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Nursing Process

Nursing Foundation

Assessment, nursing diagnosis, planning, implementation and evaluation; nursing care plans, documentation and clinical decision-making.

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06. NURSING PROCESS

1. Definition

The nursing process is a systematic, patient-centred method used to identify health needs, plan nursing interventions, provide care and evaluate outcomes.

2. Characteristics

- Systematic
- Dynamic
- Individualized
- Goal-oriented
- Evidence-based
- Problem-solving
- Continuous and cyclical

3. Steps of Nursing Process - ADPIE

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

Outcome identification may also be described as a separate step in professional nursing standards.

4. Assessment

Assessment is the systematic collection, validation and documentation of patient information.

Types

- Initial assessment.
- Focused assessment.
- Emergency assessment.
- Ongoing or time-lapsed assessment.

Types of Data

Subjective data	Objective data
Information reported by the patient	Observable or measurable findings
Pain, nausea and dizziness	Temperature, pulse and laboratory results

Sources of Data

- Patient.
- Family members.
- Clinical records.
- Physical examination.
- Healthcare professionals.
- Diagnostic investigations.

5. Nursing Diagnosis

A nursing diagnosis is a clinical judgment about human responses to health conditions, life processes or vulnerability to those responses.

Types

- Problem-focused diagnosis.
- Risk diagnosis.
- Health-promotion diagnosis.
- Syndrome diagnosis.

PES Format

- P: Problem.
- E: Etiology or related factors.
- S: Signs and symptoms.

Example: Acute pain related to surgical tissue injury as evidenced by patient-reported pain of 7/10.

Risk diagnoses are supported by risk factors rather than existing signs and symptoms.

Nursing Diagnosis vs Medical Diagnosis

Nursing diagnosis	Medical diagnosis
Focuses on human responses	Identifies a disease or medical condition
May change with patient response	Generally remains until condition changes
Guides nursing interventions	Guides medical treatment
Example: Impaired mobility	Example: Stroke

6. Planning

Planning involves prioritizing problems, establishing measurable outcomes and selecting appropriate interventions.

Priorities

- Immediate threats to life.
- Airway, breathing and circulation.
- Patient safety.
- Actual and potential health problems.
- Patient preferences.

SMART Outcomes

Specific, Measurable, Achievable, Relevant and Time-bound.

Example: Patient will report pain of 3/10 or less within one hour of the prescribed intervention.

7. Implementation

Implementation is the performance of planned nursing interventions.

Types of Interventions

- Independent: Within the nurse's authorized scope.
- Dependent: Based on an authorized prescription or order.
- Collaborative: Conducted with multidisciplinary team members.

Activities

- Provide direct nursing care.
- Administer prescribed treatment.
- Educate and support patients.
- Monitor responses.
- Coordinate services.
- Document care.

8. Evaluation

Evaluation determines whether expected outcomes have been achieved.

Possible results:

- Goal met.
- Goal partially met.
- Goal not met.

Revise the care plan according to new assessment findings.

9. Sample Nursing Care Plan

Clinical situation: Postoperative patient reporting acute pain.

Component	Description
Assessment	Patient reports pain 7/10; guarding observed
Nursing diagnosis	Acute pain related to surgical tissue injury
Goal	Pain will reduce to 3/10 or less within one hour
Planning	Assess pain, provide comfort and administer prescribed analgesia
Implementation	Assess pain, position comfortably, provide prescribed medication and monitor response
Rationale	Assessment guides treatment; analgesia and comfort measures reduce suffering
Evaluation	Reassess pain and document whether the goal was achieved

10. Clinical Decision-Making

Clinical decision-making requires:

- Recognizing relevant patient findings.
- Interpreting clinical information.
- Prioritizing problems.
- Selecting safe interventions.
- Evaluating responses.
- Escalating deterioration.

11. Nursing Documentation

Record:

- Assessment findings.
- Nursing diagnoses.
- Planned interventions.
- Treatment provided.
- Patient responses.
- Changes in condition.
- Communication and escalation.
- Evaluation outcomes.

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Important Examination Questions

1. Define nursing process and explain its steps.
2. Differentiate subjective and objective data.
3. Explain nursing diagnosis and PES format.
4. Describe planning and implementation.
5. Prepare a nursing care plan for a selected patient problem.

Conclusion

The nursing process ensures systematic, individualized and goal-directed nursing care and promotes professional accountability.

Quick Revision

- The nursing process is systematic, patient-centred, dynamic and cyclical.

- ADPIE represents assessment, diagnosis, planning, implementation and evaluation.

- Assessment collects and validates subjective patient reports and objective measurable findings.

- Nursing diagnoses address human responses; medical diagnoses identify diseases or medical conditions.

- Planning prioritizes problems and selects SMART outcomes: specific, measurable, achievable, relevant and time-bound.

- Implementation performs planned interventions; evaluation judges outcomes and guides care-plan revision.

Practice questions

Choose one best answer. The answer key and explanations follow the questions.

1. Which finding is subjective assessment data?

A. Measured temperature
B. Laboratory potassium result
C. Patient-reported nausea
D. Observed pulse rate

2. What supports a risk nursing diagnosis?

A. Existing signs only
B. An existing disease label only
C. A completed intervention
D. Risk factors

3. Which nursing-process step determines whether expected outcomes were achieved?

A. Planning
B. Evaluation
C. Diagnosis
D. Implementation

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4. A postoperative patient reports pain of 7/10. After the prescribed intervention, what best evaluates the care-plan outcome?

A. Assume that giving the medicine means the goal is met

B. Ask a colleague to estimate pain without assessing the patient

C. Reassess pain and function within the planned interval and compare with the stated goal

D. Delete the original pain assessment

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Answer key and explanations

1. C - Patient-reported nausea

Subjective data are reported by the patient.

2. D - Risk factors

Risk diagnoses use risk factors rather than existing signs and symptoms.

3. B - Evaluation

Evaluation compares outcomes with the expected goals.

4. C - Reassess pain and function within the planned interval and compare with the stated goal

Evaluation compares the patient response with a measurable outcome. Completing an intervention does not establish that it worked.

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