DOWNLOAD PDF NURSING PROCESS AND NURSING DIAGNOSIS

Chapter 1 : Nursing Process: Definition, purpose and steps

The 5 Steps of the Nursing Process The nursing process is a scientific method used by nurses to ensure the quality of patient care. This approach can be broken down into five separate steps.

Whether that behaviour makes any sense in that context? Whether the behaviour was adaptive or dysfunctional? Whether a change is needed? If the nurse has to interview the patient she should select a private place, free from noise and distraction and interview should be goal directed. This is particularly important when the patient is unable to provide reliable information because the symptoms of the psychiatric illness. She should gather Information from other information sources, including health care records, nursing rounds, change- of shifts, nursing care plans and evaluation of other health care professionals. Nursing Diagnosis After collecting all data, the nurse compares the information and then analyses the data and derives a nursing diagnosis. A nursing diagnosis may be an actual or potential health problem, depending on the situation. A nursing diagnostic statement consists of three parts: Health problem Contributing factors Defining characteristics The defining characteristics are helpful because they reflect the behaviour that are the target of nursing intervention. If a patient is making statements about dying, he is isolative, anorexic, cannot sleep and wants to die. Then the nursing diagnosis can be- Helplessness, related to physical complaints, as evidenced by decreased appetite and verbal cues indicating despondency. Outcome Identification The psychiatric mental health nurse identifies expected outcomes individualised to the patient. Outcomes should be mutually identified with the patient, and should be identified as clearly as clearly and determine the effectiveness and efficiency of their interventions. Before defining expected outcomes, the nurse must realize that patient often seek treatment with goals of their own. These goals may be expressed as relieving symptoms or improving functional ability. Clarifying goals is an essential step in the therapeutic process. Therefore the patient nurse relationship should be based upon mutually agreed goals. Once the goals are a greed on they must be stated in writing. Goals should be written in behavioural terms, and should be realistically described what the nurse wishes to accomplish within a specific time span. Example of short term goals: At the end of the two weeks patients will stay out of bed and participate in activities At the end of the one week patient will sleep well at night. At the end of the one week patient will eat properly and maintain weight. The planning consists of:

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Chapter 2 : Nursing Care Plans and Nursing Diagnosis â€¢ Nurseslabs

A nursing diagnosis may be part of the nursing process and is a clinical judgment about individual, family, or community experiences/responses to actual or potential health problems/life processes.

This approach can be broken down into five separate steps. Assessment Phase The first step of the nursing process is assessment. This data can be collected in a variety of ways. Generally, nurses will conduct a patient interview. Patient interaction is generally the heaviest during this evaluative phase. Diagnosing Phase The diagnosing phase involves a nurse making an educated judgment about a potential or actual health problem with a patient. Multiple diagnoses are sometimes made for a single patient. These assessments not only include an actual description of the problem e. The diagnoses phase is a critical step as it is used to determine the course of treatment. Planning Phase Once a patient and nurse agree on the diagnoses, a plan of action can be developed. If multiple diagnoses need to be addressed, the head nurse will prioritize each assessment and devote attention to severe symptoms and high risk factors. Each problem is assigned a clear, measurable goal for the expected beneficial outcome. For this phase, nurses generally refer to the evidence-based Nursing Outcome Classification, which is a set of standardized terms and measurements for tracking patient wellness. The Nursing Interventions Classification may also be used as a resource for planning. Implementing Phase The implementing phase is where the nurse follows through on the decided plan of action. This plan is specific to each patient and focuses on achievable outcomes. Actions involved in a nursing care plan include monitoring the patient for signs of change or improvement, directly caring for the patient or performing necessary medical tasks, educating and instructing the patient about further health management, and referring or contacting the patient for follow-up. Implementation can take place over the course of hours, days, weeks, or even months. Evaluation Phase Once all nursing intervention actions have taken place, the nurse completes an evaluation to determine of the goals for patient wellness have been met. The possible patient outcomes are generally described under three terms: In the event the condition of the patient has shown no improvement, or if the wellness goals were not met, the nursing process begins again from the first step. All nurses must be familiar with the steps of the nursing process.

Chapter 3 : Nursing Process in Psychiatric Nursing

The common thread uniting different types of nurses who work in varied areas is the nursing processâ€"the essential core of practice for the registered nurse to deliver holistic, patient-focused care.

Article Featured What are nursing diagnoses and how do they differ from medical diagnoses? How do nursing diagnoses fit in the nursing process and why are they so critical to safe, effective nursing care? A medical diagnosis, on the other hand, is the identification of a disease based on its signs and symptoms. The professional practice of nursing is the diagnosing and treatment of these basic human responses. Nurses need a common language to describe the human responses of individuals, families, and communities to health threats. NANDA strives to classify in a scientific manner these basic human responses. The nurse gathers the assessment data and from this data, identifies high-priority nursing diagnoses. The nursing diagnoses then provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable. The patient not the nurse is central to the nursing process. The nursing process involves looking at the whole patient at all times. It personalizes the patient. Nursing care needs to be directed at all times for improving outcomes for the patient. Then you need to formulate a nursing diagnosis for each of these problems. Nursing diagnoses are written in "PES" format: How can you have evidence signs and symptoms for something that is only a risk and not a manifested problem? Nursing goals are simply the antithesis of the nursing diagnostic statement with a reasonable time frame. In other words, diagnostic statements are "problems" negative. Nursing interventions are the "meat and gravy" of the nursing process and flow from the "etiology" part of the nursing diagnostic statement. The nurse must use his or her critical thinking skills to plan, coordinate, and implement nursing interventions, and then evaluate the effect of these interventions in achieving the desired patient goal. Nursing interventions always begin with "Student nurse will Nursing interventions must be backed up with a scientific rationale - otherwise, this action is just your opinion and has no merit. Remember, everything in nursing must be evidenced-based. Provide a citation for your scientific rationale, in APA 6th Edition Format, from a peer-reviewed source: When evaluating your goals, you need to state specifically: If the latter is the case unable to evaluate goal due to time constraints , then you need to state what outcome criteria would be needed in order to state goal met. In other words, if I were present at specified time element , I would look for the following outcome criteria in order to state, "goal met. Remember, you are evaluating the goals, not the interventions. So you see, it is an orderly, evidenced-based process and not that difficult with practice. Nurses cannot know what interventions to select or which outcomes to project unless they have accurate representations of what patients are experiencing using a common reference language, NANDA. Her research interests include: She is faculty in a large baccalaureate nursing program in North Carolina.

Chapter 4 : Nursing Process (ADPIE) Guide | blog.quintoapp.com

The Nursing Process The common thread uniting different types of nurses who work in varied areas is the nursing processâ€"the essential core of practice for the registered nurse to deliver holistic, patient-focused care.

A nursing care plan is a process that includes correctly identifying existing needs, as well as recognizing potential needs or risks. Care plans also provide a means of communication among nurses, their patients, and other healthcare providers to achieve health care outcomes. Planning and delivering individualized or patient-centered care is the basis for excellence in nursing practice. Care plans can be informal or formal: Formal care plans are further subdivided into standardized care plan, and individualized care plan: Standardized care plans specify the nursing care for groups of clients with everyday needs. Individualized care plans are tailored to meet the unique needs of a specific client or needs that are not addressed by the standardized care plan. Steps in writing a nursing care plan How do you write a nursing care plan? The following are the steps in developing a care plan for your client. Data Collection or Assessment Step 2: Data Analysis and Organization Step 3: Formulating Your Nursing Diagnoses Step 4: Setting Priorities Step 5: Selecting Nursing Interventions Step 7: Providing Rationale Step 9: Putting it on Paper Step 1: Data Collection or Assessment Create a client database using assessment techniques and data collection methods physical assessment, health history, interview, medical records review, diagnostic studies. A client database includes all the health information gathered. In this step, the nurse can identify the related or risk factors and defining characteristics that can be used to formulate a nursing diagnosis. Some agencies or nursing schools have their own assessment formats you can use. Formulating Your Nursing Diagnoses Nursing diagnoses are a uniform way of identifying, focusing on, and dealing with specific client needs and responses to actual and high-risk problems. Actual or potential health problems that can be prevented or resolved by independent nursing intervention are termed nursing diagnoses. Setting Priorities Setting priorities is the process of establishing a preferential sequence for address nursing diagnoses and interventions. In this step, the nurse and the client begin planning which nursing diagnosis requires attention first. Diagnoses can be ranked and grouped as to having a high, medium, or low priority. Life-threatening problems should be given high priority. Involve the client in the process to enhance cooperation. Establishing client goals and desired outcomes After assigning priorities for your nursing diagnosis, the nurse and the client set goals for each. Goals provide direction for planning interventions, serve as a criteria for evaluating client progress, enable the client and nurse to determine which problems have been resolved, and help motivate the client and nurse by providing a sense of achievement. Goals can be short term or long term. Long-term goals are often used for clients who have chronic health problems or who live at home, in nursing homes, or extended care facilities. Goals or desired outcome statements usually have the four components: The subject is the client, any part of the client, or some attribute of the client i. That subject is often omitted in writing goals because it is assumed that the subject is the client unless indicated otherwise family, significant other. The verb specifies an action the client is to perform, for example, what the client is to do, learn, or experience. Criterion of desired performance. The criterion indicates the standard by which a performance is evaluated or the level at which the client will perform the specified behavior. When writing goals and desired outcomes, the nurse should follow these tips: Write goals and outcomes in terms of client responses and not as activities of the nurse. Avoid writing goals on what the nurse hopes to accomplish, and focus on what the client will do. Use observable, measurable terms for outcomes. Avoid using vague words that require interpretation or judgment of the observer. Ensure that goals are compatible with the therapies of other professionals. Ensure that each goal is derived from only one nursing diagnosis. Keeping it this way facilitates evaluation of care by ensuring that planned nursing interventions are clearly related to the diagnosis set. Lastly, make sure that the client considers the goals important and values them to ensure cooperation. Selecting Nursing Interventions Nursing interventions are activities or actions that a nurse performs to achieve client goals. Interventions chosen should focus on eliminating or reducing the etiology of the nursing diagnosis. In this step, nursing interventions are identified and written during the planning step of the nursing process; however, they are actually performed during the

implementation step. Nursing interventions can be independent, dependent, or collaborative: Independent nursing interventions are activities that nurses are licensed to initiate based on their sound judgement and skills. Includes orders to direct the nurse to provide medications, intravenous therapy, diagnostic tests, treatments, diet, and activity or rest. Assessment and providing explanation while administering medical orders are also part of the dependent nursing interventions. Collaborative interventions are actions that the nurse carries out in collaboration with other health team members, such as physicians, social workers, dietitians, and therapists. Nursing interventions should be: Achievable with the resources and time available. Inline with other therapies. Based on nursing knowledge and experience or knowledge from relevant sciences. When writing nursing interventions, follow these tips: Write the date and sign the plan. The date the plan is written is essential for for evaluation, review, and future planning. Nursing interventions should be specific and clearly stated, beginning with an action verb indicating what the nurse is expected to do. Action verb starts the intervention and must be precise. Qualifiers of how, when, where, time, frequency, and amount provide the content of the planned activity. Providing Rationale Rationales do not appear on regular care plans, they are included to assist students in associating the pathophysiological and psychological principles with the selected nursing intervention. Evaluation is an important aspect of the nursing process because conclusions drawn from this step determine whether the nursing intervention should be terminated, continued, or changed. Putting it on Paper Different nursing programs have different care plan formats, most are designed so that the student systematically proceeds through the interrelated steps of the nursing process, and many use a five-column format. Nursing diagnoses are developed based on data obtained during the nursing assessment. These diagnoses are based on the presence of associated signs and symptoms. Risk Nursing Diagnosis A risk nursing diagnosis is a clinical judgment that a problem does not exist, but the presence of risk factors indicates that a problem is likely to develop unless nurses intervene. For example, all people admitted to a hospital have some possibility of acquiring an infection; however, a client with diabetes or a compromised immune system is at higher risk than others. Syndrome Diagnosis A syndrome diagnosis is associated with a cluster of problem or risk nursing diagnoses that are predicted to present because of a certain situation or event. Example is Rape Trauma Syndrome. Possible Nursing Diagnosis Possible nursing diagnoses are statements describing a suspected problem for which additional data are needed to confirm or rule out the suspected problem. A possible nursign diagnosis also provides the nurse the ability to communicate to other nurses that a diagnosis may be present but additional data collection is indicated to rule out or confirm the diagnosis. Writing Nursing Diagnostic Statements Diagnostic statement describe the health status of an individual and the factors that have contributed to the status. Diagnostic statements can be one-part, two-part, or three-part statements. One-Part Statements Wellness nursing diagnoses are written as one-part statements because related factors are always the same: Syndrome diagnoses also have no related factors. Risk for Infection related to compromised host defenses Risk for Injury related to abnormal blood profile Possible Social Isolation related to unknown etiology Three-part Statements An actual or problem nursing diagnosis have three-part statements: Impaired Physical Mobility related to decrease muscle control as evidenced by inability to control lower extremities. Risk for Decreased Cardiac Output related to reduced preload secondary to myocardial infarction. Chronic Low Self-Esteem related to complex factors. Ineffective Coping related to unknown etiology. Impaired Skin Integrity Right Anterior Chest related to disruption of skin surface secondary to burn injury.

Chapter 5 : Nursing Process Steps

Nursing diagnosis that identifies an existing client/patient problem that has been validated by the presence of major defining characteristics. A statement of a client problem that nurses by virtue of their education can treat.

Increased heart rate, decreased blood pressure with activity, statements of weakness, dyspnea with exertion Chapter 4. Nausea is the only problem that meets that criterion; all others are medical or collaborative problems. Productive cough and loose stools are abnormal findings but are not related to each other. Daily bowel movement and high-fiber diet are related but normal response. The vital signs are also within normal limits. If the incorrect etiology is given, the nursing care would not be appropriate for the client. The other statements are true but not a reason for the importance of the etiology being correct. A possible nursing diagnosis is based on nursing knowledge, intuition, and experience and does not have enough data to support it; it is based on incomplete data. Nurses collect data to support both risk and possible diagnoses; therefore, this statement does not differentiate them. A risk diagnosis develops into an actual diagnosis when symptoms develop. A collaborative problem requires monitoring by the nurse and intervention by a physician. A medical diagnosis requires interventions medications, treatments by the physician. Medical diagnoses do not direct all nursing care. Collaborative problems have the potential to become medical, not nursing, diagnoses. The more reliable data you gather, the more certain you can be that your inference is accurate. Because inferences are nursing diagnoses, it would be inappropriate to have a physician evaluate them. Although another experienced nurse could evaluate the inference, it still needs to be supported by sound data. Even clients can validate clinical inferences in some situations; however, adequate supporting data are still needed. Keep in mind, the clients data might or might not be sufficient to prove the inference. There need to be several certainly more than two etiological factors for the statement to be complex. There is no blame implied or harm resulting, so the statement is not legally questionable. There is no minimum amount of supportive data for a diagnosis and the stated etiology related to the nursing diagnosis. No supportive data are given in the stem of the question, so you could not choose lack of data as the best answer because all the options lack data as far as you can tell from the information given in the question. In addition, it is not necessary to include supportive data in the diagnostic statement although some do prefer to use A. The etiology and related factors are the causes or contributing factors to the problem. The diagnostic label is the name NANDA has given the problem; it is chosen based on the presence of defining characteristics. Safety is most basic in Maslows hierarchy. Even though Risk for Aspiration is not an actual problem, it poses the most immediate life-threatening risk to the client; and nursing interventions must be performed to prevent it from becoming an actual problem. However, the primary goal of nursing is to serve the good of the patient. Therefore, the most important use of a diagnosis is to specifically identify the clients needs for quality nursing care. Safe Care Environment Cognitive level: Research is currently being conducted, but many of the diagnoses are not research based. A perfect nursing diagnosis is impossible to write, so that is not an issue. Having standardized nursing diagnoses recognized in state practice acts or by other professions has nothing to do with the value of the NANDA taxonomy. Diagnostic reasoning is used to identify the appropriate nursing diagnosis; it is not meant to support the diagnosis. A health problem is a condition that requires intervention to promote wellness or prevent illness; it is sometimes, but not always, a nursing diagnosis. Nursing diagnoses are not medical diagnoses. The etiology suggests interventions. Cue clusters support whether the correct nursing diagnosis has been identified. The cause-and-effect order of Inability to Ingest Food. The etiology and symptoms A. It is possible to have a possible risk for diagnosis. The patient with possible diagnoses may have symptoms, just not enough to support the diagnosis. Constipation is a nursing diagnosis, and the etiology is a defining characteristic for a risk diagnosis because it contributes to the problem. In risk diagnoses, the etiology consists of the risk factors. If the patient does not agree that he has Decisional Conflict, the nurse might interview him more to clarify the meaning of the data. Certainly the nurse could ask another nurses opinion, but that is not essential. It would make no sense to have a social worker interview the patient unless the situation remains unclear even after confirming with the client. If the nurse did have adequate theoretical knowledge of Decisional Conflict for this

patient, she should have been informed by reading the NANDA handbook before making the diagnosis. If the patient does not confirm the diagnosis, and the nurse concludes the diagnosis is in error, she might then re-read the NANDA guide. The format for a wellness diagnosis is Readiness for Enhanced. Use a possible diagnosis when you have enough data to suspect a problem but need more data to support a diagnosis. Use a risk diagnosis when there are risk factors for a problem. The only cue that might cause Fatigue is depression. You cannot use depression as the problem because it is a medical diagnosis, and it is not a NANDA label. The other cues difficulty concentrating, inability to perform ADLs, and guilt are symptoms of Fatigue, not etiologies. These diagnoses would lead the nurse to focus on dealing with guilt and confusion, so the source of the Fatigue would not be addressed. A pain ranking of 5 is a symptom of pain, not an etiology, so it should be preceded by A. Hip fracture is a medical diagnosis that is causing an etiology of pain; therefore, it should be preceded by secondary to. Risk diagnoses do not have symptoms, so it is not correct to put anything after A. Sleep is a basic physiologic need. Infection can threaten physical health. In this question, infection is not present; therefore, there is just a risk for it. Sleep Deprivation is an immediate problem that affects general physical, mental, and emotional health. Application Leave a Reply You must be logged in to post a comment.

Chapter 6 : A better understanding of the NURSING PROCESS | allnurses

nurse, diagnosis, When you understand the whys of each step the nursing process, it's easier easy to understand how to apply them in the real world in which you will practice.

What is the Nursing Process? The nursing process is a modified version of the scientific method. It is used in the medical profession to assess client needs and create a course of action to address and solve patient problems. Developed by Ida Jean Orlando in , this method is used by nurses to balance out the usage of scientific evidence and personal interpretation when diagnosing and treating a medical patient. Critical thinking and intuition often play a part in this process. Although the resident nurse is in charge of the entire process at all times, every nurse uses this method when caring for patients. During this research, Orlando developed the Nursing Process Theory. In addition to her nursing career, Orlando served as a nursing consultant both nationally and internationally. These steps are detailed phases with their own set of actions designed streamline patient care. Each step is recorded for the reference of the whole health care team to ensure quality care. As the process is always ongoing, there is no set amount of time for any one step to begin or be completed. Characteristics of the Process This process is cyclical. The method is designed to be applied to any individual, family, or community need. While the nursing process is generally used for medical problems, it was also developed to help with emotional or social needs of patients as well. Above all, the nursing process is goal-oriented. It is used to make client-centered, measurable, realistic goals for individual or community wellness improvement. Impact on the Medical Field This process was developed to force ho spitals to treat patients as people, as opposed to identification numbers. Implementation requires constant interaction between the caregiver and the patient. The process also helps provide guidelines for patient care and typically improves patient outcomes. For some nursing students, the nursing process can be a difficult concept to grasp at first. However, once put into practice, this method becomes almost like second nature.

Chapter 7 : Nursing Process â€“ 1 | Student Nursing Study Blog

ADPIE is an acronym that stands for assessment, diagnosis, planning, implementation, and evaluation. These are the steps of the nursing process, which are steps to providing proper care to your patient.

Viber Nursing process is a scientific process which is a foundation, the essential tool, and the enduring skill that has characterized nursing from the beginning of the profession. It has changed and evolved through the years, developing in clarity and scope. It is a plan of care for the patient which may look different from institution to institution but provides both systematic and effective course of intervention to patient. The 6 steps of Nursing Process 1. Assessment â€" It is also called as data collection. Assessment is both the most basic and the most complex nursing skill which is at the same time both the initial step in the nursing process and an ongoing component in every other step in the process. In order to assess well, the five senses are being utilized to identify changes in status and in order for the nurse to intervene appropriately. Data collection is composed of observation of patient, interview of patient, family and support systems, examination of the patient, and the review of medical records. Culture consideration is given an important venue while assessing a patient and one essential skill of assessment is the ability of the nurse to collect only relevant data. In assessment, family relationships, support systems, food preferences, lifestyle habits and activities of daily living, communication styles, and health care beliefs are all included as its aspects. Nursing observations result in objective data. Objective data are factual data that are observed by the nurse. The nurse describes the signs or behaviors observed without drawing conclusions or making interpretations. While a data that is consist of information given verbally by the patient is called subjective data. Examples of objective and subjective data are: Tremors of both hands, hair combed, makeup applied, Urinated to approximately cc dark amber urine Subjective data: The use of therapeutic communication like open ended questions is very beneficial in order to elicit a comprehensive image of the health pattern. Complete examination of the patient is another integral aspect of assessment. The body system approach and the cephalucaudal head-to-toe approach are mainly used for the examination to be methodical and also to avoid omissions. An examination is composed of visualization, auscultation, percussion, also the five vital signs temperature, pulse, respiration, blood pressure, and pain. Diagnosis â€" It is the second step in the nursing process and it is the phase by which the nurse analyzes the data gathered and identifies the problem for the patient. It is the process of data analysis, problem identification, and the formulation of nursing diagnosis. There are three types of nursing diagnosis: Examples of diagnosis are: Outcome Identification â€" The nurse develops outcomes for the patient to achieve showing an optimum or improved level of functioning in the problem areas identified in the nursing diagnoses. It is developed to make the nursing care both individualized for the patient and realistic for the hospital or home care setting. It is composed of setting priorities and establishing outcomes. The SMART technique abbreviated as specific, measureable, attainable, realistic and time- bound is usually used in making an outcome statement. Meanwhile, an outcome statement is composed of patient behavior, criteria of performance, conditions if needed , and time frame. Examples of an outcome statement: The patient will pass flatus within 24 hours postoperatively. Planning â€" The nurse develops a plan of care that prescribes interventions to attain expected outcomes. Nursing interventions are considered activities that are planned and implemented to help patient achieve identified outcomes. Nursing interventions are often given nursing rationale to prove that those interventions are based on principles and knowledge integrated from nursing education and experience as well as from behavioural and physical sciences. Nursing interventions should be safe for the patient, must be congruent with other therapies, realistic, and it should consider meeting the lower level survival needs before higher level needs. Knowledge and skill deficit in taking newborn rectal temperature related to first- time parenting. These are the environmental management, independent nursing intervention or the one that is nurse-initiated and ordered intervention, the dependent nursing intervention or nurse- initiated and physician-ordered intervention, and the collaborative intervention or intervention applied with the assistance of other health team members, like dietician, pharmacist, midwife and others. Implementation â€" It is the fifth phase in the nursing process and is consists of validating the care plan, documenting the care plan, giving and

documenting the nursing care, and continuing data collection. It is primarily focused on working with the patient and the family to carry out the plan of care. This is done not only to know if how the patient responds to the nursing interventions but also to provide increased information for revising the plan of care as the status of the patient changes. The patient is an active participant in care as they are given the right to refuse or request interventions. On the other hand, the nurse is flexible and should be open to suggestions in changing patient and family priorities, but still committed to help promote health, reduce and eliminate, or prevent problems. Evaluation â€" It should be done continuously while care is being given and as the nurse evaluate progress from intermediate outcomes up to discharge outcomes. Evaluating is composed of documenting responses to interventions, evaluating effectiveness of interventions, evaluating outcome achievement, and reviewing nursing care plan. There are three alternatives when deciding how well an outcome was met: An outcome evaluation statement when written includes if met, partially met or not met and actual patient behavior as evidence. Outcome partially met as evidenced by decubitus ulcer still present but is half in size. Outcome not met as evidenced by decubitus ulcer broken and draining. Review of the nursing care plan is composed of reassessment, review of nursing diagnoses, review of outcomes and replanning, and review of implementation.

Chapter 8 : Nursing Diagnosis â€¢ Guides and Care Plans â€¢ Nurseslabs

The nursing process is an interactive, problem-solving process. It is systematic and individualized way to achieve outcome of nursing care. The nursing process respects the individual's autonomy and freedom to make decisions and be involved in nursing care.

Client data should include past history as well as current problems. For example, a history of an allergic reaction to penicillin is a vital piece of historical data. Past surgical procedures, folk healing practices, and chronic diseases are also example of historical data. Current data relate to present circumstances, such as pain, nausea, sleep patterns, and religious practices. To collect data accurately, both the client and nurse must actively participate. Data can be subjective or objective and constant or variable types, and from a primary or secondary source. Types of Data Subjective data: Itching, pain, and feeling of worry are examples of subjective data. Objective data , also referred to as signs or overt data, are detectable by an observer or can be measured or tested against an accepted standard. They can be seen, heard, felt, or smelted, and they are obtained by observation or physical examination. For example, a discoloration of the skin or a blood pressure reading is objective data. Variable data can be change quickly, frequently, or rarely and include such data as blood pressure, age, and level of pain. Source of Data Sources of data are primary and secondary. The client is the primary source of data. Family member or other support persons, other health professionals, records and reports, laboratory and diagnostic analyses, and relevant literature are secondary or indirect sources. Data Collection Methods The principal methods used to collect data are observing, interviewing, and examining. Observing To observe is to gather data by using the senses. Observation is a conscious, deliberate skill that is developed through effort and with an organized approach. Interviewing An interview is a planned communication or a conversation with a purpose, for example, to get or give information, identify problems of mutual concern, evaluate change, teach, provide support, or provide counseling or therapy. There are two approaches to interviewing: The directive interview is highly structured and elicits specific information. The nurse establishes the purpose of the interview and controls the interview, at least at the outset. During a non-directive interview, or rapport-building interview, by contrast, the nurse allows the client to control the purpose, the subject matter, and pacing. Rapport is an understanding between two or more people. Examining The physical examination or physical assessment is a systematic data collection method that uses observation i. To conduct the examination the nurse uses techniques of inspection, auscultation, palpation, and percussion. Organizing Data The nurse uses a written or computerized format that organizes the assessment data systematically. This is often referred to as a nursing history, nursing assessment or nursing data-base form. Validating Data The information gathered during the assessment phase must be complete, factual and accurate because the nursing diagnoses and interventions are based on this information. Validating data helps the nurse to complete these tasks: Ensure that assessment information is complete Ensure that objective and related subjective data agree Obtain additional information that may have been over-looked. Differentiate between cues and inferences. Cues are subjective or objective data that can be directly observe by the nurse; that is, what the clients says or what the nurse can see, hear, smell, or measure. Avoid jumping to conclusions and focusing in the wrong direction to identify problems. Documenting Data To complete the assessment phase, the records client data. Data are recorded in a factual manner and not interpreted by the nurse. Restating in other words what someone says increase the chance of changing the original meaning. Nursing diagnosis is a pivotal step in the nursing process. Activities preceding this phase are directed toward formulating the nursing diagnoses ; the care-planning activities following this phase are based on the nursing diagnoses. Types of nursing diagnoses The five types of nursing diagnoses are actual, risk, wellness, possible, and syndrome. An actual nursing diagnosis is a client problem that is present at the time of the nursing assessment. Examples are ineffective breathing pattern and anxiety. An actual nursing diagnosis is based on the presence of associated signs and symptoms. A risk nursing diagnosis is a clinical judgment that a problem does not exist, but the presence of risk factors indicates that a problem is likely to develop unless nurses intervene. For example, all people admitted to hospital have some possibility of acquiring an infection; however, a client with diabetes or

a compromised immune system is at higher risk than others. Therefore, the nurse would appropriately use the label risk for infection to describe the clients health status. Examples of wellness diagnoses would be readiness for enhanced spiritual well-being or readiness for enhance family coping. A possible nursing diagnosis is one in which evidence about a health problem is incomplete or unclear. A possible diagnosis requires more data either to support or to refute it. Fro example, an elderly widow who lives alone is admitted to the hospital. The nurse notices that she has no visitors and is pleased with attention and conversation from the nursing staff. Until more data are collected, the nurse may write a nursing diagnosis of possible social isolation related to unknown etiology. Risk for disuse syndrome, for example, may be experienced by long-term bedridden clients. Clusters of diagnoses associated with this syndrome include impaired physical mobility, risk for impaired tissue integrity, risk for activity intolerance, risk for constipation, risk for infection, risk for injury, risk for powerless, impaired gas exchanged, and so on. In the diagnostic process, analyzing involves the following steps: Compare date against standards identify significant cues. Cluster cues generate tentative hypothesis. Identify gaps and inconsistencies. For experienced nurses, these activities occur continuously rather than sequentially. Comparing data with Standards Nurses draw a knowledge and experience to compare client data to standards and norms and identify significant and relevant cues. A standard or norm is generally accepted measure, rule, model, or pattern. The nurse uses a wide range of standards, such as growth and developmental patterns, normal vital signs, and laboratory values. Clustering Cues Data Clustering or grouping cues is a process of determining the relatedness of facts and determining whether any patterns are present, whether the data represent isolated incidents, and whether the data are significant. This is the beginning of synthesis. Identifying Gaps and Inconsistencies Skillful assessment minimizes gaps and inconsistencies in data. However, data analysis should include a final check to ensure that the data are complete and concrete. Inconsistencies are conflicting data. Possible sources of conflicting data include measurement error, expectations, and inconsistent or unreliable reports. Identifying Health Problems, Risks, and Strengths After data are analyzed, the nurse and client can together identify strengths and problems. This is primarily a decision-making process. Determining Problem and Risks After grouping and clustering the data, the nurse and client together identify problems that support tentative actual, risk, and possible diagnosis. Most people have a clearer perception of their problems or weaknesses than of their strengths and assets, which they often take for granted. By taking inventory strengths, the client can develop a better-rounded self concept and self image. Strengths can be an aid to immobilizing health and regenerative processes. Formulating Diagnostic Statements Most nursing diagnoses are written as two-part or three-part statements, but there are variations of these. Basic Two-Part Statements The basic two-part statement includes the following: The two-parts are joined by the words related to rather than due to. The phrase due to implies that one part causes or is responsible for the other part. By contrast, the phrase related to merely implies a relationship. Actual nursing diagnoses can be documented by using the three-part statement because the signs and symptoms have been identified. This format cannot be used for risk diagnoses because the client does not have signs and symptoms of the diagnosis. The PES format is especially recommended for beginning diagnosticians because the signs and symptoms validate why the diagnosis was chosen and make the problem statement more descriptive. As the diagnostic labels are refined, they tend to become more specific, so that nursing interventions can be derived from the label itself. Therefore, an etiology may not be needed. For example, adding an etiology to the label Rape-Trauma Syndrome does not make the label any more descriptive or useful. Evaluating the Quality of the Diagnostic Statement In addition, to using the correct format, nurse must consider the content of their diagnostic statements. The statements should, for example, be accurate, concise, descriptive, and specific. The end product of the planning phase is a client care plan. Nurses do not plan for the client, but encourage the client to participate actively to the extent possible. Types of planning Planning begins with first client contact and continues until the nurse-client relationship ends, usually when the client is discharge from the health care agency. All planning is multidisciplinary involves all health care providers interacting with the client and includes the client and family to the fullest extent possible in every step. Initial planning The nurse who performs the admission assessment usually develops the initial comprehensive plan of care. Planning should be initiated as soon as possible after the initial assessment,

especially because of the trend toward shorter hospital stays. Ongoing planning Ongoing planning is done by all nurses who work with the client. Ongoing planning also occurs at the beginning of a shift as the nurse plans the care to be given that day. Using ongoing assessment data, the nurse carries out daily planning for the following purposes: Because the average stay of clients in acute care hospitals has become shorter, people are sometimes discharge still needing care. Although many clients are discharge to other agencies e. Developing a nursing care plan The end product of the planning phase of the nursing process is a formal or informal plan of care.

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Nursing process is a systematic, rational method of planning and providing nursing care. Its purpose is to identify a client's health care status, and actual or potential health problems, to establish plans to meet the identified needs, and to deliver specific nursing interventions to address those needs.

The planning step of the nursing process includes which of the following activities? Assessing and diagnosing Performing nursing actions and documenting them. Setting goals and selecting interventions. The nursing care plan is: A written guideline for implementation and evaluation. A documentation of client care. A projection of potential alterations in client behaviors A tool to set goals and project outcomes. After determining a nursing diagnosis of acute pain, the nurse develops the following appropriate client-centered goal: Encourage client to implement guided imagery when pain begins. Determine effect of pain intensity on client function. Administer analgesic 30 minutes before physical therapy treatment. Pain intensity reported as a 3 or less during hospital stay. When developing a nursing care plan for a client with a fractured right tibia, the nurse includes in the plan of care independent nursing interventions, including: Apply a cold pack to the tibia. Elevate the leg 5 inches above the heart. Perform range of motion to right leg every 4 hours. Administer aspirin mg every 4 hours as needed. Which of the following nursing interventions are written correctly? Select all that apply. Apply continuous passive motion machine during day. Elevate head of bed 30 degrees before meals. Change dressing once a shift. The nurse first considers: Calling the wound care nurse Changing the wound care treatment. Consulting with another nurse. When calling the nurse consultant about a difficult client-centered problem, the primary nurse is sure to report the following: Length of time the current treatment has been in place. The primary nurse asked a clinical nurse specialist CNS to consult on a difficult nursing problem. The primary nurse is obligated to: Report the recommendations to the primary physician. Clarify the suggestions with the client and family members. Discuss and review advised strategies with CNS. After assessing the client, the nurse formulates the following diagnoses. Place them in order of priority, with the most important classified as high listed first.