purpose

- To identify healthcare needs
- To analyze assessment information and derive meaning from this analysis
- To provide direction for nursing care plan.

Importance

- Nursing diagnosis provides nurses with a common frame of reference and standardizes language that improves communication among nurses, helps organize research and is useful in educating new practitioners
- Nursing diagnosis provide a classification system to describe the scientific foundation of nursing practices.
- Nursing diagnosis provide nomenclature for the reimbursement of nursing activities.

Diagnosing = Data analysis + Problem identification + Formulation of nursing diagnosis.

Nursing Diagnosis Process

The diagnostic process is the decision-making steps, the nurse use to develop a diagnostic statement. This process include:

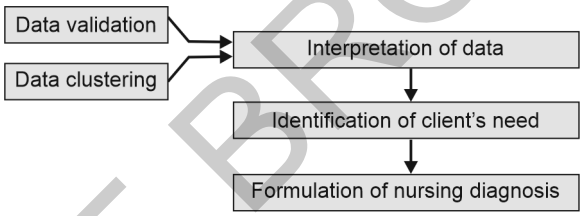

Fig. 1.6: Steps of nursing diagnosis.

Analysis and interpretation of data, identification of problem and formulation of nursing diagnosis.

Analysis and Interpretation of Data

The analysis involves recognizing patterns and trends, comparing these patterns with normal health patterns and drawing conclusions about the client response. When a relationship among these patterns is identified, a list of client centered problems or needs begins to emerge.

When looking for a pattern or trend, the nurse examines clusters of data that are a set of signs or symptoms grouped together in a logical order.

Steps in data analysis

Recognize a pattern or trend
↓
Compare with standards for normal
↓
Make a reasoned conclusion

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Identification of Needs/Problems

Before formulating the nursing diagnosis, the nurse identifies the clients general health, needs or problems.

To identify the client's need the nurse first determine what the client's health problem are and whether they are actual or potential problems.

An actual health problem is one that is perceived or experience by the client, for example, sleep pattern disturbance related to noisy environment.

A potential health problem is one for which the client is at risk, for example, an overweight smoker at risk for in effective airway clearance related to incisional pain.

This step bring the nurse close to forming nursing diagnosis and making general analysis of clustered data.

Formulation of Nursing Diagnosis

Once cluster's of data containing defining characteristics are sorted client's needs or problems are identified the nurse is ready to formulate nursing diagnosis. Nursing diagnosis is based on the identification of client's needs. The actual diagnosis is a statement of conclusion. It should be concise, precise and highly personalized to apply to the individual client. The diagnostic label should include the problem and its etiology.

- NANDA has identifies four types of nursing diagnosis:
  1. Actual nursing diagnosis (Describe human response to health conditions)
  2. Risk nursing diagnosis (Refer to human responses to health conditions)
  3. Wellness nursing diagnosis (Focus more on opportunity than need)
  4. Resolved diagnosis (No longer require intervention)
- Some author given six steps involved in formulating nursing diagnosis these are:
  1. Problem sensing
  2. Rule out process
  3. Synthesizing the data
  4. Evaluating hypothesis
  5. List the client's needs
  6. Re-evaluate the problems list

Potential Errors in Choosing a Nursing Diagnosis

- Overlooking cues
- Making a diagnosis with an insufficient database
- Stereotyping

Characteristics of Nursing Diagnosis

- It states a clear and concise health problem
- It is derived from existing evidences about the client
- It is potentially amenable to nursing therapy
- It is the basis for planning and carrying out nursing care.

Components of Nursing Diagnosis (PES Format)

- Problem statement (P)
- Etiology/causes (E)
- Defining characteristics/signs/symptoms (S)

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Types of nursing diagnosis	Example
Actual nursing diagnosis	◆ Imbalanced nutrition related to nausea ◆ Disturbed sleep pattern related to cough, pain
Potential nursing diagnosis	◆ Possible nutrition deficit ◆ Possible low self-esteem related to job
Risk nursing diagnosis	◆ Risk for impaired skin integrity related to decrease peripheral circulation ◆ Risk for infection related to compromised immune system
Wellness diagnosis	Appropriate family coping

Steps in Nursing Diagnosis Formulation

Compare data against standards
↓
Cluster/group data
↓
Data analysis after comparing with standards
↓
Identifies gaps inconsistences in data
↓
Determine the client's health problem, health risks, strengths
↓
Formulate nursing diagnosis

Illness	Risk of illness	Wellness
Actual nursing diagnosis	Risk nursing diagnosis	Wellness nursing diagnosis
◆ Trifocal model for client assessment (Kelly, Frisch, Avant 1995)		

3. Planning

- ❖ Once the etiology, signs and symptoms previously identified are incorporated into a client diagnostic statement, nurse can proceed to the planning step of the nursing process.
- ❖ Action is focused on the actions that are most appropriate to effectively address the patient's problems or need.
- ❖ The nurse begin to set priorities, establish goals, identifies desired outcomes and determine specific nursing interventions. These actions are documented as plan of care.
- ❖ It is a priority that the client and significant others be included in the planning process so that they may contribute to participate in and take responsibility for their own care.

Process of Nursing Planning

Setting priorities for client care

The starting point for planning care is to rank the patient's problems or needs so that nurses attention and subsequent actions are properly focused.

The process helps a nurse attend to the client's most important needs and assists the nurse in organizing ongoing care. Activity although there many ways of prioritizing client needs, a useful framework is one developed by Abraham Maslow.

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Fig. 1.7: Maslow's hierarchy of needs.

According to Maslow physiological needs are generally considered baseline survival needs because they must be met in order for life to continue.

Richard Kalish (1983) expanded and further subdivided the structure of Maslow's hierarchy.

This hierarchy can help nurse to identify and prioritize client needs more and to plan desired outcome and the associated nursing interventions.

After determination of priority of care, the clients care needs can also be ranked according to a system that can help in identifying basic to higher level actions/interventions.

By ranking the client's needs, nurse can proceed in a logical way to facilitate their client's recovery.

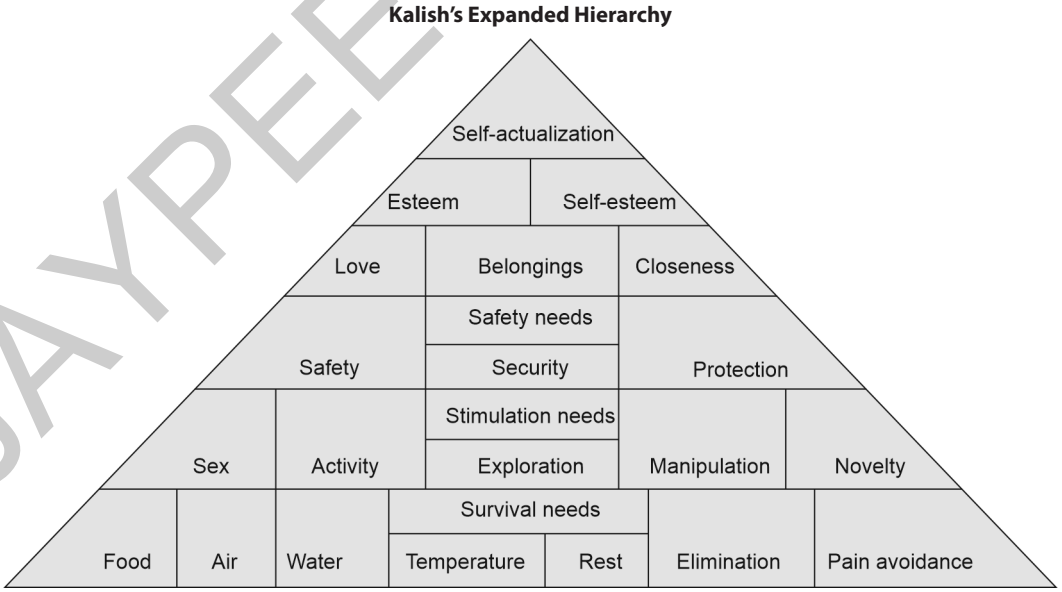

Fig. 1.8: Expanded hierarchy of basic human needs (Richard Kalish 1983).

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