The Nursing Process and Diagnosis Based on Patient Data Essay

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The role of nurses in patient care in the healthcare facilities includes a broad range of responsibilities. Therefore, nurses need to thoroughly plan their activities to make sure that they solve the acute problems first before making other interventions. Therefore, Jean Orlando, a nurse by profession, developed a series of steps to be taken when managing the patients (as cited in Haapoja, 2014, p. 1). Significantly, nurses have to use their critical thinking skills while applying their scientific knowledge to ensure that patients benefit immensely from nursing interventions. The procedure suggested by Orlando has undergone a series of changes and currently contains five steps that include assessment, diagnosis, planning, implementation, and evaluation. The content of this paper explains the nursing process in detail and analyzes how nurses reach a nursing diagnosis based on the subjective and objective data.

Assessment

The initial step in the nursing process is assessment, and it involves the collection of data. Using this data, nurses can establish the database for the development of an appropriate plan. The data collected here is objective, what the nurse observes, and subjective, what the client feels. Munroe, Curtis, Considine, and Buckley (2013) argue that assessment has a significant impact on patient care because it determines the outcome. For that reason, nurses observe the patients as soon as possible when the latter are admitted to the hospital. Additionally, family health nurses and community health nurses use this step to identify the needs of the family and the community respectively. After collecting necessary data, nurses proceed to the diagnosis stage.

Diagnosis

At this stage, nurses identify patient's problems. The problem may be actual or potential. Since the nursing process involves the collection of holistic data, nurses usually come up with various diagnoses. For instance, a patient may be in pain and feel anxious at the same time. The nurse identifies the pain and relates it to the cause since it is the most urgent need. Then, the nurse proceeds to anxiety and associates it with the cause. Finally, the nurse makes a proper diagnosis related to the problem, considering the evidence. For example, pain related to head injury the patient has mentioned. This diagnosis means that the head injury causes pain, and only the patient can feel the pain. From this diagnosis, the nurse can create a proper plan to address the problem.

Planning

At this stage, the nurse develops a plan within a given timeframe. The plan has to address the needs of the patient, family, and community. The nurse then prioritizes the problems.

The plan can only be implemented once the client and the nurse agree on the problems. The problems identified at the diagnosis stage are assigned Specific, Measurable, Achievable, Realistic, and Time-bound (SMART) goals (Mamseri, 2012). For instance, a nurse who takes care of a patient experiencing pain can set a goal to ensure that the client verbalizes reduced pain within 30 minutes. Setting an effective plan of care is important because it has a significant impact on the outcome for the patient. The nurse then proceeds to implementing the plan.

Implementation

Proper implementation happens where the nurse closely follows the developed plan. The interventions at this stage must be personalized, depending on the client, family or community. Most importantly, the interventions must begin by addressing the key problems before other issues are addressed. Nurses also need to consult the current literature while taking care of the patient. When evidence-based practice is applied to interventions, nurses can ensure high-quality care that can optimize patient outcome (Makic, Martin, Burns, Philbric & Rauen, 2013). Patient outcome is monitored at the evaluation stage.

Evaluation

At this final stage, nurses examine the outcomes of their actions. If the actions are not met sufficiently, nurses analyze the extent of the outcome and then plans to restart the process. Significantly, nursing process is not a rigid framework. The condition of the patient can change due to unavoidable factors, and the nurse has to start the whole process with new plans of action. The evaluation phase is also critical because it happens continuously and determines more interventions that the patient might need.

How to Develop a Nursing Diagnosis Based on Subjective and Objective Data

The subjective and objective data is obtained during the assessment phase of the nursing process. Subjective data is what the patient says he/she is experiencing. For instance, the nurse cannot diagnose pain or perceptions without the patient expressing them. Therefore, the nurse takes the time to listen to the patient, record the history and then associates the problem of the patient with the causative factor. For instance, pain related to the surgical incision as evidenced by the verbalization of the patient.

Objective data is what the nurse can see. The nurse can measure the vital signs and perform a physical examination to notice physiological abnormalities. The data obtained is then associated with the causative factor, and the nurse makes the diagnosis. For example, a patient with the temperature of 38 degrees C might be having hyperthermia related to infection.

Conclusion

The nursing process is important when managing various illnesses that patients complain about at the healthcare setting. The process not only addresses critical concerns but also handles problems beyond the disease. In this regard, nurses collect comprehensive data

that they use to deliver holistic care. Most importantly, nurses manage the urgent needs of patients. Additionally, nurses have to consider the complaints of a patient while making a clinical judgment. Therefore, subjective and objective data is vital in the dynamic nursing process. The framework developed by Jean Orlando ensures that all concerns of the patients are addressed.

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