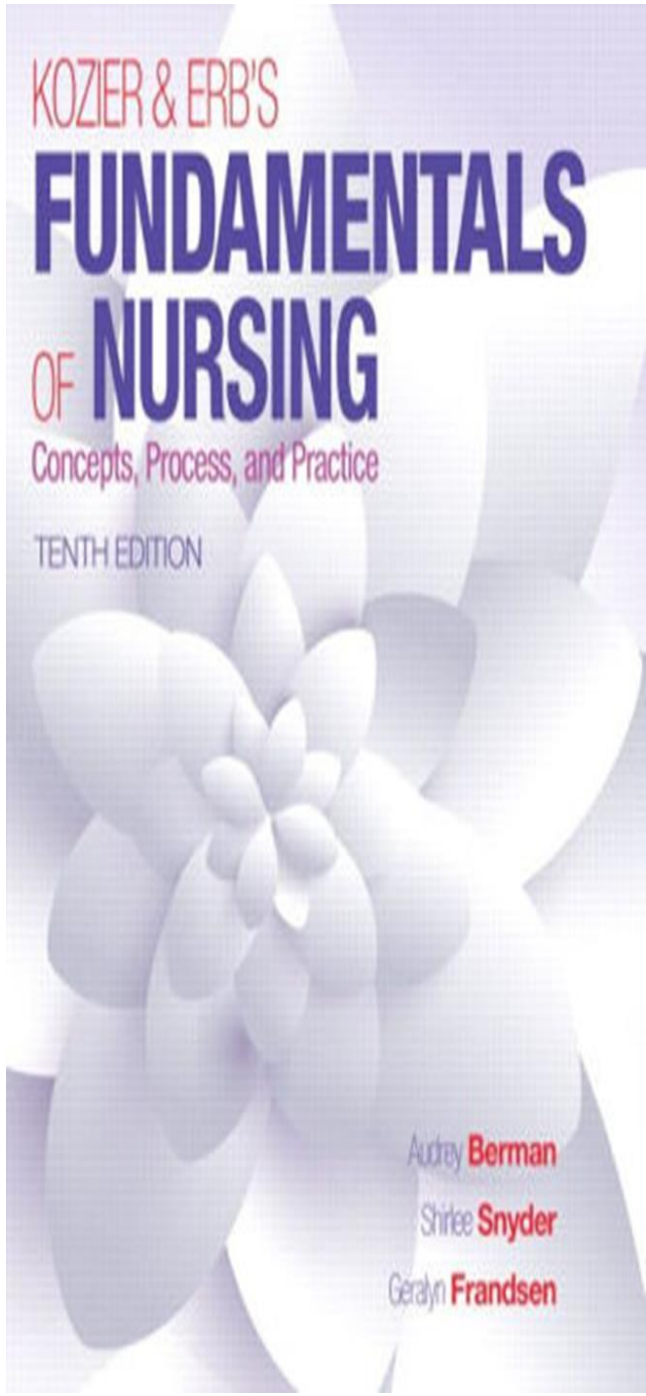
Fundamental of Nursing/ Theory

ZUJ. Course No. 0301113

Dr. N. Shawish



Fundamental of Nursing
Introduction

- Nursing is an art and a science.
- A professional nurse will learn to deliver care artfully with compassion, caring, and respect for each patient's dignity and personhood.
- As a science nursing practice is based on a body of knowledge that is continually changing with new discoveries and innovations.
- When nurse integrate the art and science of nursing into practice, the quality of care provide to patients is at a level of excellence that benefits patients and their families.

Fundamental of Nursing
Introduction

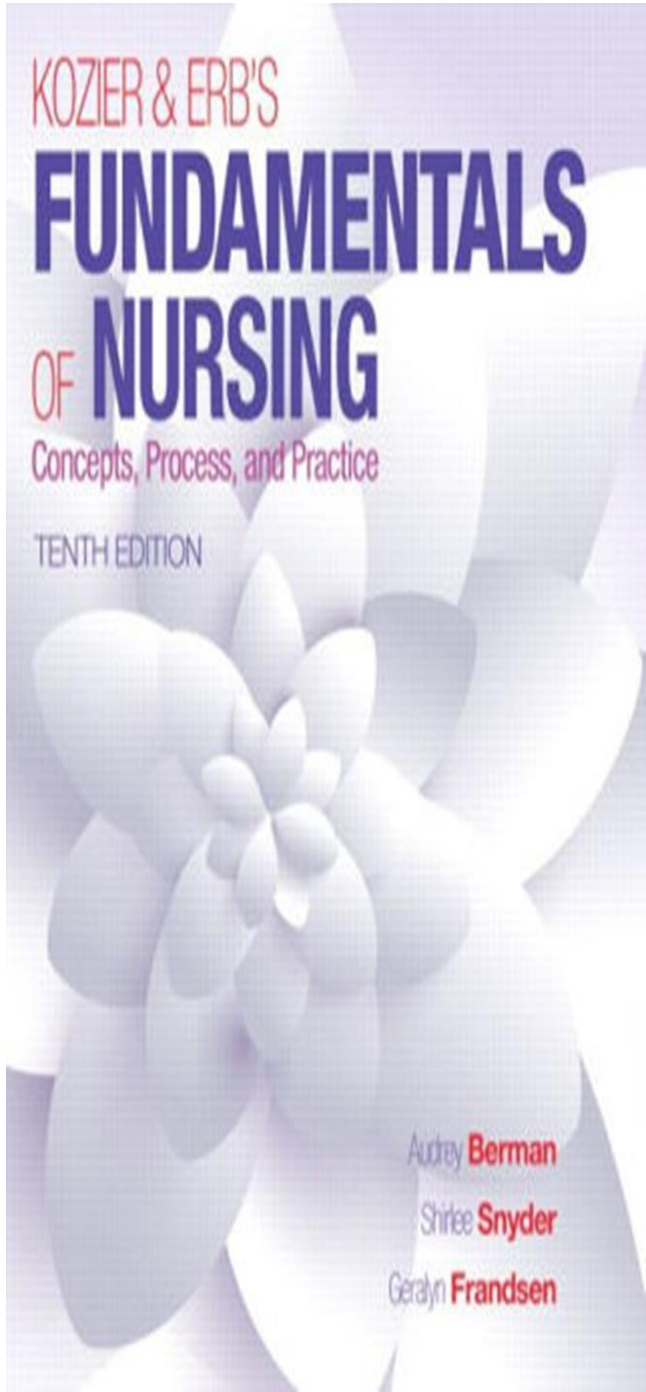
- Nursing opportunities for a career are limitless.
- There are a variety of career paths, including clinical practice, education, research, management, administration,.
- As a student it is important to understand the scope of nursing practice and how nursing influences the lives of patients

Unit 1

NURSING PROCESS

Overview of the nursing process:

- Assessment.
- Diagnosis
- Planning.
- Implementing action
- Evaluation.
- Documenting and Reporting.



Overview of the Nursing Process:

Process :It is a series of planned actions or operations directed towards a particular result or goal.

THE NURSING PROCESS

- A systematic problem-solving approach used to identify, prevent and treat actual or potential health problems and promote wellness.
- A systematic way to plan, implement and evaluate care for individuals, families, groups and communities.

NURSING PROCESS COMPONENTS

- Assessment.
- Diagnosis
- Planning.
- Implementing action
- Evaluation.
- Documenting and Reporting.

Characteristics of the Nursing Process

- Open, flexible
- Cyclical and Dynamic
- Client-centered
- Planned
- Goal directed.
- Emphasizes feedback
- Interpersonal and collaborative
- Permits creativity
- Universally applicable
- Humanistic and individualized
- Outcome focused (results oriented)

Skills needed to apply the Nursing Process

- Interpersonal skills communicating; listening; conveying; interest, knowledge, and information
- Technical skills: using equipment and performing procedures
- Intellectual skills :analyzing, problem solving, critical thinking and making nursing judgments.

NURSING PROCESS
1)ASSESSMENT

- Systematic and continuous collecting, organizing, validating, and recording data about a client's health status.
- It is a continuous process carried out during all phases of nursing process.
- All phases of the nursing process depend on the accurate and complete collection of data.

Types of Assessment

1. Initial Assessment:

Performed within specified time after admission to a health care agency

2. Problem Focused Assessment:

Ongoing process integrated with nursing care to determine specific problem identified in an earlier assessment and to identify new or overlooked problems. E.g.. Assessment of clients ability to perform self-care while assisting client to bathe.

Types of Assessment

3. Emergency Assessment:

Done during health crisis of the client to identify life threatening problems eg. assessment of airway, breathing and circulation during cardiac arrest

4. Time lapsed-Reassessment:

Done several months after initial assessment to compare the clients status to baseline data previously obtained.

Activities of Assessment Process

1- Collection of data

2- Organizing data

3- Validating data

4- Recording and documenting data

Activities of Assessment Process
1- Collection of Data:

It is the process of gathering information about a clients health status.

Data base: It is all information about a client.

It includes:

- Nursing health history,
- Physical assessment,
- The physician's history,
- Physical examination,
- Results of laboratory and diagnostic tests
- Material contributed by other health personnel.

Types of Data:

- **SUBJECTIVE DATA:**

✓It is symptoms or covert data are apparent only to person affected and can be described or verified only by that person eg. itching, pain, feelings of worry

- **OBJECTIVE DATA:**

✓It is signs or overt data.

✓These are detectable by an observer or can be measured or tested against an accepted standard.

✓They can be seen, heard, felt or smelled and they are obtained by observation or physical examination

eg. a blood pressure data discoloration of the skin

Sources of Data:

1) Primary source (Direct source)

- Client: best source

2) Secondary source (Indirect source)

- Family members
- Client's records

a. Medical records: eg. medical history, physical Examination

b. Records of therapies done by other health professionals eg. social workers, dieticians, physical therapist

c. Laboratory records

- Literature

Methods of Data Collection: I H O P E

I Interview

H History

O Observation

P Physical

E Examination

Data Collection Methods

1) Observation: Gather data by using the five senses

2) Physical assessment: Is a systematic data collection method that uses observational skills (senses of sigh, hearing, smell, and touch) to detect health problems.

3)Interviewing: Planned communication or a conversation with a purpose, to give information, identify problem of mutual concern, evaluate change, teach, provide support, or provide counseling or therapy

Types of interview

a. Directive interview by using closed questions required only yes or no answers
b. Nondirective interview : open ended questions allow patient to express feelings

Activities of Assessment Process

2- ORGANISING DATA: Nurses uses a written or computerized format for arranging he data systematically

3- VALIDATING DATA: The act of double checking or Verifies data to confirm that they are accurate and factual, by comparison with another source e.g Patient or family member, Record, Health team member

4- DOCUMENTING DATA: Record in permanent record , Use patient's own words in subjective data enclose in " ___" (quotation marks), be specific, avoid generalizations, The data should be written in details.

Nursing Process 2) Diagnosis

- It is a process of making clinical judgment (nursing diagnosis) about a client's potential or actual health problems.
- In diagnosis, interpretation to assessment data and identifying client strengths and problems.
- Nurses use **nursing diagnosis** to produce a statement of client's health status.

North American Nursing Diagnosis Association (NANDA)

Define diagnosis as

- "a clinical judgment about individual, family, or community responses to actual and potential health problems /life processes. Nursing Diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable".

Types of Nursing Diagnosis

1-Actual diagnosis. For example: ineffective breathing pattern.

2-A risk nursing diagnosis For example, all people admitted to a hospital have some possibility of acquiring an infection .“Risk for infection"

3-A possible nursing diagnosis : "Possible social isolation related to unknown etiology".

4-Wellness diagnosis :indicate a healthy response of a client who desires a higher level of wellness.

For example: potential for enhanced nutrition.

Components of NANDA Nursing Diagnosis

1) Problem (Diagnostic label)

- The problem statement, or diagnostic label, describes the client's health problem or response for which nursing therapy is given.
- It describes the client's health status clearly and concisely in a few words.

Components of NANDA Nursing Diagnosis

1) Problem (Diagnostic label)

e.g. knowledge deficit (dietary adjustment).

-Altered: change from baseline.

-Impaired: made worse, weakened, damaged, reduced, deteriorated.

-Decreased: smaller in size, amount, or degree.

-Ineffective: not producing the desired effect.

-Acute: severe or of short duration.

-Chronic: lasting along time, recurring, or constant.

Components of NANDA Nursing Diagnosis

2) Etiology (Related factors and risk factors)

- It identifies one or more probable causes of the health problem
- It gives direction to the required nursing therapy, and enables the nurse to individualize the client's care.
- For example: Activity intolerance, etiology /causes/related factors are: sedentary life-style, obesity, sensory deficits, and generalized weakness.

Components of NANDA Nursing Diagnosis

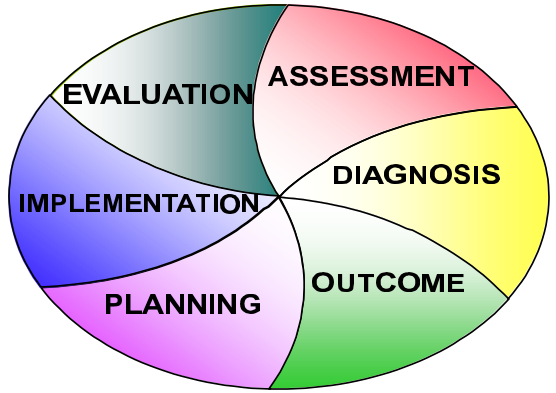
3) Defining Characteristics

- Defining characteristics are the cluster of signs and symptoms that indicate the presence of a particular diagnostic label.
- Defining characteristics are major (must be present) and minor (may be present).
- Major such as weak, tachycardia, hypotension, weakness, and fatigue;
- Minor such as pallor, cyanosis, vertigo, diaphoresis, and confusion.

Diagnostic Process Components:

1-Analyzing data:

a. Compare data with standards
b. Clustering cues
c. Identifying gaps and inconsistencies in data



2- Identifying health problems, risks, &strengths

a. Determining problems or etiologies.
b. Determining strength. The nurse establishes client's strength, resources, & abilities to cope.

3-Formulating diagnostic statements

a. Basic Two-Part Statements
b. Basic Three-Part Statements
c. One- Part Statement

A) Basic Two-Part Statements

- It is used for actual, high risk, and possible nursing diagnoses.
- It includes the following:
- Problem (P): statements of the client's response.
- Etiology (E): factors contributing to or causes of the response.

Two parts are joined by related to or associated with.

Examples: Ineffective breast- feeding **(Problem)** related to breast engorgement **(Etiology)**

B) Basic Three-Part Statements

- ✓Problem (P): statement of the client's response.
- ✓Etiology (E): factors contributing to or causes of the response.
- ✓Signs and symptoms: defining characteristics manifested by the client.
- ✓Actual nursing diagnosis can be documented by using three-part statement using related to and as manifested by, or as evidenced by, because the signs and symptoms have been identified.
- ✓This format cannot be used for high risk diagnosis, because the no any signs and symptoms.
- ✓The main disadvantage of this statement is creating very long problem statement.

An example: Ineffective airway clearance **(Problem**) related to accumulation of secretion**(Etiology)** as manifested by productive cough, wheezes **(Defining characteristics)**.

C) One- Part Statement

- Wellness diagnosis and syndrome nursing diagnosis.
- Etiology is unknown etiology (causes not known).
- **Examples**: Post-trauma response

Differences between nursing diagnosis & medical diagnosis

Nursing Diagnosis	Medical Diagnosis
▪ Describes an individual's ▪ response to a disease process, ▪ condition, or situation.	▪ Describes a specific disease ▪ process.
▪ Is oriented to the individual.	▪ Oriented to pathology.
▪ Changes as the client's responses change.	▪ Remains constant through out ▪ the duration of illness.
▪ Guides independent nursing activities: planning, intervening & evaluation.	▪ Guide medical management, ▪ some of which may be carried ▪ out by the nurse.
Self-care deficit: bathing, related to joint stiffness	Rheumatoid Arthritis

Nursing Process 3) PLANNING

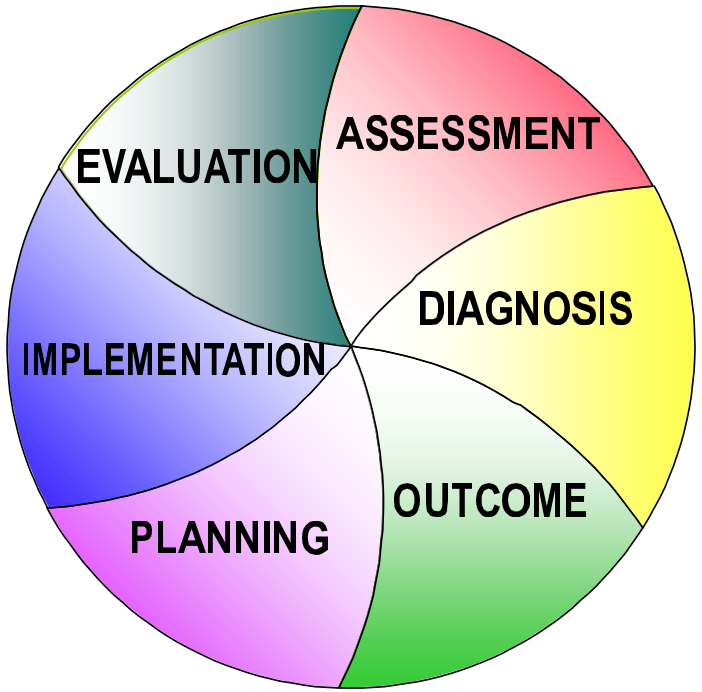
Planning is a deliberative, systematic phase of the nursing process that involves decision- making and problem solving. The product of the planning phase is a client care plan.

Types of Planning

1. Initial planning..

2. Ongoing planning.

3. Discharge planning.



Planning Process

It includes the following activities:

1) Setting priorities:

✓High priority

✓Medium priority

✓Low priority

2) Establishing client goals/expected outcomes.

✓A goal is broad statements about the effects of nursing interventions, desired outcome, or change in a client behavior.

✓Expected outcomes/objective/outcome criterion/predicted outcome is more specific, measurable criteria used to evaluate whether the goal has been met.

Characteristics of Outcome Criteria:

- **S** SPECIFIC
- **M** MEASURABLE
- **A** ATTAINABLE
- **R** REALISTIC
- **T** TIME – FRAMED

- **CAN BE SHORT TERM OR LONG TERM GOAL.**

Components of Expected Outcome Statement

a. Subject is a client, or any part of the client, or some attribute of the client.

For example: client's pulse or urinary output.

b. Verb denotes an action the client is to perform, e.g. what the client is to do, learn, or experience.

It denotes directly observable behaviors, e.g. administer, demonstrate, show, walk and so on.

c. Conditions or modifiers

- May be added to the verb to explain the circumstances under which the behavior is to be performed. They explain what, where, when, or how.

Example: - Walks with the help of a walker (how).

- After attending two group diabetes classes, lists signs and symptoms of D.M (when)
- When at home, maintains weight at existing level (where).
- Discusses four food groups and recommended daily servings (what

Components of Expected Outcome Statement

d. Criterion of desired performance:

- Standards by which a performance is evaluated or level at which client will performed the specified behavior.
- Criteria may specify time or speed, accuracy, distance, and quality, examples:

✓Weighs 65 Kg by April (time).

✓Lists five out of six signs of diabetes mellitus (accuracy).

✓Walks one block per day (time and distance).

✓Administers insulin using a septic technique (quality).

Planning Process

3) Selecting nursing strategies. (intervention)

Nursing interventions

- Any direct care treatment that a nurse performs on behalf of a client.
- These treatments include:

✓ Nurse-initiated treatments resulting from nursing diagnosis,

✓ Physician treatments resulting from medical diagnosis

✓ Performance of the daily essential functions for the client who cannot do these.

- *Interventions should be:*

-Consistent with the established plan of care.

-Are implemented in safe and appropriate manner

-Are documented

Types of Nursing Strategies (interventions)

- **Independent interventions** are those activities that nurses are licensed to initiate on the basis of their knowledge and skills.
- **Dependent interventions** are those activities carried out under the physician's orders or supervision
- **Collaborative interventions** are

Planning Process

4) Developing nursing care plans.

✓The nursing care plan is a written guide that organized information about clients care into a meaningful whole.

Purposes of a Written Care Plan

✓To provide direction for individualizes care of the client.

✓To provide for continuity of care.

✓To provide direction about what needs to be documented on progress notes.

✓To serve as a guide for assigning staff to care for the client.

✓To serve as a guide for reimbursement from medical insurance companies.

Planning Process

Format of Nursing Care Plan

Although formats differ from agency to agency, the plan is organized into four columns or categories:

1) Nursing Diagnosis,

2) Goals and Outcome,

3) Nursing Orders,

4) Evaluation.

Nursing Process 4) Implementing:

- The provider carries out the plan of care
- Putting nursing care plan into action to help client attain goals and achieve optimal level of health.
- Requires: knowledge, technical skills, communication skills, therapeutic use of self.
- Continues data collection and modifies the plan of care as needed

Implementing Skills

1- Cognitive skills (intellectual skills)

2- Interpersonal skills.

3-Teaching skills

❖**Documents care : Something that is not written is considered as not done!!!**

Nursing Process 5) Evaluating:

Evaluating is a planned, ongoing, purposeful activity, in which client and health care professionals determine:

1) The client's progress toward goal achievement

2) Effectiveness of the nursing care plan.

Types of evaluation

1. Ongoing
2. Intermittent
3. Terminal indicates

Nursing Process 5) Evaluating:

Four Possible Judgments:

- The goal was completely met.
- The goal was partially met.
- The goal was completely unmet.
- New problems or nursing diagnoses have developed.

DOCUMENTING AND REPORTING

- **A report** is oral, written, or computer-based communication intended to convey information to others. For example, nurses report on clients at the end of a hospital work shift.
- **A record** is written, or computer-based; it is a formal, legal documentation of a client's progress.
- **Recording or charting** is the process of making an entry on a client record is called recording, charting or documenting.

Purposes of Client's Record /Chart

1. Communication
2. Legal Documentation
3. Research
4. Statistics
5. Education
6. Audit and Quality Assurance
7. Planning Client Care
8. Reimbursement

9.Prevents duplication errors (Meds, dressing change, activity, diets, etc.)

TYPES OF RECORDS

A. Source Oriented Medical Record “traditional client record”

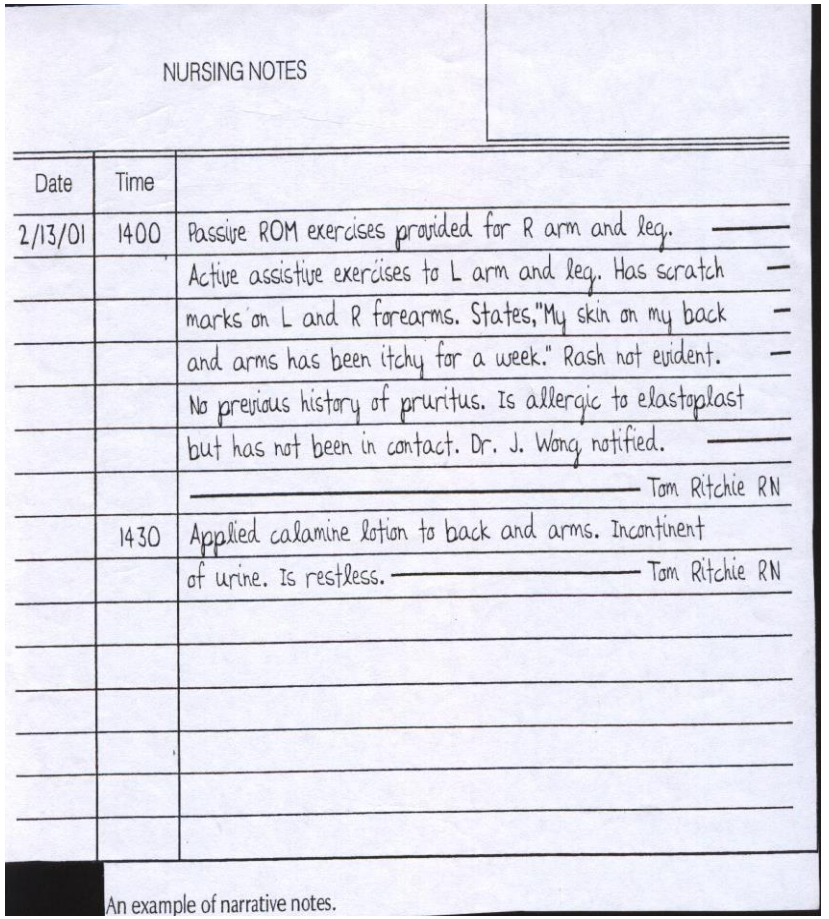
Five Basic Components:

1. Admission sheet
2. Physician’s order sheet
3. Medical history
4. Nurse’s notes
5. Special records and reports

TYPES OF RECORDS

B- Narrative Note

- Chronological
- Baseline charted q shift
- Lengthy, time-consuming
- Separate pages for each
- Source-oriented



NURSING NOTES

Date	Time	
2/13/01	1400	Passive ROM exercises provided for R arm and leg. ——
		Active assistive exercises to L arm and leg. Has scratch —
		marks on L and R forearms. States,"My skin on my back —
		and arms has been itchy for a week." Rash not evident. —
		No previous history of pruritus. Is allergic to elastoplast
		but has not been in contact. Dr. J. Wong notified. ——
		—— Tom Ritchie RN
	1430	Applied calamine lotion to back and arms. Incontinent
		of urine. Is restless. —— Tom Ritchie RN

An example of narrative notes.

TYPES OF RECORDS
c- COMPUTERIZED CHARTING

- Password. Never share. Change frequently.
- Legible (Understandable)
- Can be voice-activated, touch-activated.
- Date and time automatically recorded.
- Abbreviations and terms are selected by a menu provided by the facility.
- Terminals are usually easily accessible, in patient’s rooms, convenient hallway locations.
- Make sure terminal cannot be viewed by unauthorized persons.

Nursing Discharge Notes/ Referral Summaries

A discharge note and referral summary are completed when the client is being discharge and transferred to another institution or to a home setting.

Discharge summaries include the following:

- Description of client's condition at discharge.
- Current medications.
- Treatment, e.g. O2 therapy, wound care.
- Diet.
- Activity level.
- Any restrictions.
- **Discharging A client against Medical Authority**

USES FOR THE MEDICAL RECORD

❖Patient confidentiality

- Never leave chart in a public place.
- Discuss contents only with persons directly involved in the patient’s care or those that are authorized by the patient. These people should be listed by name.
- Ask for identification card prior.
- Do not discuss patient or patient's information in public places, eg. Elevators, cafeteria.

USES FOR THE MEDICAL RECORD

- Six items that nurses must document
- Assessment
- Nursing diagnosis and patient’s needs
- Interventions
- Care provided
- Pt response to care
- Pts ability to manage continuing care after discharge

Guidelines for Recording

- ✓Date and time.
- ✓Timing.
- ✓Legibility (Readability)
- ✓Permanence. All entries on the client's record are made in dark ink.
- ✓Use of standard terminology.
- ✓Correct spelling.
- ✓ Signature.
- ✓ Sequence.
- ✓ Appropriateness.
- ✓ Completeness.
- ✓ Conciseness (Brevity).
- ✓ Accuracy
- ✓ Legal prudence.
- ✓ Confidentiality

Reporting

- Change-of-shift reports.
  - ✓Person to person
  - ✓Be prepared
  - ✓Avoid gossip/socialization
- Telephone reports.
- Telephone orders.

INCIDENT REPORTS

- Objective
- Do not blame or admit liability
- What did you do?
- Do not include names/addresses of witnesses
- Document time/name of doctor
- Do not file in chart
- Do not write “incident report made”

CORRECTING ERRORS

- If you spill something on the chart, do not discard notes. Recopy, put original and copied sheets in chart. Write “copied” on copy.
- Do not scribble out charting.
- Avoid using “error” or “wrong patient” when making correction.
- Follow your facilities policy.
- Do not alter charting, it is a legal document.