APPLICATION OF NURSING PROCESS INTO PATIENT CARE

TUYISHIME Aphrodis,RN,BSCN,PCCN,MSN
Pediatric intensivist nurse
RWANDA MILITARY HOSPITAL

Nursing Process

It is a systematic, rational method of planning and providing individualized nursing care.

Purpose of Nursing Process

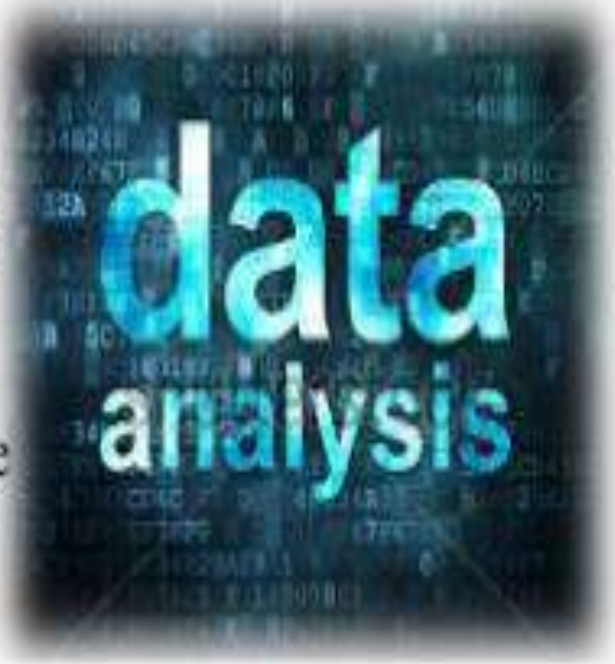
- To identify a client's health status, actual or potential health care problems or needs, to establish plans to meet the identified needs, and to deliver specific nursing interventions to meet those needs.
- It helps nurses in arriving at decisions and in predicting and evaluating consequences.
- It was developed as a specific method for applying a scientific approach or a problem solving approach to nursing practice.

PHASES OF THE NURSING PROCESS

- Assessment
- Diagnosis
- Outcome Identification
- Planning
- Implementation
- Evaluation

ANALYSIS & INTERPRETATIONS OF DATA

- ✓ In the assessment phase, data are initially collected from a variety of source & validated. The nurse then applies reasoning & begins to look for patterns in the assessment data.
- ✓ To arrive at nursing diagnosis we must go through the steps of data analysis. This process requires diagnostic reasoning skills, often called critical thinking.



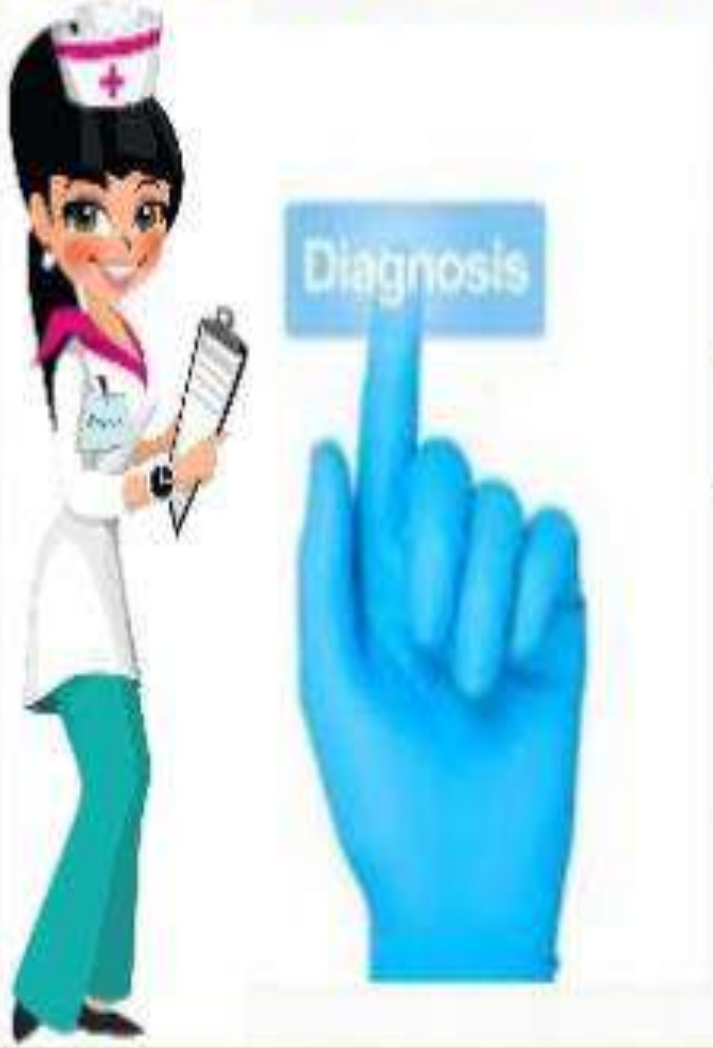
NURSING DIAGNOSIS

Definition of a Nursing Diagnosis
(NANDA, 1996)

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)

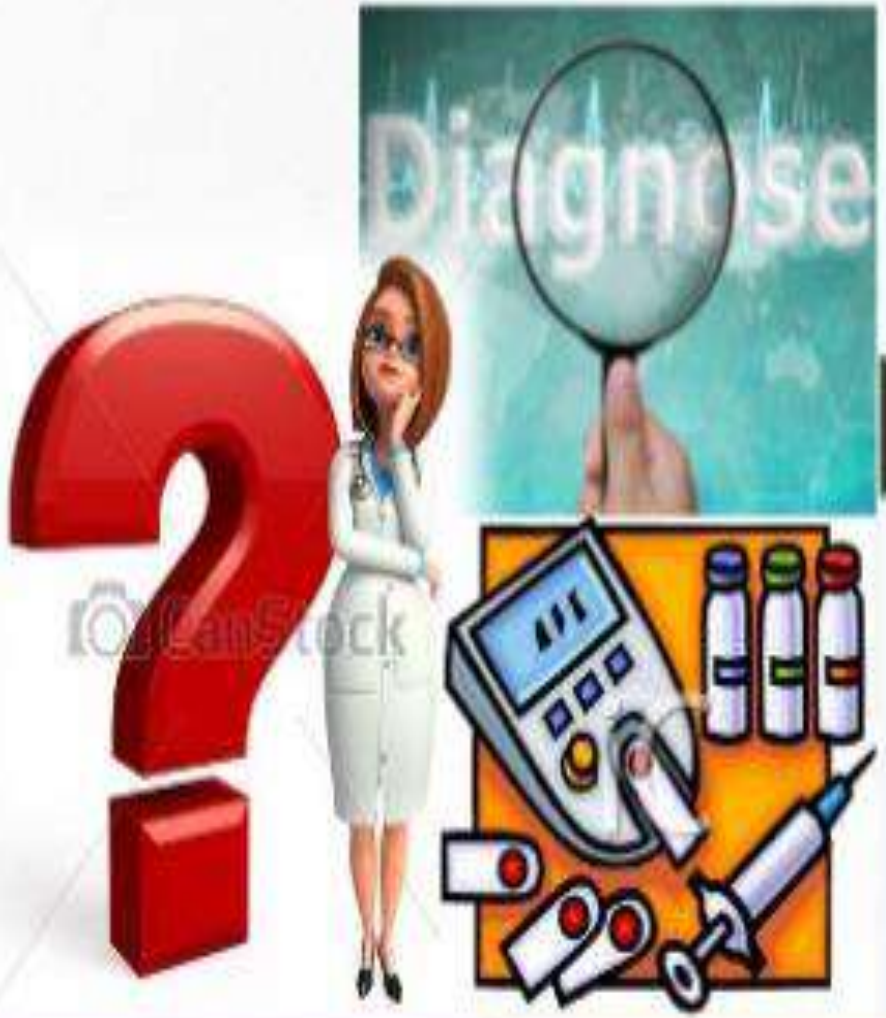
TYPES OF NURSING DIAGNOSIS

1) ACTUAL NURSING DIAGNOSIS
2) RISK NURSING DIAGNOSIS
3) POSSIBLE NURSING DIAGNOSIS
4) WELLNESS DIAGNOSIS
5) SYNDROME DIAGNOSIS



WHAT IS NOT A NURSING DIAGNOSIS?

- ✓ Medical diagnosis
- ✓ Medical pathology
- ✓ Diagnostic tests
- ✓ Treatments
- ✓ Equipments

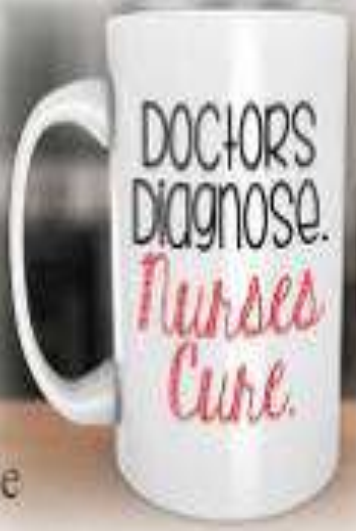


MEDICAL DIAGNOSIS v/s NURSING DIAGNOSIS

- ✓ Identify diseases **v/s** focus on unhealthy responses
- ✓ Directs the primary treatment **v/s** independent nursing practice
- ✓ Remains the same **v/s** change from day to day
- ✓ **Example:**

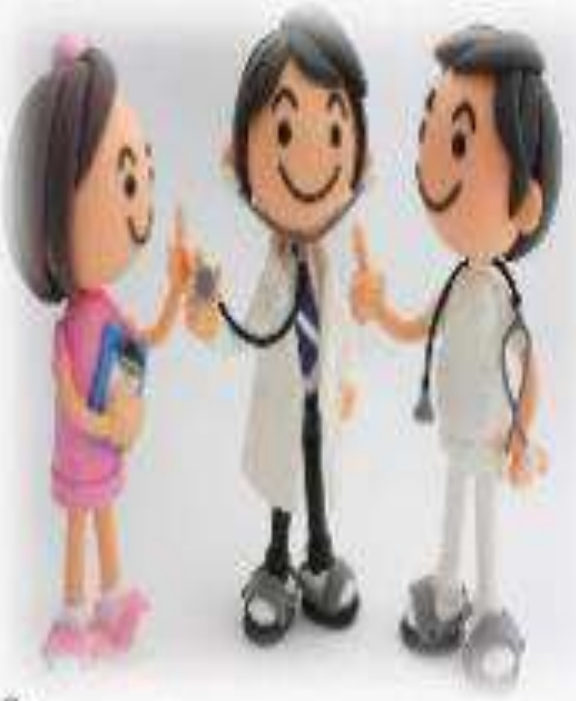
Myocardial infarction is a Medical Diagnosis

Nursing Diagnosis for a person with myocardial infarction include fear, altered health maintenance, knowledge deficit, pain, & altered tissue perfusion.



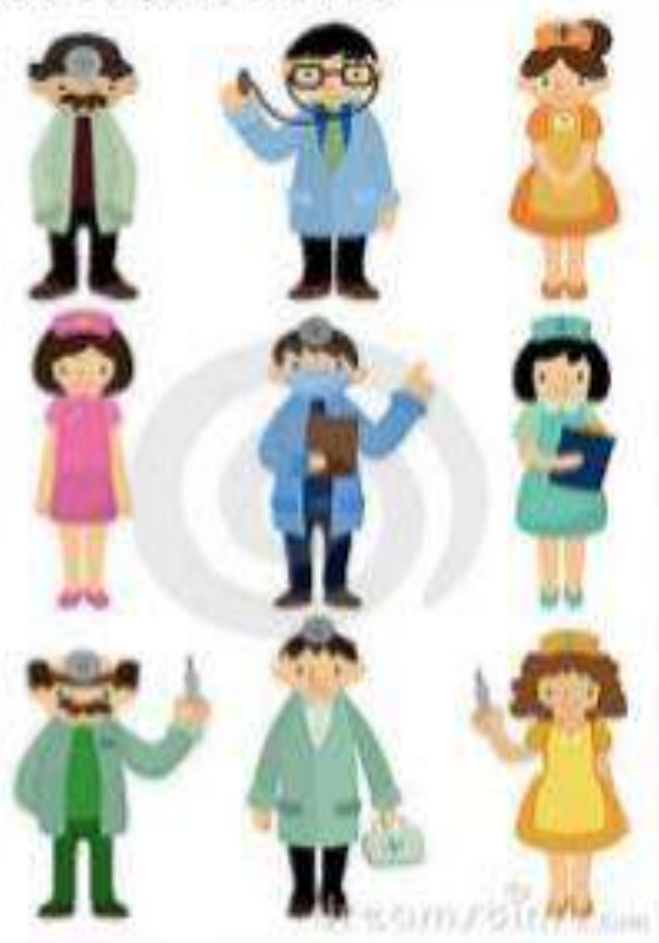
NURSING DIAGNOSIS v/s COLLABORATIVE PROBLEMS

- ✓ Collaborative problems are "certain physiologic complications".
- ✓ When the nurse writes patient outcomes that require delegated medical orders for goal achievement, that situation is not nursing diagnosis but a collaborative problem
- ✓ Collaborative problems involve potential complications, they must be identified early so that the preventive nursing care can be instituted early.

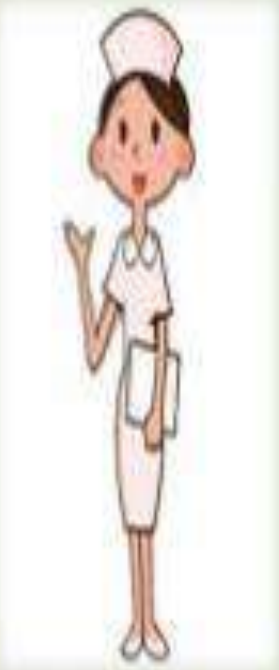


NURSING DIAGNOSIS v/s COLLABORATIVE PROBLEMS

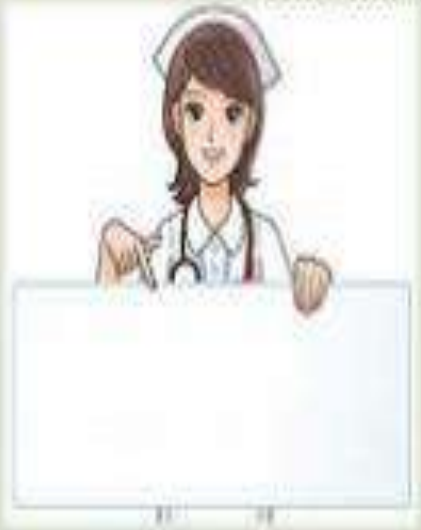
MEDICAL DIAGNOSIS	MEDICAL/SURGICAL Rx	DIAGNOSTIC STUDY
OVARIAN CANCER	RADIOTHERAPY	EXP. LAPROTOMY
PC: acute stress syndrome r/t disease condition	PC: infection r/t stage-iii skin reaction	PC: paralytic ileus r/t anesthesia



DIFFERENCE BETWEEN MEDICAL,COLLABORATIVE & NURSING DIAGNOSIS

S.NO	CRITERIA	NURSING DIAGNOSIS	COLLABORATIVE DIAGNOSIS	MEDICAL DIAGNOSIS
2	FOCUS 	Monitoring human responses to actual & potential health problems.	Monitoring pathophysiological responses of body organs or systems	Correcting or preventing pathology of specific organs or body system.

DIFFERENCE BETWEEN MEDICAL,COLLABORATIVE & NURSING DIAGNOSIS

S.NO	CRITERIA	NURSING DIAGNOSIS	COLLABORATIVE DIAGNOSIS	MEDICAL DIAGNOSIS
3	SAMPLE DATA CLUSTER 	56yr old mother of 7; 5'4" ; "whenever I sneeze, I dribble urine. This is embarrassing"	42yr old woman, 1hour after delivery, spinal anesthesia, 1500ml fluid infused in past 4hrs without patient voiding; unable to void	"Whenever I have to urinate it burns terribly. I also feel like I have to go all the time-real bad" small frequent voiding, cloudy urine, T-100.8

DIFFERENCE BETWEEN MEDICAL,COLLABORATIVE & NURSING DIAGNOSIS

S.NO	CRITERIA	NURSING DIAGNOSIS	COLLABORATIVE DIAGNOSIS	MEDICAL DIAGNOSIS
4	DIAGNOSTIC STATEMENT 	Stress urinary incontinence r/t degenerative change in pelvic muscles & structural supports associated with advanced age, obesity, gravid uterus.	Potential complication: urinary retention r/t fluid overload & effects of anesthesia.	Cystitis

FORMULATION OF AN EFFECTIVE NURSING DIAGNOSIS

- Identify a **treatable etiology rather than a clinical sign** or chronic problem.
  Wrong Example: altered respiratory function related to abnormal arterial blood gas levels
  Right Example: "altered tissue perfusion related to the inadequate oxygen intake"

- Identify **the problem caused by the treatment or diagnostic study rather than the treatment** or study (client experiences much of responses to diagnostic tests & medical treatment).
  Wrong Example: cardiac catheterization related to angina
  Right Example: "anxiety related to cardiac catheterization"

FORMULATION OF AN EFFECTIVE NURSING DIAGNOSIS

- Identify the **client's response to equipments rather than the equipment** itself

  Wrong Example: anxiety related to cardiac monitor

  Right Example: "knowledge deficit regarding the need for cardiac monitoring"

- Identify the **client's problem rather than the nurse's problem**

  Wrong Example: potential complications related to poor vascular access indicates nursing problem in initiating & maintaining intravascular therapy

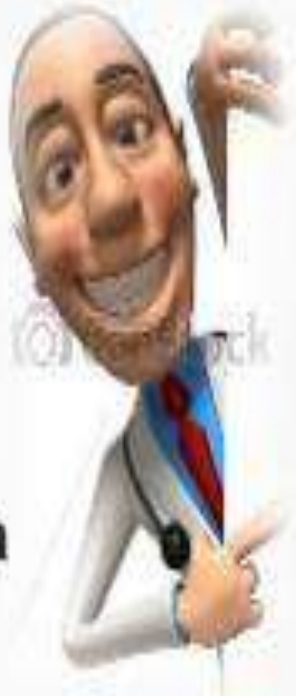
  Right Example: "potential infection related to presence of invasive lines" properly centers attention on client's need.

FORMULATION OF AN EFFECTIVE NURSING DIAGNOSIS

a) Identify the **client's response instead of medical diagnosis**

Wrong Example: pain related to myocardial infarction

Right Example: pain related to physical exertion



b) Identify NANDA **diagnostic statement rather than the symptom**

Wrong Example: excessive mucus production

Right Example: "ineffective breathing pattern related to increased airway secretions"

FORMULATION OF AN EFFECTIVE NURSING DIAGNOSIS

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FORMULATION OF AN EFFECTIVE NURSING DIAGNOSIS

- Identify the **client's problem rather than nursing intervention**

  Wrong Example: offer bedpan frequently because of altered elimination patterns

  Right Example: identity the problem & etiology. "Diarrhea related to food intolerance" corrects the mis-statement & allows proper implementation of the nursing process.

- Identify the **client's problem rather than the goal**

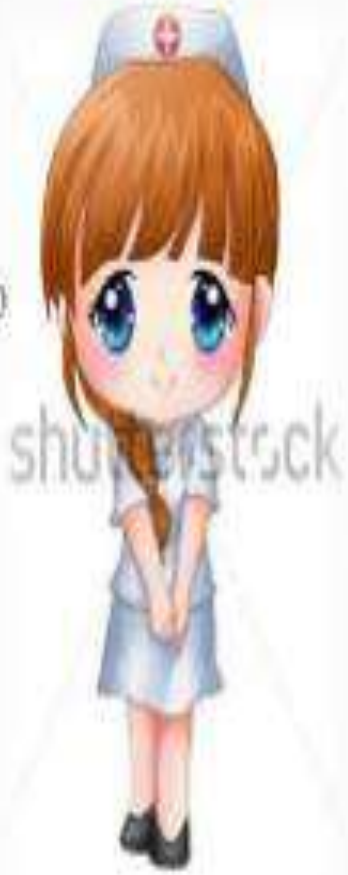
  Wrong Example: client need high protein diet related to alteration in nutrition

  Right Example: "altered nutrition less than body requirement related to inadequate nutritional intake" to allow for planning to correct the etiology.

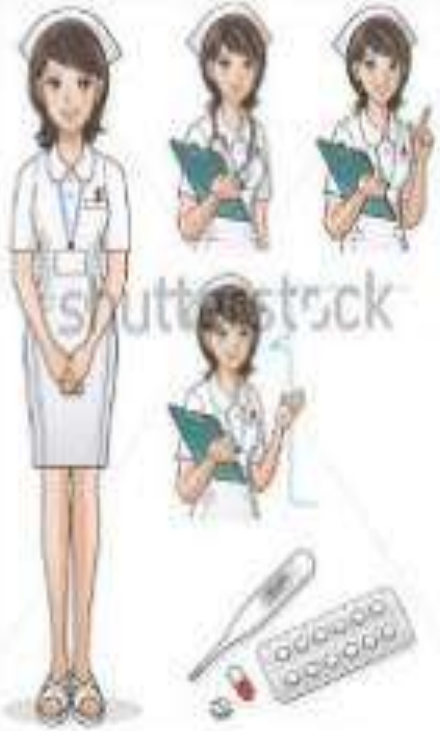
FORMULATION OF AN EFFECTIVE NURSING DIAGNOSIS

- Identify **the problem & etiology.**

  Example: alteration in comfort related to pain can be caused to identify the client problem & the cause: ineffective breathing pattern related to incisional pain.



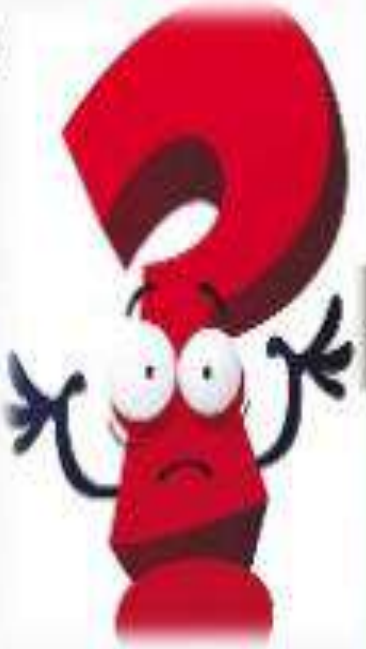
NURSING DIAGNOSIS APPLICATION TO CARE PLANNING



Example:

Lisa is a registered nurse in orthopedic unit & Mrs.Divine a 52yrs women who is scheduled to have a lumber laminectomy for a herniated lumbar disk.

Ms.Divine's **medical diagnosis is herniated lumbar disk**. Lisa has conducted an assessment of Ms.Divine's health status & needs & has collected information in four different problem areas. Lisa needs to review clusters & pattern of data collected to correctly identify the nursing diagnoses that apply to Ms.Divine's situation. **One cluster of data includes information about Ms.Divine's inexperience with the surgery & her statement that she has not received information about post-operative activities**. Lisa decides that the data include defining characteristics for the nursing diagnosis deficient knowledge regarding post-operative routines related to inexperience.



DIAGNOSTIC PROCESS:

ASSESSMENT OF CLIENT'S STATUS:

- ✓ Ms.Divine's reports being concerned about the surgery
- ✓ Has concerns about possible paralysis
- ✓ Restless
- ✓ Uncertain about what to expect

VALIDATE THE DATA:

- ✓ Nursing staff confirms findings & also reports Ms.Divine has poor eye contact when talking about planned surgery

MORE DATA NEEDED?

INTERPRET & ANALYSE DATA:

- ✓ Cluster findings
- ✓ Group signs: restlessness, poor eye contact
- ✓ Group behaviors: reports concern, uncertain about what to expect

LOOK FOR DEFINING CHARACTERISTICS:

Reveals a problem with coping

NURSING DIAGNOSIS: anxiety related to threat of surgery

Benefits of the NURSING PROCESS: for the Client

- QUALITY CLIENT CARE
- CONTINUITY OF CARE
- PARTICIPATION BY CLIENTS IN THEIR HEALTH CARE

Benefits of the NURSING PROCESS: for the Nurse

- CONSISTENT AND SYSTEMATIC NURSING EDUCATION.
- JOB SATISFACTION.
- PROFESSIONAL GROWTH.
- AVOIDANCE OF LEGAL ACTION.
- MEETING PROFESSIONAL NURSING STANDARDS.
- MEETING STANDARDS OF ACCREDITED HOSPITALS.

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