

Health Promotion

Nursing Process

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Nursing Process

- The nursing process is a problem-solving method that involves gathering and interpreting data to formulate a plan of care.
- The nursing process is a scientific method used by nurses to ensure the quality of patient care.


used to:

- Identify needs of the patient.
- To establish priorities of care.
- To maximize strengths.
- To resolve actual & or potential patient problem.
- To apply health promotion to possible for each patient



Nursing process is consider as:

- *Theory for practice.
- * Systematic overview of action.
- *A problem solving approach.


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- Documenting the nursing process is the ability to record communicated nursing skills in a

1. Accurately

2. Concisely

3. Timely

4. Relevant , to provides the member of the care giver a complete picture of the patient health.

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- The nursing process in health promotion utilizes the original steps of assessing, diagnosing, planning, implementing, and evaluating. The primary foci in it when utilized for health promotion appear to be its emphasis on wellness without a primary physical or mental condition, empowerment of the client, promotion of lifestyle changes, and health enforcement. The nurse looks at potential illnesses or problems and then seeks to provide preventive measures. Use of the nursing process in health promotion is congruent with Pender Health Promotion model (1996) in that it seeks to increase wellness and actualize human potential.

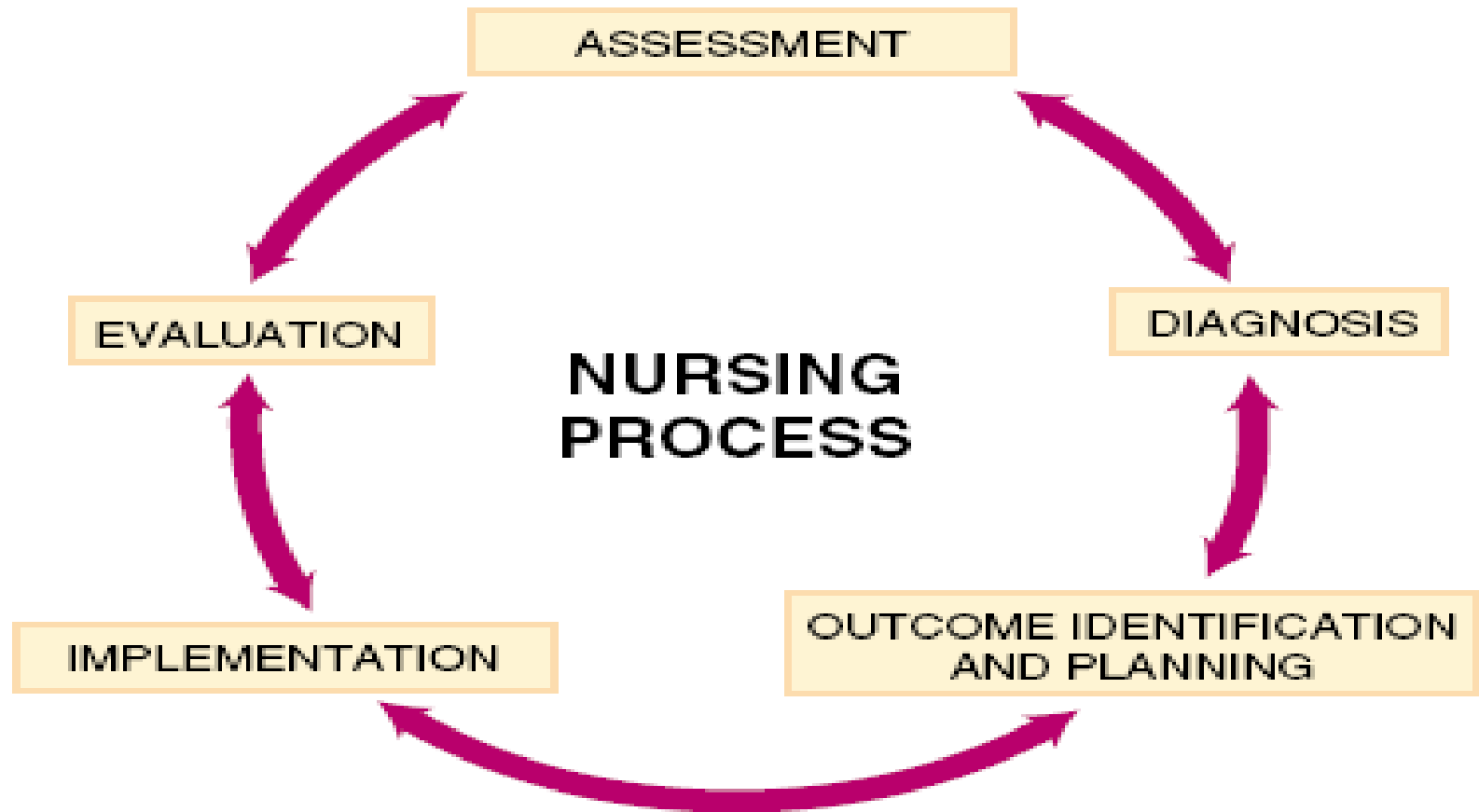


Figure 5-1 Components of the Nursing Process

1.Assessment:

Is the first steps of nursing process and it is systematic approach of data collection data analysis and interpretation for needs and problems identification .

The data may be subjective or objective or historical or current are collected from various sources such as the client interview and physical assessment etc. Subjective data are what the client or significant others report(symptoms), believe, or feel, and objective data are what can be observed ,described and verified by nurse (signs)or obtained from other sources, such as laboratory and diagnostic studies, old medical records, or other healthcare providers.

Sources of the data

- 1-patient , is the primary source of information.
- 2-family &significant others , friends.
- 3- patient record , records from members of health care , provide essential information related to him.
- 4-Medical history ,physical examination ,& progress notes.
- 5-laboratory test &other health professions.

TYPES OF ASSESSMENT

-Initial assessment ; is performed shortly after patient admission to a health agency or hospital . Often includes: health history, physical exam,

psychosocial assessment

-Focused assessment ; the nurse gathers data about a specific problem that has already been identified.

-Emergency assessment , the nurse performs this type of assessment on a physiological or psychological crisis to identify the life – threatening problems. Assessment follows ABCs

-Time – lapsed assessment , this assessment done to compare a patients current status to the base line data obtained earlier . Occurs after initial assessment & period of time.

Nursing Diagnosis

the 2nd step of nursing process. Is a clinical judgment about individual , family or community response to actual or potential health problem. It provides the bases for selection of nursing intervention.

- Activities of nursing diagnosis

- *Interpret & analyze patient data.

- *Identify patient strength and health problem.

- *Detect & refer signs and symptoms that may indicate a problem beyond the nurses.

Parts of Nursing Diagnosis

- *Problem ; statement that describe the health problem of the patient clearly & concisely.

- *Etiology ; The reason (etiology)that identifies the physiological , psychological ,social ,spiritual & environmental factors related to the problem

- *Defining characteristics (signs or symptom).

The subjective & objective data that signal the existence of the problem

Planning

- The third step of the nursing process 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.
- For the nursing diagnosis , a plan of care is formulated and implemented.
- The step in the nursing process that includes measurable goal setting, realistic goals, identification of time frame and recognition of potential problems
- Planning is approach by which a plan of action can be formulation: goal(needs and problems) , resources (personal ,funds ,material),and alternative .



Objective of planning :

1. There are need to be meet.
2. There are problem to be solved.
3. There are desire for change.

Type of planning


- The type of planning are depend on objective of plan can be classified to:
 1. Single use plan
 2. Short term plan
 3. Intermediate plan
 4. Long term plan
 5. Permanent plan

The four critical elements of planning include:

- Establishing priorities
- Setting goals and developing expected outcomes
(outcome identification)
- Planning nursing interventions (with collaboration and consultation as needed)
- Documenting

Implementation

- Intervention , which are based on the nursing diagnoses , are nursing actions that enable the person to achieve desire goal. Interventions for health promotion and /or health protection are identified during the implementation phase.
- Intervention directed at health promotion are motive by the desire to increase wellness , while health protection intervention are motivation by a patients desire to avoid illness.

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- Patient intervention are determined by primary , secondary , or tertiary prevention
 - The intervention can be direct or indirect .
 - Is an approach through which an nursing plan of action can be implemented (practice , performance , review and revision).

Benefits of implementation :

1. Implement of nursing care plan.
2. Identify strengths and weakness of the plan.
3. Review and revise the nursing plan for modification or change .
4. To overcome specific health problems or need.

Types of interventions

1. Dependent
2. Independent
3. Collaborative

Evaluation and re Evaluation

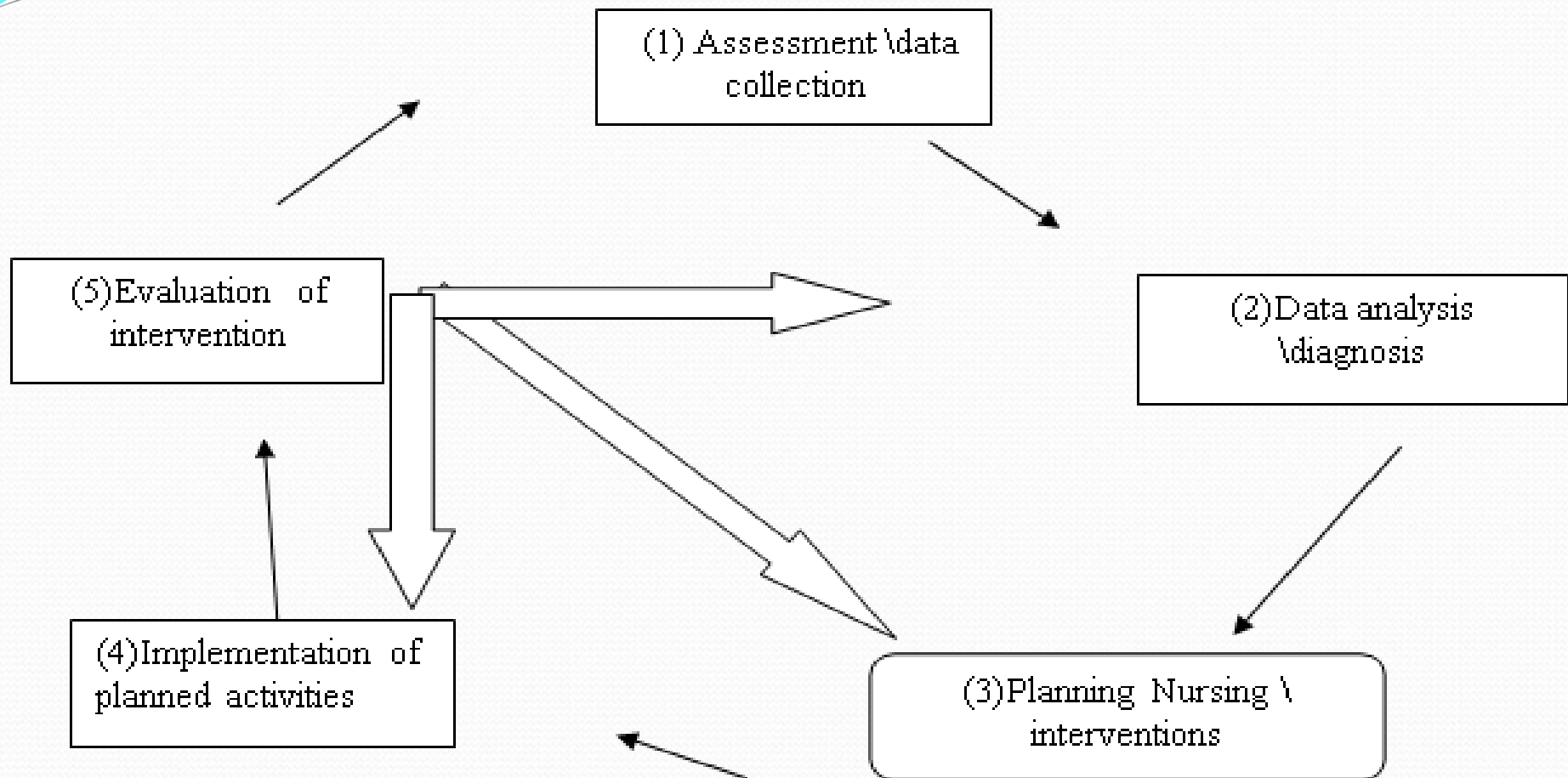
- It is judgment oriented approach by which the outcome the nursing process can be accredited (evaluated)and the effectiveness of nursing plan of action can be measured .
- Approach by which decision can be make concerning the outcome and values based are generated .
- **Evaluating compliance**(quality assurance and performance appraisal).
- Role of evaluation to assess the outcome(positive or negative).
- Reevaluation : to repaid plan positional to ward benefit of nursing process .

Advantage of evaluation

1. To determine the relevancy of nursing plan.
2. To determine the impact of plan
3. To determine the progress of plan.
4. To estimate the sufficiency of nursing plan
5. To estimate the cost of plan .

Approaches for evaluation

1. Observation
2. Survey
3. Field study
4. Case- control study
5. Quazi – experimental study
6. Experimental study
7. Pre – post test study



Relationship of Evaluation and reevaluation to Nursing Process



Thank you for All