Advanced Concept of Nursing- I

UNIT 1: OVERVIEW OF NURSING PROCESS AND OVERVIEW OF NANDA

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Objectives

• At the end of the unit, students will be able to:
  1. Define the purposes of nursing process
  2. Review the components of the nursing process.
  3. Formulate nursing diagnosis
  4. Develop a concept map-Nursing Care Plan
  5. Describe the Functional Health approach to nursing process
Overview of NANDA

• NANDA (North American Nursing Diagnosis Association) was founded in 1982.

• The First National Conference on the Classification of Nursing Diagnoses, held in 1973 in St. Louis, Missouri, USA.

• In 2002, NANDA became NANDA International (NANDA-I) to reflect increasing worldwide interest in the field of nursing diagnosis terminology.

• NANDA International has approved more than 200 nursing diagnoses for clinical use, testing and refinement.
Conti...

• 1973 - 1979
• BEGINNINGS
• Held First Task Force Meeting to Name and Classify Nursing Diagnoses
  – Dr. Marjory Gordon serves as chairperson

• Established First Clearinghouse for Nursing Diagnoses Resources
  – Served as a depository for nursing diagnosis materials and National Conference Group on the classification of Nursing Diagnoses

• Published First Conference Proceedings
  – Edited by Gebbie and Lavin
Continued...

- 1980 – 1989
- **MOMENTUM AND CONNECTIONS**
  - Established North American Nursing Diagnosis Association (NANDA) in *1982*.
    - Dr. Marjory Gordon elected as *first president of NANDA*. Dr. Gordon was re-elected in 1986 and served until 1988.
  - NANDA and American Nurses Association Developed Nursing Diagnosis Collaboration Model in *1987*
  - Facilitated International Participation in NANDA in *1988*
    - Jane Lancour elected as second president of NANDA.
• 1990 – 1999
• PUBLICATION, COLLABORATION & CELEBRATION!
• Published Nursing Diagnosis - The Official Journal of the North American Nursing Diagnosis Association in 1990 by published by J. B. Lippincott

• Held First Joint Meeting of the NANDA, NIC and NOC (National Outcome Classification) in 1997 and also Journal title changes to International Journal of Nursing Terminologies and Classifications.

• Celebrated NANDA’s 25th Anniversary in in St. Louis, MO. In 1998!
Conti...

• 2000 – 2009

• A WORLD VIEW

• NANDA becomes NANDA International in 2002

• Online System Launched for Worldwide Membership Review of Nursing Diagnosis Submissions in 2008

• Published Taxonomy II in 2002
Conti...

• 2010 – Present

• CELEBRATING 40 YEARS AND LOOKING FORWARD

• The organization celebrates its 40th Anniversary in May, 2012.

• NANDA-I becomes an affiliate member of the International Council of Nurses (ICN) in 2010.

• The NANDA-I journal, International Journal of Terminologies and Classification, is relaunched as the International Journal of Nursing Knowledge in 2010.

• The PRONANDA Continuing Education Program is launched in 2013, in Portuguese.
Definition

ICN Definition of Nursing

• “Nursing Encompasses Autonomous and Collaborative Care of Individuals of All Ages, Families, Groups and Communities, Sick or Well and in All Settings”

• “Nursing Includes the Promotion of Health, Prevention of Illness, and the Care of Ill, Disabled and Dying People”

• “Advocacy, Promotion of a Safe Environment, Research, Participation in Shaping Health Policy and in Patient and Health Systems Management, and Education are Also Key Nursing Roles”

(International Council of Nurses, 2010)
Conti…

- Organizational framework for the practice of nursing

- Nursing process is a patient centered, goal oriented method of caring that provides a framework to the nursing care. It involves five major steps of assessment, nursing diagnosis, planning, and implementation and evaluating.
Purposes of Nursing Process

• Continuity of care
• Prevention of duplication
• Individualized care
• Standards of care
• Increased client participation
• Collaboration of care
Characteristics of nursing process

1. Cyclic and Dynamic
   – Nursing process has unique properties that enable it to respond to changing health

2. Systematic
   – It is well organized and applied stepwise.

3. Client Centered
   – Nurse organize the plan of care according to client problem

4. Universal applicable
   – It is applicable/ useful not only for disease but also in wellness

5. Problem solving
   – In this process nurse solve the patient’s health problem.

6. Scientific
   – It is scientific in nature.
Components of the nursing process.

- Six phases per the ANA or a modified 5 phases (ADPIE).

1. Assessment
   Information collection/gathering data

2. Diagnosis
   Information interpretation
   Stating problems and strengths

3. Planning
   Setting goals with patients and choosing interventions

4. Implementation
   Performing nursing interventions

5. Evaluation
   Patient’s status and effectiveness of nursing interventions

8/22/2016
Shahzad Bashir, Lecturer NLCON
Relationships among the steps of the nursing process.

Nursing Diagnosis

• 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)

• The first conference on nursing diagnosis was held in 1973 to identify nursing knowledge and establish a classification system to be used for computerization.
## Difference between nursing diagnosis and medical diagnosis

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<tr>
<th>S #</th>
<th>Nursing diagnosis</th>
<th>Medical diagnosis</th>
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<tbody>
<tr>
<td>1.</td>
<td>Nursing diagnosis is based on health problems.</td>
<td>Medical diagnosis is based on the physiologic conditions.</td>
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<td>2.</td>
<td>Nursing diagnosis can be changed at any time.</td>
<td>It remains same throughout course of disease</td>
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<td>3.</td>
<td>Nursing diagnoses focus on human response to stimuli.</td>
<td>Medical diagnosis focus on the disease process</td>
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Types of Nursing Diagnosis

1. Actual diagnosis (Sometimes Referred to as a “Problem” Diagnosis): describes health conditions that exist and supported by defining characteristics

2. Risk diagnosis: those which describe disease or other conditions that may develop and are supported by risk factors

3. Wellness diagnosis: describe levels of wellness and potential for enhancement to a higher level of functioning

Components of a Nursing Diagnosis

• **Actual or Problem Nursing Diagnoses are Composed of:**

  • **Nursing Diagnosis Label and Problem Definition**
    ⇒ Naming and Defining the Problem

  • **Etiologies or Causes**
    ⇒ Related Factors

  • **Signs and Symptoms**
    ⇒ Defining Characteristics
Components of a Nursing Diagnosis

1. **Label or Name and definition:** the label is selected base upon a matching the related factors or defining characteristics and the definition of the label validates your decision.

2. **Related Factors OR Risk Factors:** which describe conditions antecedent to or associated with the diagnosis OR

   Risk factor(s) which describe the environmental factors and physiologic, genetic or chemical elements that increase the vulnerability of a (client) to an unhealthful event (NANDA, 2009)

3. **Defining Characteristics:** which are observable signs and symptoms that are manifestations of the diagnosis (Denehy & Poulton. 1999)
Case Study

- 4 year old boy with ALL
- Admitted one week after chemo with a fever of 102.5F
- WBC is 0.3, absolute neutrophil count is zero
- New central line placed 10 days ago
- C/O nausea & vomiting
- Cries and hides behind mother when approach by nursing staff.
Examples

• 1. Risk for infection related to immunosuppression secondary to chemotherapy, inadequate primary defenses (central venous catheter), chronic disease (ALL) and developmental level.
Was our choice correct?

- **Definition of the label:** At increased risk for being invaded by pathogenic organisms
- **Risk Factors:**
  - Insufficient knowledge to avoid exposure to pathogens (developmental level)
  - Inadequate secondary defenses (leukopenia)
  - Inadequate primary defenses (broken skin from newly placed central line)
  - Pharmaceutical Agents (immunosuppressant, i.e. chemotherapy)

(NANDA, 2009)
Examples

• 2. Nausea related to chemotherapy as evidenced by vomiting, patient c/o “tummy ache” and aversion toward food.
Examples

• 3. Fear related to unfamiliarity with environmental experiences as evidenced by avoidance behaviors (hides behind mother) and crying.
# Nursing Care Plan

## Peptic Ulcer

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<th>ASSESSMENT</th>
<th>DIAGNOSIS</th>
<th>PLANNING</th>
<th>INTERVENTION</th>
<th>RATIONALE</th>
<th>EVALUATION</th>
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| SUBJECTIVE: "Sumasakit ng timog ng pares (I’ve been experiencing abdominal pain immediately after eating) as verbalized by the patient."
- Abdominal guarding
- Restlessness
- Facial grimacing
- Pain scale of 6 out of 10
- V/S taken as follows:
  - T: 37.5°C
  - P: 65
  - R: 14
  - BP: 110/80 | Acute pain r/t Chemical burn of gastric mucosa | After 8 hours of nursing intervention the patient will verbalize relief of pain. >Demonstrate relaxed body posture and be able to sleep/rest appropriately. | Independent
- Note reports of pain, including location, duration, intensity (0–10 scale) | Pain is not always present, but if present should be compared with patient’s previous pain symptoms. This comparison may assist in diagnosis of etiology of bleeding and development of complications. Goal met, patient has verbalized relief of pain. >Demonstrated relaxed body posture and be able to sleep/rest appropriately. | |
| OBJECTIVE: | | | | | |
| PLANNING | INTERVENTION | RATIONALE | EVALUATION |
| Hospitalized | | | |
| **OVERALL GOAL:** Relieve abdominal pain |
| **NURSE’S GOALS:** | | | |
| 1. Pain relief | | | |
| 2. Comfortable body position | | | |
| 3. Hydration and nutrition | | | |

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<td>• Provide and implement prescribed dietary modifications.</td>
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<td>• Administer medications as indicated</td>
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<td>• Analgesics, e.g., morphine sulfate</td>
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<td>• Antacids</td>
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<td>• Anticholinergics, e.g., belladonna,</td>
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- May be narcotic of choice to relieve acute/severe pain and reduce peristaltic activity. Note: Meperidine (Demerol) has been associated with increased incidence of nausea/vomiting.
- Decreases gastric acidity by absorption or by chemical neutralization. Evaluate choice of antacid in regard to total health picture, e.g., sodium restriction.
- May be given at bedtime to decrease gastric motility, suppress acid production, delay gastric emptying, and alleviate nocturnal pain associated with gastric ulcer.
Functional Health Patterns

• Functional Health Patterns developed by Marjory Gordon in 1987.

• Marjory Gordon is a nursing theorist and professor who created a nursing assessment theory known as Gordon's functional health patterns. Gordon served in 1973 as the first president of the *North American Nursing Diagnosis Association (NANDA)* until 1988.
Marjory Gordon developed a way to make nursing assessment more effective; Gordon’s functional patterns as they are known are the following:

1. Health perception and management
2. Nutrition and metabolism
3. Elimination
4. Activity and exercise
5. Sleep and rest
6. Cognition and perception
7. Self-perception and self-concept
8. Roles and relationships
9. Sexuality and reproduction
10. Coping and stress management
11. Values and beliefs
References

