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The Nursing Process

LEARNING OBJECTIVES

At the end of this chapter the learner should be able to:

- describe the stages of the Nursing Process
- describe how each stage relates to patient care

The Nursing Process

The Nursing Process is a dynamic, systematic, goal-orientated framework for problem-solving that helps the nurse to plan care for the patient while promoting critical thinking. It is cost efficient and is part of the standard of care in nursing. The Nursing Process enhances the quality of decisions made and promotes professionalism in nursing, while increasing patient participation, enhancing communication and improving efficiency of care.

What is critical thinking?

Critical thinking is when the nurse thinks about their own thoughts and what they say, write and do, in addition to what others say, write and do. While thinking about all of this they are questioning the appropriateness of their actions, applying nursing standards and seeing how things measure up. Alternatively the nurse may be thinking about alternative ways of handling a situation (Brookfield, 1991).

Purposes of the Nursing Process

The Nursing Process has many purposes. Its primary aim is to provide a systematic method for nursing practice. In addition it unifies, standardises and directs nursing practice (Christensen, 1995). It is a thought and procedure process.

The Nursing Process

- enhances communication

- is an educational tool
- increases patient participation in care
- promotes continuity of care
- facilitates documentation
- improves efficiency
- promotes critical thinking
- gives direction to nursing practice

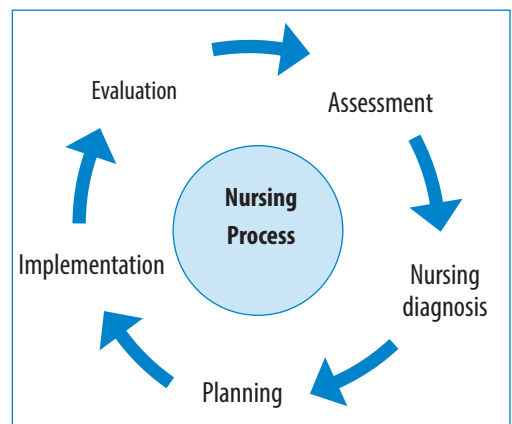
Stages of the Nursing Process

In 1967 Yura and Walsh established a number of stages in the Nursing Process and advocated a more systematic and analytical approach to patient care (Aggleton, 1992).

There are currently five stages of the Nursing Process and it is important to know the purpose of each stage.

The acronym ADPIE may help you to remember the stages in order:

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



Assessment

During this stage the nurse has their initial contact with the patient and establishes a database of the patient's healthcare needs and their ability to manage their needs. During this stage the nurse gathers information about the patient in a systematic, organised way.

The assessment stage is systematic and continuous and is a vital part of the Nursing Process as all other stages rely on valid and complete data collected and documented at this point.

During the assessment the nurse

- collects data
- organises data
- validates data
- documents data

Subjective and objective data

Data collected is defined as either subjective or objective and it is important to be able to distinguish between the two.

Subjective data

This may be described as symptoms or other information that the patient gives you, for example a description of their pain.

Objective data

This is data that can be measured or tested against an accepted standard. Objective data can be seen, heard, felt or smelt. It is obtained through observation or physical assessment (for example the patient's pulse rate or blood pressure measurement).



Methods of data collection

Data can be collected through the following methods:

Observation

The nurse uses the five senses to gather data.

Interviewing

An interview is a structured form of communication. Prior to the interview the nurse should explain the purpose of the interview and provide privacy and comfort while ensuring confidentiality. Both open and closed questions are used while always making sure that the patient is comfortable with the process.

Physical examination

A head-to-toe approach is often used to avoid data omission and in addition a review of body systems may be carried out by the nurse.

The following are some of the elements noted, measured and recorded:

- observation of general health status
- vital signs (temperature, pulse, respiration and blood pressure)
- weight
- urinalysis
- skin, hair and nails
- dress
- hygiene
- nutritional status
- mobility evaluation
- posture
- mood
- hearing and sight (do there appear to be any issues?)
- bowel elimination
- urine elimination
- language and memory
- circulation
- oedema
- social data
- lifestyle
- spiritual data

It is important to remember to see the person as a whole and not just a review of body systems or a head-to-toe checklist as above. These are merely designed to avoid omissions during the assessment phase and not in any way to dehumanise the patient.

The nurse should also note any signs of distress, wincing or breathing difficulties etc.

A complete health history is reviewed and recorded taking into account information such as biographical data, history of present illness, previous medical history, family history, known allergies, current and past medication and the patient's perception of their current health status.

Data gathering

Data can be obtained from primary and secondary sources.

Primary sources

This is data gathered or obtained directly from the patient themselves. In the majority of incidences data gathered from the patient is considered to be the most reliable source. However in cases where this may not be possible due to age, mental status or the seriousness of the illness a secondary source may be used.

Secondary sources

Secondary sources may be family members, previous medical, laboratory and nursing records and information obtained from other health professionals.

Data validation

Information gathered must be accurate, factual and complete as the nurse will base their diagnosis and intervention on this data.

Validation involves double checking the information collected to ensure that it is accurate and factual. Any discrepancies noted should be reviewed by the nurse before proceeding to the next step in the process.

Documenting data

To complete the assessment stage the nurse should document the patient's data in the nursing notes. Accurate documentation is essential as this forms part of the patient's healthcare record.

Data is always recorded in a factual manner, for example 'Lunch: 150 mls soup, 1 slice brown bread, 100 mls tea' **rather than** 'not hungry so very light lunch taken'.

Assessment is not a step that is undertaken once and not repeated. It is required at any time when there is a change in the patient's status, and is required continually in any rapidly changing situation. Responsibility for assessment is not just the duty of the admitting nurse but is shared across the entire nursing team caring for the patient.

However the first assessment will be used and updated by many nurses during the patient's stay, so accurate, concise, clear and up-to-date data is required.

ACTIVITY

Using role play in a group of four, take a nursing history using the case study below. One member of the group should act as the nurse, another as the patient and the remaining two members observe, taking notes and giving constructive feedback after the activity is completed.

Case study

Mary Smith

Mary is a 76-year-old lady admitted to your hospital following an unexplained fall. She has had X-rays which confirm a fractured hip and she will be listed for surgery tomorrow morning. She has Type 2 diabetes and appears agitated and is pulling on her IV cannula. She lives alone and has one son.

Diagnosis

The nursing diagnosis is the nurse's clinical judgement about the patient's response to actual or potential health problems or needs; it is a vital element of the process and forms the basis for the nurse's care plan. A clear diagnosis enhances communication between team members. It is important to remember that nurses do not make medical diagnoses, for example 'chest infection', but do however use an international standardised language for making clinical judgements, for example dyspnoea (shortness of breath), activity intolerance, cyanosis etc.

Actual and potential health problems are identified and priorities are established through the following stages:

- Analysis of data: data collected during the assessment stage is categorised and investigated to highlight significant signs and symptoms.
- Interpretation of data: all the various pieces of the puzzle are placed together so that signs, potential causes and correct problem-identification become clear.



- Formulation of the problem statement: the nurse draws conclusions based on signs, pointers and possible causes.

Actual and potential health problems

Actual problems	Potential problems
A problem that is present at the time of the nursing assessment, for example acute pain or breathlessness.	Evidence about the health problem is incomplete or unclear or the problem is considered only a possibility, for example risk of constipation due to inactivity or insufficient fluid intake.

As the nursing problem statement forms the basis for the planning, implementation and evaluation stages, care should be taken to ensure concise, accurate information is documented (Basford, 1999).

Planning

During this stage a care plan is written in order to plan how to achieve outcomes or solve problems identified in the assessment and diagnosis stages.

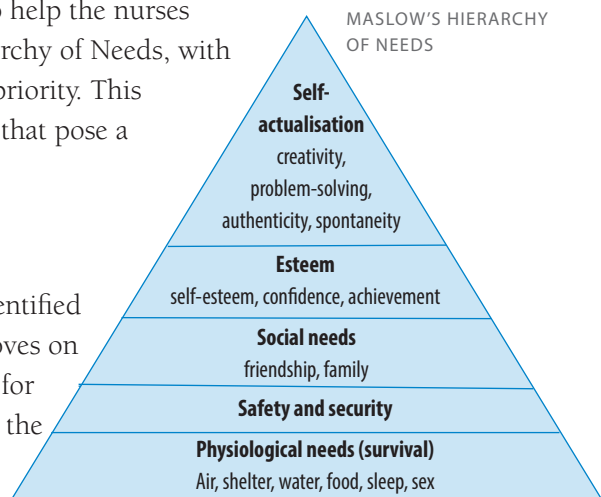
It is important that priorities are established with immediate attention given to any life-threatening issues, then non-life threatening issues and lastly potential problems that may arise. Remember that reassessment of needs is required as the patient's health status changes.

The nursing care plan must clearly specify who will effect the desired outcome, the actions required and a time-frame. Outcomes are often describes as goals. The individualised care plan is stored in the nursing records.

A commonly used framework to help the nurses identify problems is Maslow's Hierarchy of Needs, with physiological needs requiring first priority. This incorporates life-threatening issues that pose a threat to physiological needs.

Maslow's Hierarchy of Needs

Once all physiological needs are identified and goals established, the nurse moves on to the next stage, identifying needs for safety and security, and so on up to the final stage of self-actualisation.



Establishing goals

Goals give direction to nursing actions and a focus for the evaluation stage. Goals can be short-term or long-term depending on the problem identified. They are written in a clear, non-ambiguous manner in the care plan and communicated to the rest of the team.

Goals need to be SMART

- **Specific** (clear and detailed for everyone to understand)
- **Measurable** (be specific: what changes will you see?)
- **Achievable** (is the goal possible given the patient's health status or healthcare resources?)
- **Relevant** (is it realistic?)
- **Time-limited** (deadlines motivate, but need to be realistic)

(College of Nurses of Ontario, 2012)

The written care plan should identify and communicate all action to be delivered to meet the patient's care needs.

ACTIVITY

Mrs Johnson fell while walking to the bathroom in your ward at 3 a.m. You did not witness the fall but were alerted by another patient. She appears to have hit her head and there is a large amount of blood coming from a wound to the side of her left ear. She is crying and complaining of pain in her left arm which she tells you she cannot move. The left arm appears to be at an odd angle to her body.

What are your priorities in caring for Mrs Johnson?

Give reasons for your choices.

Implementation

During this stage nurses implement the individualised care plan that has been prepared for the patient.

Nursing action may be

- direct – for example assisting with the activities of daily living, teaching, observations or counselling

- indirect – performed away from the patient but on their behalf, for example advocacy or supervision

Evaluation

This is the final stage in the Nursing Process and can only take place when all other stages have been implemented. During this stage the nurse reviews the nursing interventions or actions and decides if they have met the desired outcomes identified in the care plan.

Questions the nurse needs to consider include:

- Have goals been met?
- If not, why not?
- Does the plan need to be altered or amended?
- Did the patient's health status change?
- Were the goals realistic and achievable?

Evaluation is an ongoing process designed to improve patient care by systematically reviewing the results of nursing care against each goal set in the care plan. It involves both practical knowledge and evidence-based research in order to identify appropriate outcomes. Through evaluation both the nurse and patient can gain an understanding of what goals have or have not been achieved.

Critical thinking plays an important role here, to differentiate between appropriate outcomes and actual outcomes.

Revision

1. What are the five stages of the Nursing Process?
2. Describe the nurse's action at each stage.
3. How does each stage relate and contribute to patient care?
4. What does critical thinking involve?
5. What is the difference between objective and subjective data?
6. What are SMART goals?
7. State the difference between actual and potential health problems.
8. Look at Maslow's Hierarchy of Needs and list possible nursing care priorities at each stage.

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