National Comprehensive Training on Standards of Nursing Practice

August, 2017

Participants' Manual

FOREWORD

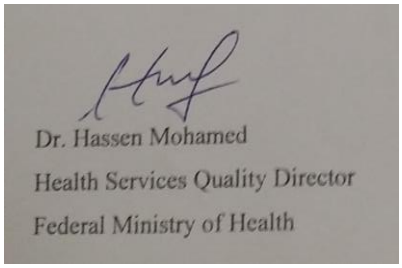
The development of the Standards of nursing/midwifery Care Practice in Ethiopia is an important milestone in the history of nursing/midwifery in this country. Standards are an essential tool for unifying the nursing/midwifery profession and setting criteria by which nursing practice can be measured.

The standards will also promote accountability and good quality of nursing/midwifery care. Evidence suggests that when high quality nursing/midwifery services are available, there is a corresponding reduction of maternal, neonatal and inpatient morbidity and mortality.

The Standard of nursing/midwifery Care Practice in Ethiopia defines the expectations placed on registered nurses/midwives, underpinned by principles such as quality, equity, access, and collaboration. The standards have an emphasis on patient -centered care and seek to ensure that nursing services are affordable, appropriate to local needs and sustainable over the long term.

It is our hope that all nurses in Ethiopia adhere to the standards set out in this document and strive to contribute to the ongoing development of high quality client's health services in our country. Healthcare quality continues to be a subject of intense criticism and debate. Nurses are important part of each patient's care; they provide continuous care to patients by assessing the patient, answering questions, giving medications and treatments, and assisting with medical procedures

Nurses/midwives have the responsibility to help patients understand the care they will receive and what the patients must do to cooperate in their care. They have the responsibility to explain to patients what they should and shouldn't do as they go through treatment and recovery, and they must quickly respond to patients in need. They are a key part of any healthcare team, and the way they perform their jobs has a real impact on healthcare quality.



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LIST OF ACRONYMS AND ABBREVIATION

ANA	American Nursing Association	**HSTP**	Health Sector Transformational Plan
CU- ICAP	Colombia University, International Center for HIV/AIDS Program	**ICN**	International Council of Nursing
CNA	Canadian Nurse Association	**ISTC**	In Service Training Center
CPD	Continuing Professional Development	**KPI**	Key Performance Indicator
EHMI	Ethiopian Hospital Management Initiative	**NNTWG**	National Nursing Technical Working Group
EHRIG	Ethiopian Hospital Reform Implementation Guidelines	**NOCI**	Nursing Outcome Identification
EHAQ	Ethiopian Hospital Alliance for Quality	**RN**	Registered Nurse
EHSTG	Ethiopian Hospital Service Transformations Guidelines	**SMT**	Senior Management Team
ENA	Ethiopian Nurses Association	**SOAP**	Subjective data, Objective data, Assessment and Plan
FHP	Functional Health Pattern	**SOP**	Standard Operating Procedures
FMHACA	Food, Medicine, Health care Administration Control Authority		

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ABOUT THIS MANUAL

This manual is a resource for trainers who lead training in standards of nursing practice. It contains all the instructions and materials needed to enable trainers to help trainees develop the knowledge and skills necessary to provide high quality nursing care services.

Trainers should keep this manual with them each day they prepare and facilitate sessions.

The Training Package

The training package includes participant manual, facilitator's guide and power point presentation. The content contained in this trainee's manual is drawn directly from a reference manual for nurses and health care managers in Ethiopia, of Version 2. Dec 2011 Addis Ababa Ethiopia, in a much updated form.

Participant Manual: The participant manual is designed to provide all information needed to conduct the course in a logical manner. It serves as the "text" for the participants and the "reference source" for the trainer.

Facilitator's Guide: The facilitator's guide is for use by course facilitators. It provides an outline of the training and guidance on how to conduct each session.

Approach to Training

This training package is grounded in two specific principles. First, the training methodologies used here are grounded in competency based skills acquisitions and learner centered, participatory learning based on the principles of adult education. Second, the participant manual and facilitator's guide are divided into modules. A modular approach to the organization of this training content allows trainees and organizers the flexibility to tailor individual course to the specific needs of different training participants and situations.

Learners utilizing the materials in this training meet knowledge-based objectives through theoretical training contained in the modules. Each module includes the presentation of information, active practice through participatory activities such as role plays, video show group work and case studies. Skills- based objectives are addressed by simulated practice with coaching and feedback in the classroom.

Rationale for revising the Manual

Quality and equity of health care is one of the four interrelated transformation agendas set by the HSTP which was built upon the sucesses and challenges of the successive HSDPs implemented over the last 20 years. A national health care quality strategy will be developed

to guide our investment towards safer, more effective, more accessible, and more equitable care for every Ethiopian by 2020 (FMOH-HSTP, 2015). In addition, Ethiopian is estimated have a population of around 100 million and there are over 50,000 nurses in the country. The number of clients with chronic non-communicable diseases are increasing therefore requiring an increasing demand for quality nursing care (FMOH-HRH Strategic Plan, 2016). In addition, with existing communicable diseases especially HIV/AIDS and TB, they make a double burden among health care workers. That is why FMOH gives attention for the competency of nursing professionals who make the majority of the health care professionals.

This manual is a resource for trainees who are actively involved in training Standards of Nursing Practice. It contains all the four sequential modules with different sessions, exercises, practical examples and annex materials needed to enable trainees to use and develop additional knowledge and skills necessary to provide high quality nursing services.

The major reasons for revision of this manual are as follows

1. The previous training package lacked facilitators guide
2. Operational standards extracted from EHRIG should be revised as per EHSTG
3. The old model five step approach of Nursing process should be revised into new six step international approach
4. The length of previous training was short to address gaps
5. The practical session was less emphasized in the previous course

This manual is a resource for trainees who are actively involved in training on standards of Nursing practice standard. It contains all the four sequential modules with different session, exercises, practical examples and annex materials needed to enable trainees to use and develop additional knowledge and skills necessary to provide high quality nursing services.

Goal and objectives of the manual

Goal

The overall goal of this participant manual is to provide all information needed for trainers and trainees to conduct the nursing practice course in a logical manner, as well as, a guide for practicing nurses in order to provide quality nursing care for the needy

The objectives of the manual are:

- To build the capacity of nurses in terms of knowledge, attitude and practice in order to provide holistic quality nursing care
- To serve as the "text" for the participants without the need for special hand-outs or supplementary material during training period.
- To provide information to both trainers and participants that is consistent with the course goals and objectives.

Modules in this manual

This participant manual consists of four modules. Each of the modules is interactive, providing learners with questions and activities to make their learning as relevant, stimulating and effective as possible. By taking time to answer all the questions and complete any activities, learners have the opportunity to draw on their own experience, reflect on current practice, digest new concepts and apply them to their work place.

Each module begins with learning objectives, which explain what learners will be able to do when they have completed it. Upon completing the module, learners can then assess for themselves whether they have achieved the objectives.

The contents for each module are summarized as follows:

Module I: Operational Standards of nursing care

- Introduces the 23 operational standards
- Details the operational standards using implementation guide
- Categorizing the 23 operational standards

Module II: Nursing ethics emphasizes on fundamentals of ethical principles, values, and ethical dilemmas, code of ethics and legal aspects of nursing.

Module III: Communication in nursing explains

The presentation focuses on communication types, facilitators, inhibitors, barriers and strategies of communication. It also details nursing record documentation.

Module IV: Nursing process: This is the core module which covers principles of nursing process that includes assessment, diagnosis, outcome identification, planning, implementation and evaluation. Physical examination is integrated with functional health patterns in assessment part of nursing process.

CORE COMPETENCIES FOR TRAINEES

Competence is the ability to effectively and efficiently deliver a specified professional service. This implies that the health worker is able to practice at proficiency (mastery of learning) in accordance with local conditions to meet local needs.

The core competences that the trainees are expected to attain after going through this course are

- Building therapeutic nurse client relationship
- Assessing clients using history taking and physical examination in terms of Gordon's approach of functional health patterns
- Formulating nursing diagnosis by using NANDA-I approach
- Developing holistic nursing care plan that address basic human needs
- Providing individualized, holistic and ethically accepted nursing care
- Evaluating whether the goals are met, partially met or unmet
- Recording and reporting nursing activities using standard protocol

INTRODUCTION

Nursing is a profession that ensures the successful implementation of interventions that welcome and nurture life, promotes or restores health, enables the means to a peaceful, dignified and pain-free death. Nursing reflects the value society places on the work of nurses and the centrality of this work for the good of society. Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well in all settings. It includes the promotion of health, the promotion of health, the prevention of illness, and the care of ill, disabled and dying people (WHO, 2017).

A nurse is a person who is trained and experienced in the nursing profession and interested in caring for the sick / well person, has completed a program of basic, generalized nurse education and is authorized by the appropriate regulatory authority to practice nursing (ICN 1987).

The Federal Ministry of Health (FMOH) has long acknowledged the critical contribution of Nurses and Midwives in improving health outcomes of individuals, families and communities. In acting as individuals, members and coordinators of inter-professional teams, nurses and midwives bring people–centered care close to the communities where they are needed most, thereby contributing greatly to improving the health outcomes of those under their care as well as improving the overall cost effectiveness of health care services.

Similarly, patient safety and quality health outcomes will be highly compromised if services delivered by other healthcare professionals are not duly supported and complemented by a competent nursing workforce. In recognition of this important role of the nursing profession and services they provide, the Federal Ministry of Health (FMOH) has incorporated Nursing Standards (NS) as one chapter in the Ethiopian Hospital Services Transformation Guideline (EHSTG).

There are essential guidelines and checklists to check how the nurses perform their duties professionally and how they exercise the care, cure and co-ordination aspects of nursing. As an independent profession, nursing has increasingly set its own standards for practice which we call Standards of Nursing Practice. As a result, nursing services complement and support other health care services and are a subsystem of health services that are provided by a range of personnel globally who share common attributes like caring, supporting, comforting, advocating and educating clients.

TRAINING COURSE SYLLABUS

Course description

This **seven** days training course is developed to equip nurses and midwives with knowledge, skill and the right attitude to enable them to deliver scientifically sound, ethically acceptable and holistic quality care.

Course goals

- To provide the trainees with the knowledge and clinical skills needed to respond appropriately to patients' health care needs.
- To provide the trainees with the decision-making skills needed to respond appropriately to patients' health care needs
- To influence in a positive way the attitudes of the trainees towards client centered and ethically accepted nursing care.
- To provide the trainees with the interpersonal communication skills needed to build therapeutic relationship with clients.

Course Objectives

By the end of this course, the trainees will be able to:

- Describe nursing Operational Standard Practices
- Demonstrate Nursing Code of conduct and Ethics
- Employ client centered effective communication
- Apply the nursing process in clinical setting.

Training methods

- Interactive Presentation
- Small and Large group Discussion
- Daily Recap
- Group work /practice
- Brainstorming
- Demonstration
- Role play

- Case studies
- Video Show
- Practicum

Training materials

- National trainees and trainer guide
- Nursing process format ,
- Updated NANDA list
- Audiovisuals on physical examination
- Job aid for physical examination procedures
- Course evaluation formats
- Knowledge assessment questionnaire
- Gowns
- Vital sign equipments and checklists
- Flip charts/white board and Markers
- LCD projector, Laptops, computer

Trainee selection criteria

Trainee selection is based on the national IST guidelines.

- For basic training, nurses and or midwives who are actively involved on the day to day health service activities and have an interest to be trained and provide the nursing care service after training will be selected from hospitals/health care facilities.
- For TOT training, nurses and or midwives who undergo basic training in standards of nursing practice and actively involved on the day to day health service activities and have an interest to be trained and provide the nursing care service after training will be selected from hospitals/health care facilities. .

Trainer qualification criteria/ requirement

In competency-based training, the responsibility for meeting learning objectives is shared by the trainer and each trainee. The role of the trainer is to facilitate learning. The trainer guides trainees during the training toward the acquisition of new or improved skills in standards of

nursing practice and also seeks to influence trainee attitudes by serving as a role model. In selecting trainers to use this training package, the following criteria should be considered:

- Demonstrated proficiency in application of nursing Process. The trainer must have knowledge and skills in the selected areas of standards of nursing practice to be taught in this training.
- The trainers must have received training of trainers' course on standards of nursing practice.

The trainer of standards of nursing practice must have experience using the mastery learning approach to provide the training, which is conducted according to adult learning principles—learning is participatory, relevant, and practical—and uses behavior modeling, is competency-based, and incorporates humanistic training techniques. The trainers for this course must be aware of basic principles of transfer of learning to help the trainees, transfer the new knowledge and skills in nursing practice and improve job performance.

It is strongly recommended that at least three clinical trainers conduct this course. The trainers can divide roles and responsibilities according to their expertise, such as sharing the roles of "coach" and "facilitator" throughout the course.

Methods of course evaluation

Trainee evaluation

- Pre- and post-course knowledge assessment
- Skill assessment of observed practice during role plays and practicum
- trainer and trainees demonstration of FHP and through physical examination
- Skill assessment of application of nursing process
- Attendance 100%

Course evaluation

- Daily evaluation
- End course evaluation

Post training evaluation

- Integrated supportive supervision and Mentorship

Course duration

- The total duration for this training is seven days

Suggested class size

Assuming role plays and other group activities, a class room that accommodates 20-25 is recommended.

Trainer to trainee ratio

Ratio of trainers to trainees will be 1:6

Course venue

This training will be provided at health facilities or accredited CPD centers /IST centers

Certification criteria

- Trainees are expected to score 75% and above for Basic training and 85% and above for TOT to qualify for certification.

Composition

- Suggested training composition:
- 20-25 participants per classroom
- 3-4 trainers per classroom

Course Agendas

Days	Time	Topics	Facilitator
Day 1	8:30-9:00 AM	Registration	
	9:00-9:40 AM	• Opening remark: Welcome and introduction, • Group norms , Expectations • Goals ,objectives ,schedule • Review of course materials	
	9:40-10:30 AM	Pre-test	
	10:30-10:45 AM	**Tea Break**	
	10:45-11:30 AM	**Presentation and discussion:** Overview and Introduction of the Course	
	11:30-12:30 AM	**Presentation and discussion:** Operational standards of Nursing Practice	
	12:30-2:00 PM	**Lunch Break**	
	2:00- 2:40 PM	Operational standards of Nursing Practice	
	2:40 -3:30	**Group work** : Categorizing operational standards of nursing practice	
	3:30-3:45 PM	**Tea Break**	
	3:45-4:45 PM	**Presentation and discussion:** Operational standards of Nursing Practice: Implementation guide	
	4:45-5:00 PM	Day Summary	
Day 2	8:30-8:40AM	Day one Recap	
	8:40-9:20AM	**Presentation and discussion:** Introduction to Ethics	
	9:20-10:30AM	**Presentation and discussion:** Ethical principles	
	10:30-10:45 AM	**Tea Break**	

	10:45AM– 11:15PM	**Group Activity on case studies** Ethical principles	
	11:15-11:45 AM	**Presentation and discussion:** Nursing Values	
	11:45-12:30PM	**Presentation and discussion:** Ethical dilemma and Ethical distress in nursing practice	
	12:30 -2:00PM	**Lunch Break**	
	2:00-2:30 PM	**Group Activity on case studies** Ethical dilemma and Ethical distress in nursing practice	
	2:30-3:00PM	**Presentation and discussion:** Ethical Decision Making in the Nursing Practice	
	3:00-3:30 PM	**Group Activity on case studies:** Ethical Decision Making in the Nursing Practice	
	3:30-3:45 PM	**Tea break**	
	3:45-4:20 PM	**Presentation and discussion :** Legal Aspects of the Nursing Practice	
	4:20-4:45 PM	**Presentation and discussion :** Legal Aspects of the Nursing Practice	
	4:45-5:00 PM	Day Summary	
Day 3	8:30-8:40AM	Day two Recap	
	8:40-10:00 AM	**Presentation and discussion :** Communication in nursing	
	10:00-10:30AM	**Group Activity:** Elements of communication	
	10:30-10:45 AM	**Tea break**	
	10:45-11:00AM	**Presentation and discussion:** 7 Cs of communication	
	10:45AM– 11:30AM	**VIDEO SHOW :** Therapeutic relation ship	

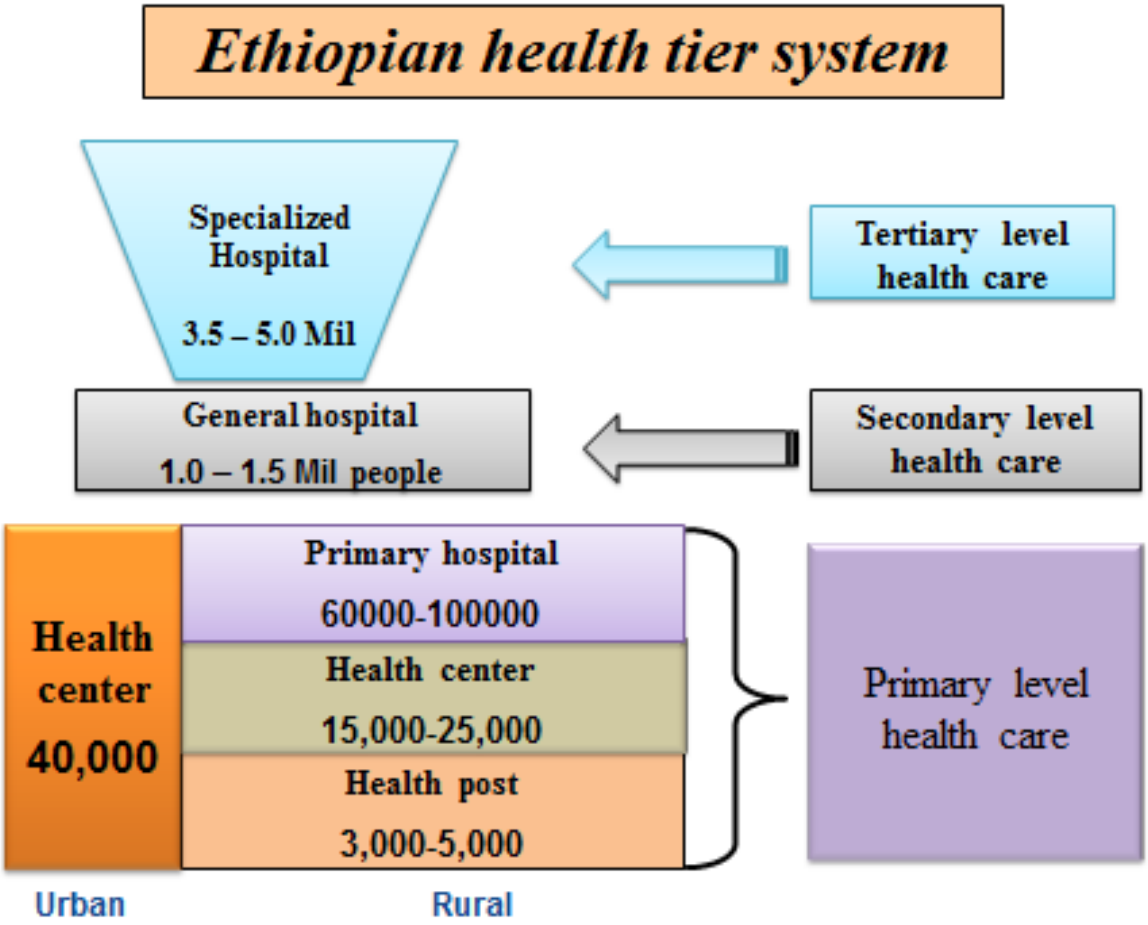
	11:30 -12:30 PM	**Presentation and discussion:** Documentation and reporting	
	12:30-2:00 PM	**Lunch Break**	
	2:00-2:30 PM	**Presentation and discussion:** Introduction to nursing process	
	2:30-3:30 PM	**Presentation and discussion:** Nursing Assessment	
	3:30-3:45 PM	**Tea break**	
	3:45-4:45 PM	**Presentation and discussion** • Integration of history taking and physical examination with FHP • Health perception and management up to nutrition and metabolism	
	4:45-5:00	Day Summary & Recap	
Day 4	8:30-8:40 AM	Day three Recap	
	8:40-10:00 AM	**Presentation and discussion** Nursing Assessment : Elimination pattern	
	10:00 -10:30 AM	**VIDEO SHOW**: Nursing Assessment : Elimination pattern	
	10:30-10:45 AM	**Tea break**	
	10:45-12:30 PM	**Presentation and discussion** Nursing Assessment : Activity and exercise	
	12:00-1:30 PM	**Lunch Break**	
	2:00-2:30 PM	**VIDEO SHOW:** Nursing Assessment : Activity and exercise	
	2:30-3:30PM	**Presentation and discussion:** Nursing Assessment : Sleep and rest up to cognitive and perceptual	
	3:30 -3:45 PM	**Tea break**	

	3:45-4:45 PM	**Presentation and discussion** **Self-perception/self-concept up to value and belief**	
	4:45-5:00	Day Summary and Recap	
Day 5	8:30-8:40 AM	Day four Recap	
	8:40-9:20 AM	**Clinical practice:** Nursing Assessment	
	9:20-10:30AM	**Clinical practice:** Nursing Assessment	
	10:30-10:45 AM	**Tea Break**	
	10:45-12:30 PM	**Clinical practice:** Nursing Assessment	
	12:30-2:00 PM	**Lunch Break**	
	2:00-3:30 PM	**Group presentation** Nursing Assessment	
	3:30 -3:45 PM	**Tea Break**	
	3:30-4:45	**Group presentation** Nursing Assessment	
	4:45-5:00	Day Summary and Recap	
Day 6	8:30-10:30 AM	**Presentation and discussion**: Nursing diagnosis	
	10:30-10:45 AM	**Tea break**	
	10:45-12:30 PM	Nursing diagnosis	
	12:30-2:00PM	**Lunch Break**	
	2:00-3:30 PM	**Group activity:** **Writing** Nursing diagnosis for cases from hospital	
	3:30-3:45 PM	**Tea break**	
	3:45-4:45 PM	**Presentation and discussion**: Planning : Outcome identification	
	4:45-5:00 PM	Day Summary	

Day 7	8:30-10:00 AM	Planning (Nursing Intervention/Instruction)	
	10:00-10: 30AM	Implementation and evaluation	
	10:30-10:45 AM	**Tea break**	
	10:45-12:30 PM	**Group Presentation**: developing nursing care plan based on cases from hospital	
	12:30-2:00PM	**Lunch Break**	
	2:00-2:40 PM	Post-test	
	2:40-3:00 PM	**Tea break**	
	3:00-4:45 PM	Discussion : The way forward	
	4:45-5:00 PM	Closing Remark	

OVERVIEW OF HOSPITAL SERVICES

Modern medicine in Ethiopia began to be practiced by government at the beginning of the 20th Century. The Russian Mission established the 1st hospital in Addis Ababa in 1897. The first government sponsored hospitals were established in Harar and Addis Ababa (Menelik II Hospital) in 1909.Subsequently, majority of the hospitals were built in urban centers but still not enough.



Situation of Hospital Services in Ethiopia before 2006

Evaluation of the hospital services in Ethiopia in 2006 indicated that hospital services are characterized by:

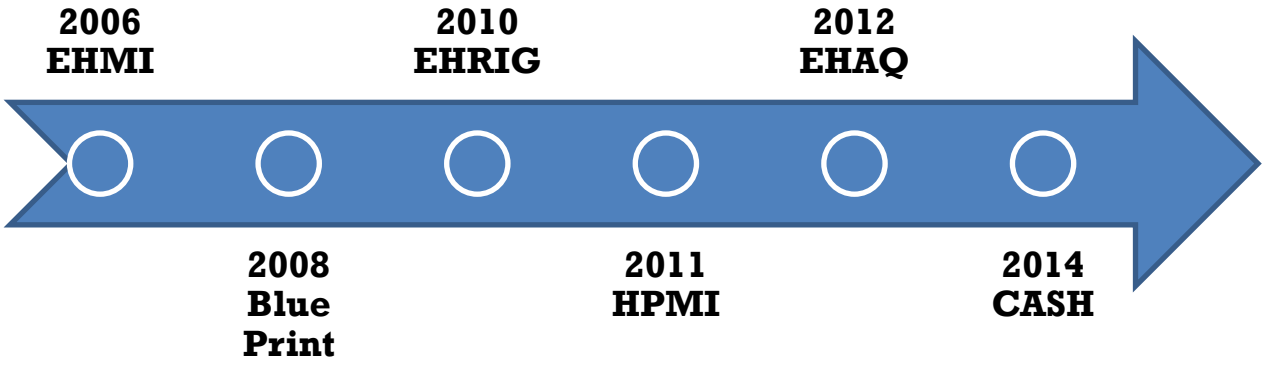
- Lack of comprehensive care
- Poor quality of care

- Inefficient &inaccessible services
- Inadequate attention to delivery and emergency
- Management not customer oriented

Policy Responses by FMOH

- The earliest modern efforts to improve the quality of government hospitals throughout Ethiopia began in 2006 with the Ethiopia Hospital Management Initiative (EHMI), envisioned by the then Minister of Health, Dr. Tedros Adhannon, and supported by the Clinton Health Access Initiative in collaboration with the Yale Global Health Leadership Institute. The EHMI resulted in the creation of the Ethiopian Hospital Reform Implementation Guidelines (EHRIG), which built on both the Business Process Reengineering (BPR) and Hospital Blueprint efforts, as well as the Masters in Hospital and Healthcare Administration (MHA) degree program. Subsequently, the country developed a hospital performance monitoring system based on the achievement of Key Performance Indicators (KPI) and the Ethiopia Hospital Alliance for Quality (EHAQ) to spread best practices and promote collaborative learning in government hospitals nationally. EHAQ has focused on patient satisfaction, labor and delivery management, and provides a national framework for continuous quality improvement in hospitals across Ethiopia.
- The Ethiopian Hospital Transformation Guidelines (EHSTG) builds on and expands the Ethiopian Hospital Reform Implementation Guidelines (EHRIG) and is consistent with the Health Sector Transformation Plan (HSTP). The EHTG, which is consistent with the national focus on quality improvement in health care, contains a common set of guidelines to help hospital Chief Executive Officers(CEOs), managers, and clinicians (care providers) in steering the consistent implementation of these transformational systems and processes in hospitals throughout the country. The EHSTG focuses on selected management and clinical functions, including new individual service specific chapters for Emergency Medical, Outpatient and Inpatient Services, Nursing and Midwifery, Maternal, Neonatal and Child Health and Teaching Hospitals' Management. These guidelines also incorporate recent lessons from the operationalization of the EHRIG, as well as, new national initiatives such as the Guidelines for the Management of Federal Hospitals in Ethiopia, Hospital

Development Army (HDA), Clean and Safe Hospital (CASH), and Auditable Pharmaceutical Transaction and Service (APTS).



- 2006 : Ethiopian Hospital management initiative
- 2010: The Ethiopian Hospitals Reform Implementation Guidelines launched
- 2011-2012: Hospital Performance Monitoring Framework introduced with KPI reports, site visits and review meetings
- 2012 The Ethiopian Hospital Alliance for Quality (EHAQ) launched.
- 2014 The CASH initiative lunched

EHRIG Overview

- Document developed to solve the problem related to hospital service
    - Led by FMOH
    - Participation of over 62 different bodies including government offices, RHBs, hospitals, NGOs
    - EHRIG had two volumes and 13 management areas

EHRIG has been revised into EHSTG

- It contains
    - 20 chapters
    - 197 operational standards with their distinct verification criteria.
    - Minimum standards for patient satisfaction

Rational for EHRIG revision

- Some standards are already met by most hospitals and a need to revise/upgrade them
  - Laboratory service management
  - Pharmacy service management
- Some standards were incomplete
  - A need to harmonized academic activities with patient centered care
- Some services were not covered
  - Radiologic service
  - Rehabilitative and palliative care services
- Did not include the context of teaching hospitals
- Has to be aligned with the HSTP transformation agendas
  - New indicators
- Some services were packed in one chapter
  - Patient flow chapter packing liaison, emergency, outpatient, inpatient services
- Incorporated learning from CASH, HDA etc

Quality

- Quality is the extent to which health services:
  - Improve desired health outcomes and its provision involved
    - clinical evidence basis
    - Client/patient centeredness
    - good communication
    - shared decision making

Six domains of health care quality:

1. Safe - avoiding harm to patients from care that is intended to help them.
2. Effective – improve pt outcome
3. Patient-Centered – based on unique patient's needs.
4. Timely - reducing waiting times and harmful delays for patients and providers.
5. Efficient - avoiding waste of equipment, supplies, ideas and energy.
6. Equitable - providing care that does **not vary** across intrinsic personal characteristics

Module I: - Operatonal Standards of Nursing Practice

Module I: Operational Standards of Nursing Practice

Module description: This module is designed to give an opportunity for trainees to analyze the 23 operational standards of nursing care and categorize them into three expectations.

Course objective: At the end of the course, the trainees will be able to analyze operational standards of nursing practice to apply nursing process in the direct quality of patient care.

Enabling objectives: at the end of the course, the trainees will be able to:

- Define Nursing
- Describe Standard
- Explain Nursing standard
- Identify the 23 operational standards of nursing practice
- Differentiate the three categories of operational standards of nursing practice

Outline

- Session 1.1 Operational standards of nursing practice
- Session 1.2 Implementation guideline

Session 1.1 : Operational Standards of Nursing Practice

Session objectives

After completing this session, the trainee will be able to

- Describe Standard And Nursing Standards
- Identify the 23 Operational Standards of Nursing Practice
- Differentiate the three categories of Operational Standards of Nursing Practice

1.1.1 Introduction

Nurses play a pivotal role in any hospital encompassing the largest workforce in a hospital. Nurses act as direct caregivers who serve a hospital twenty-four hours a day, seven days a week. This gives nurses a unique perspective on both patient care and hospital operations.

Given the complexities of hospital management and the direct relationship between hospital operations and patient care, nursing responsibilities have expanded to include a greater managerial role. This includes the increased role in hospital leadership and contributing to effective decision-making within the overall hospital structure, as well as within case teams, wards/units or departments.

1.1.2 Operational Standards

Operational standards are generally accepted rules, models, patterns, measures and are a minimum level or range of performance or quality considered acceptable by professionals. As an independent profession, nursing has increasingly set its own standards for practice. This is called standards of nursing care. The standards guide and assure clients that they are receiving high-quality care and that the nurses know exactly what is necessary to provide nursing care. They are also measurements to determine whether the care meets the standards.

1.1.3 Operational standard for nursing practice

The operational standards below have been extracted from the Ethiopian Hospital Service transformational Guidelines/EHSTG document, which all hospitals should fully implement to ensure proper nursing care.

1. The hospital has established nursing/midwifery service management structures and job descriptions that detail the roles and responsibilities of each nursing and midwifery professional, including reporting relationships.
2. The hospital has a nursing and midwifery workforce plan that addresses nurse /midwife staffing requirements and sets minimum nurse /midwife to patient ratios in each service area.
3. The hospital has written policies describing the responsibilities of nurses and midwives for the nursing process including the admission assessment, diagnosis, planning, implementation and evaluation of nursing/midwifery care.
4. All admitted and emergency patients/clients have a nursing/midwifery care plan that describes holistic nursing/midwifery interventions to address their needs. The plan is regularly reviewed and updated as required.
5. All hospital nurses/midwives comply with the professional code of conduct and ethics which governs their professional practice.
6. The hospital has established guidelines for verbal and written communication about patient/client care that involves nurses/midwives and their patients/clients, families, other case team professionals of the disciples, including verbal orders and timely documentation of accomplished activities.
7. The hospital has standardized procedures for the safe and proper administration of medications by nurses or designated clinical staff.
8. The hospital has established nursing/midwifery care practice audit program, including the documentation of completed audits and resulting practice improvements.
9. The hospital implements regular nursing/midwifery eight hours' shift, hourly rounds, and central medication cabinet or room.
10. The hospital has a centralized nursing/midwifery station set-up in each ward with adequate space, equipment and consumables.

    Additionally, trainers and nurse practitioners should consider the operational standards below at a regional/local level when implementing the national guidelines to enable nurses to fully address the holistic needs of patients under their care.

11. Hospitals should provide on a regular basis complete uniforms for all nursing staffs who are assigned or allowed to work in the facility.

12. Nurses ensure delegation of nursing care to nursing students and assistants is appropriate, safe and in the best interests of the person in the care of a nurse.
13. Nurses should work with others to protect and promote the health and wellbeing of those under their care.
14. Nurses should take part in the ongoing continuing professional development (CPD) required by their professional body and maintain a CPD portfolio.
15. Nurses should find solutions to conflicts caused by deep moral, ethical and other beliefs arising from a request for nursing service through dialogue with patients /employer and or professional body.
16. All nurses should be in full uniform as designated by hospital guidelines
17. Nurses should be open and honest, act with integrity and uphold the reputation of their profession.
18. Nurses should care for all patients equally and without prejudice to age, gender, and economic, social, political, ethnicity, religious or other status and irrespective of their personal circumstance.
19. Nurses should not disclose confidential information relating to their patients and /or about their matters and conditions unless in line with the Ethiopian law and / as required by their professional body /employing hospital.
20. Nurses should seek verbal or written informed consent from their patients or their relatives/next of kin (for incompetent patients) before any procedure.
21. Nurses adhere to and provide information on infection prevention practices to patients, clients, family members and other caregivers, as appropriate.
22. Nurses may not receive gifts, favors or hospitality of any kind from patients, caregivers, or visitors at any time including prior to or after the provision of care.
23. Hospitals have appropriate arrangements to ensure nurses access clinical supervision and support and participate in regular clinical audit and reviews of clinical services.

Activity 1

Duration: 30 minutes

Group work:

- Categorize the operational nursing standards according in to the following three categories
    - Expectations of nurses from hospital (10)
    - Expectation of hospital from nurses (6)
    - Expectation of patient from nurses (7)

Session summary

- Standard is the benchmark of achievement
- Nursing standards are professionally developed expressions of the range of acceptable variations from a norm or criterion

Session 1.2. Implementation Guideline/Handout

Session objectives

After completing this session, participants will be able to

- Describe how to implement each operational standard
- Prepare organogram to show managerial structure for nurses
- Indicate job description for nurses

1.2.1 Organizational Support for Nursing/Midwifery Function

Nurses/midwives play a pivotal role in any health facility. Encompassing the largest workforce in hospitals, nurses/midwives act as direct caregivers who serve a hospital twenty-four hours a day, seven days a week. This gives a unique perspective on hospital operations. Nurses/midwives should be allowed to assume managerial roles that will enable them to make decisions affecting patient/client care at the case team, unit and department levels.

1.2.2 Organizational structure of the Nursing and Midwifery Service

Nurses and midwives play a pivotal role in any hospital. Encompassing the largest workforce in a hospital, nurses/midwives act as direct caregivers who serve a hospital twenty-four hours a day, seven days a week. This gives nurses/midwives a unique perspective on both patient care and hospital operations. Given the complexities of hospital management and the direct relationship between hospital operations and patient care, nursing/midwifery responsibilities have expanded to include a greater managerial role. This includes assuming an increased role in hospital leadership and contributing to effective decision-making within the overall hospital structure, as well as within case teams, wards/units or departments.

Nursing/Midwife Director is a member of the senior management team (SMT) and responsible for the overall function of nursing and midwifery activities in the hospital. Head nurses/midwives are responsible for the overall function of nursing and midwifery activities in each ward and accountable to the Nursing/Midwifery Director.

Managerial structure

Although planning is the key to effective management, the organizational structure furnishes the formal framework in which the management process takes place. The organizational structure should provide an effective work system, a network of communications, and identity to individuals and the organization and should consequently foster job satisfaction. The organization contains both formal and informal structures.

Types of organizational structures:

A. The formal organizational structure:

It describes positions, tasks, responsibilities and relationships among people in their positions in the different departments in the organization, and presented in diagrammatic form called organizational chart (see Annex 1).

B. Informal organizational structure:

- It describes the personal and social relationships that do not appear on the organizational chart.
- It helps members to meet their personal objectives and provides social satisfaction.
- It also has its own channels of communication, which may distribute information more broadly and rapidly than the formal communication system.
- The informal organizational structure is important to management, thus, the supervisor should be aware of its existence, study its operating techniques, and use it to meet the organizational objectives.

Organizational chart:

It is a diagram shows the different positions and departments, and the relationships among them. It is used to show:

- The formal organizational relationships.
- Areas of responsibility.
- Persons to whom one is accountable.
- Channels of communication.

Advantages of an organizational chart:

- It provides a quick visual illustration of the organizational structure.
- It provides help in organizational planning.
- It shows lines of formal authority, responsibility and accountability.
- It clarifies who supervises whom and to whom one is responsible.
- It emphasizes the important aspect of each position.
- It facilitates management development and training.
- It is used to evaluate strengths and weakness of current structure.
- It provides starting points for planning organizational changes.
- It describes channels of communication.

1.2.3 Job description

Job descriptions clarify what an employee is responsible for and what is expected of them (See Annex 2 and 3).

Essential Elements of Job Descriptions

- General statement describing the concept and specific duties of the position
- Classification title, position number, geographic location, division and work unit of the position, name and title of supervisor, and effective date of duties.
- If supervisor position, list classifications supervised.
- General statement describing the nature of the unit in context with the department/program
- Description of the positions supervisory reporting relationship.
- List of typical essential and marginal functions/duties, grouped in related categories
- Duties broken down by percentage of time spent on each task or group of similar tasks
- Signature and date of employee and supervisor.

1.2.4 Team Work

Nursing practice requires teamwork, an on-going interaction between members of the multidisciplinary team, the patients, patients' relatives and hospital managers. In working with colleagues and hospital management, the nurse must:

- Collaborate with the patient and their caregivers,
- Work with colleagues in formulation of overall goals, plans and decisions related to patients,
- Work with other members of the multidisciplinary team in caring for patients,
- Consult with other health care providers on patient care, as appropriate,
- Make referral, including provisions for continuity of care, as appropriate,
- Collaborate with other disciplines in teaching, consultation, management, and research, activities as opportunities arise,
- Participate in an organized health development army, and
- Nurses/midwives should assume responsibility for monitoring, evaluating and reporting of their activities within the Health Development Army.

It is essential that within a case team, ward/unit or department there exists a clear management structure that delineates the ultimate roles and responsibilities within the given team and clinical setting, determining who has clear authority over certain decision-making processes.

1.2.5 Clinical supervision and delegation

1.2.5.1 Clinical supervision

Clinical supervision is "a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance client/patient protection and safety of care".

It has also been defined as "an ongoing professional relationship with an experienced practitioner, to engage in guided reflection on current practice in ways designed to develop and enhance that practice in the future"

Effective processes for nursing clinical supervision will enable hospital to improve the quality of nursing care, to promote patient safety and to contribute to the professional development of our nursing staff. This document provides guidelines for the Clinical Supervision of Nursing Staff within

Model of Clinical Supervision

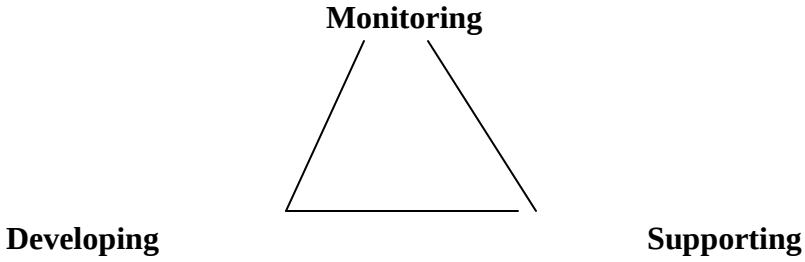
The interactive model of supervision developed by Proctor (1986) identified three functions for clinical supervision supportive, educative and managerial.

- ***Supportive:*** *This aims to support and enable nurses to* understand and manage the emotional stress of clinical practice.
- ***Educative:*** This approach aims to develop the skills and evidence based practice of the nurse/s.
- ***Managerial:*** This focuses on performance monitoring of the nurse/s professional and operational practice. It aims to promote nursing compliance with policies, protocols, procedures and standards and nursing contribution to clinical audit.

Function and Tasks of Clinical Supervision

Function	Task
• supportive	• To counsel • To consult
• educative	• To set up learning relationship • To teach
• managerial	• To monitor administrative aspects • To monitor professional and ethical issues • To evaluate

A supervisory relationship can also be described as one of 'monitoring, development and support'.



Some supervisees will require one aspect more than another depending on the nature of their work, for example supervisees working within critical care will perhaps need a greater emphasis on monitoring, while supervisees working in stressful situations such as mental health nursing or palliative care may need a more supportive type of supervision.

Application of Clinical Supervision within Nursing

It is in individual job descriptions and within individual case teams in the local health care facility that the format of Clinical Supervision will be agreed on, and clarification of the roles of team leaders/coordinators /managers, clinical supervisors and supervisees will be identified and made explicit. Senior Managers (Matron, Case Team Leaders etc) are expected implement Clinical Supervision for nursing staff following these guidelines. The role of clinical supervision for individual clinical staff should be determined collaboratively between the staff member (supervisee) and his/her line manager.

Clinical supervisor recruitment

Clinical supervisors should have the following characteristics:

- **Expertise:** This recognition may be either informal or formal through skills and experience in one's clinical role. Informal recognition may come primarily from peers. Formal recognition occurs through status and training, and possible senior or advance practitioner positions held within the hospital.
- **Experience**: The clinical supervisor will be recognised as having a breadth and depth of experience in his/her field of expertise.
- **Acceptability**: It is of prime importance that the clinical supervisor is acceptable to those he/she supervises.
- **Training:** It is desirable that all clinical supervisors receive appropriate training to provide them with the theories and models underpinning the principles of clinical supervision, the use of documentation, to practice experience at facilitating clinical supervision and to give opportunities for reflection on their own skills and areas for development.

The Clinical Supervisor may be the immediate line manager of the employee or could be another assigned individual. If the supervisor is not the line manager then the roles of the line

manager and clinical supervisor should be clearly known so that there is no confusion or misunderstanding between all parties.

Every nurse providing individual supervision or facilitation of a group should preferably have undergone preparation for the role. Experienced nurses will need to identify how this learning and development is provided to ensure that clinical supervisors are adequately prepared for the role and should identify further development needs in their own supervision.

The provision of clinical supervision

Each Department/Case Team should establish Clinical Supervision using one of the following approaches:

- **One-to-one supervision =** This is the most common form of clinical supervision. The supervisor is an expert from the same or another discipline. This may be the line manager, in which case clinical supervision will form part of the regular one to one support and operational monitoring function of supervision.
- **Group supervision =** This model of clinical supervision is with an expert supervisor from the same or another discipline; and can be utilised as peer review or action learning sets.
- **Network supervision =** This form of clinical supervision is a group of people with similar expertise, who do not work together on a day-to-day basis.

Developing a Working Agreement and how to supervise

Clinical supervision is a relationship and a commitment to regular clinical supervision meetings is essential. Clinical supervision is most effective when sessions last for a minimum of 1 hour, occur on a regular basis (at least 4 to 6 weekly) and are held away from the day to day workplace free from interruptions. [1]

The question on how to supervise should include:

- **First meeting**- the supervisor should focus on the nurse's understanding of his/her job description. He/she could then be asked if he/she believes they have the skills and knowledge for the job. If not, what needs to be done. Nurses could also be asked about the past month work experience (or the time period since last meeting) and to highlight any successes, problems or stresses they faced. The first supervision should finish with both

the supervisor and supervisee agreeing on an action plan that will address nursing care practice issues/developmental needs identified during the supervision session.

- **Second and subsequent meetings** - The supervisor and the supervisee should review the action plan agreed at the first supervision session. This will inform the focus of the supervision

Record Keeping

A record of the clinical supervision meetings may be maintained depending on the purpose of the clinical supervision. Any records must respect and maintain confidentiality of the patients/clients. Supervisees should be encouraged to maintain their own record of supervision and Supervisors should maintain a record so that they can follow up and build on previous discussions.

Confidentiality and Professional Responsibility and Accountability

It is important to remember that the supervisor's ultimate responsibility and accountability remain with the welfare of the patient or client. Lines of accountability and responsibility need to be clearly defined at the outset of the clinical supervision, during the negotiation of the contract between the supervisor and supervisee. If the supervisor becomes concerned about the practice of the supervisee, the supervisor is accountable to address it. In the first instance the supervisor should raise his/her concerns with the supervisee. However if, for whatever reason, the supervisee refuses to admit or recognise the problem or issue, it will be necessary for the supervisor to present the issue to a higher authority, such as the Department/Case Team Head, Human Resource Director or CEO, depending on the nature of the problem. In such circumstances this most probably will mean breaking confidentiality with the supervisee. Such action should only be taken after first informing the supervisee.

1.2.5.2 Delegation

Nurses/midwives may delegate tasks and responsibilities to junior nurses/midwives, student nurses/midwives or parallel position nurses/midwives. Before delegating, he/she must ensure that anyone they delegate to, is able to carry out the responsibility of what she/he delegates, and must provide adequate supervision to ensure that the outcome of any delegated task meets required standards.

1.2.6 Nursing/Midwifery Workforce Plan

Shortages of appropriate nursing/midwifery staff or inappropriate distribution of available staff adversely affects the quality of patient care. Inappropriate workforce planning has been related to staff dissatisfaction and nurse/midwife turnover, patient mortality, hospital-acquired infections, and the risk of needle- stick injuries.

The hospital should establish a nursing/midwifery workforce plan that:

- Establishes minimum nurse/midwife to patient ratios for each inpatient ward/service, taking the skill mix of staff into consideration,
- Identifies priority areas where the nurse/midwife count must at all times meet the minimum ratio requirements (for example intensive care/high dependency units, post-operative recovery, emergency department, labor and delivery etc.), and
- Establishes a procedure for transferring nurses/midwives across clinical settings, or calling in extra nurses/midwives from home in order to maintain minimum nurse to patient ratios, especially in the priority areas.

To determine the minimum nurse/midwife staff ratio the following factors to be considered include:

- The severity of the clinical condition of patients,
- The intensity of nursing/midwifery care needed, for example the frequency of nursing interventions such as observations, medication administration, wound care, stoma care, bathing etc..,
- The number of admissions and discharges,
- The availability of technology (patient monitors, beepers etc…),
- The skill mix of staff, availability and responsibilities of caregivers

There should be a minimum of a registered professional nurse/midwife in-charge of each ward/unit that has relevant knowledge, skills and experience with compassion and respect to manage a ward/unit and the nursing /midwifery staff therein. The nurse/midwife management team, together with hospital management should determine the minimum nurse/midwife to patient ratio for the unit. The ratio should be kept under review and amended as necessary.

The nursing/midwifery workforce plan should also consider the role of nurses/midwives in outpatient and specialist clinics and the nursing/midwifery contribution to hospital management and governance structures (such as quality committees, infection prevention committees etc.)

1.2.7 CPD and Professional Portfolio

The Professional Portfolio contains the four steps:

1. Self-Assessment of your learning needs,
2. Planning your learning goal,
3. Implementation of your plan, and
4. Self-Evaluation of what you have achieved.

This process is designed to encourage nurses to reflect in an effort to gain more from their learning. It is assumed that nurses are learning on a regular, if not daily, basis simply by virtue of practicing. The Portfolio provides a format for nurses to track all of those day-to-day learning activities in the Learning Log. These activities might include:

- In-services' training
- Grand rounds
- Reading journal articles
- Online searches on nursing related practice areas
- Conferences /workshops
- Discussion with colleagues or physicians

Nurses need to maintain a professional Portfolio because it:

- Supports nurses' progression throughout their nursing career.
- Serves as an evaluation tool that guides professional development.
- Offers a showcase for nurse performances related to essential knowledge, skills and dispositions.
- Allows the nurse to demonstrate growth and proficiency in regard to operational standards of nursing care practice.
- Facilitates collaboration and interaction through the sharing of on line projects and discussion of teaching skills.

- Provides a forum for publication and dissemination of artifacts that support instruction.
- Meets regulatory requirements.

Please refer **Teaching Portfolio in the diagram below as an example**

Teaching Portfolio

I am excited to be working with children and really making a difference in their lives.

I remember being so upset in class as a child because I did not understand what was being talked about in the classroom. A dedicated teacher helped me by recognizing my learning disability and finding ways to assist me. I owe my success to this amazing teacher who changed my life.

Those experiences made me who I am today and I am now helping others. I assist children making the transition to our school systems here in the United States both academically and culturally. I love my job and am very proud to be in this position making a difference.

I come to this profession with definite beliefs in mind in relation to who I will be as a successful teacher, employee, and member of your community. I am a teacher who most importantly embraces the development of a trusting environment with my students. In my opinion, students only open up to learning beyond the borders of basic requirements when trust is present. One of the skills I will utilize in building the before mentioned environment is found in the ability to communicate efficiently with one's students. I will not only provide educational data from the curriculum, but am a good listener willing to respond in kind to all ideas presented by the classroom community. I will also respond well to change in being open to learning from others in trying new approaches in lesson construction and delivery.

My teaching methodologies main objective is to inspire learning of content as well as developing the skills necessary for students to explore content and draw intelligent conclusions independently. I am committed to inspiring this critical exploration through stimulating teamwork amongst peers, being aware of different learning styles, teaching across subject boundaries, providing individualized accommodations, involving students in goal setting where appropriate, and being able to recognize and seize the moment when teachable moments occur. All of these approaches can be fostered through creative lesson planning.

1.2.8 Provision of Resources

Hospitals should ensure that nurses/midwives have access to and are trained on how to use resources (including equipment and consumables) correctly and cost-effectively. Nurses/midwives are responsible for forecasting stock-outs of nursing/midwifery formats and other consumables on the ward, and should inform the appropriate party of the need for additional resources to prevent stock out.

1.2.9 Nursing Process

The nursing process is an organized, systematic and holistic approach through which nursing/midwifery care provision is organized to achieve **patient/client** centered care. The nursing process involves Assessment, Diagnosis, Planning, Implementation and Evaluation of care (ADPIE). This should be done in collaboration with the patient/client, family and community. Assessment: the nurse/midwife collects comprehensive data pertinent to the patients'/client's health or situation.

Admission Assessment

A nurse/midwife collects and documents critical data regarding patient/client health status. This assessment remains accessible to the entire health care team during the course of the client/patient stay and beyond, in order to assist the team in determining proper client care and treatment. In the nursing assessment, the nurse gathers and examines both *Subjective* and *Objective* data within eight hours of patient admission.

- *Subjective data* are what the patient/client actually states (e.g. "I'm tired"). These are his/her feelings and perceptions.
- *Objective data are concrete, observable information and* investigation.

Ongoing nursing assessment

- Collects data on what is currently (during each shift) happening with the patient
  - Data can be objective or subjective
    - Objective: blood pressure, pulse, temperature
    - Subjective: patient's symptoms, what the patient reports

1.2.10 Nursing/midwifery practice audit program

The nursing/midwifery practice audit program should be part of the overall hospital quality improvement program. Nursing/midwifery practice audit is one of the tools to ensure the clinical effectiveness of nursing/midwifery care patients/clients receive. See chapter 19 EHSTG for more information on clinical audit process.

Purposes of Nursing Audit

- Evaluates nursing/midwifery care patients/clients receive.
- Promotes quality improvement of nursing/midwifery care.
- Improves quality of record keeping.
- Focuses on care provided and not on care provider.
- Contributes to research.

There are two methods of Nursing/midwifery audit:

1. Retrospective Review - this refers to an in-depth assessment of the quality of care after the patient has been discharged. The patient's chart is the source of data.

Retrospective audit is a method for evaluating the quality of nursing care by examining the nursing care, as it is reflected in the patient care records for discharged patients. In this type of audit, specific behaviors are described then they are converted into questions and the examiner looks for answers in the record. For example, the examiner looks through the patient's records and asks:

- Was the problem solving process used in planning nursing care?
- Was patient data collected in a systematic manner?
- Was a description of patient's pre-hospital routines included?
- Were laboratory test results used in planning care?
- Did the nurse perform a physical assessment? How was the information used?
- Did the nurse write nursing orders? And so on.

2. Concurrent Review - this refers to the evaluations conducted on behalf of patients who are still undergoing care. It includes assessing the patient at the bedside in relation to a pre-determined criterion; interviewing the staff responsible for this care and reviewing the patient's record and care plan.

Criteria Development Method:

- Define patient population
- Identify a time framework for measuring outcomes of care
- Identify commonly recurring nursing problems presented by the defined patient population
- State patient outcome criteria
- State acceptable degree of goal achievement
- Specify the source of information
- Determine the design and type of data collection tool

1.2.11 Standard Operational Procedure (SOP)

An SOP is a procedure specific to your operation that describes the activities necessary to complete tasks in accordance with health service regulations, provincial laws or even just your own standards for running your service.

Standard Operational Procedure can create,

- Efficiencies, and therefore profitability
- Consistency and reliability in service delivery
- Fewer errors in all service areas
- A way to resolve conflicts between service provider and client
- A healthy and safe environment
- Protection of employers in areas of potential liability and personnel matters
- A roadmap for how to resolve issues – and the removal of emotion from troubleshooting – allowing needed focus on solving the problem
- A first line of defense in any inspection, whether it be by a regulatory body, a partner or potential partner, a client, or a firm conducting due diligence for a possible purchase
- value added to your service should you ever wish to sell it

Developing an SOP is about systemizing all of your processes and documenting them

Steps in developing Standard Operational Procedures

- Designate a responsible person/persons
- Research the evidence
  - Literature
  - Ask other hospitals
- Write the SOP in standard format
- Publish in a SOP Manual
- Educate

Standard Operational Procedure standard format

- Policy/Purpose: statement that defines what the policy is about and the reason for it
- Equipment: list necessary equipment to do the procedure
- Procedure: Outlines and describes each step
- Documentation: Defines how, where and how often the procedure should be documented.
- Sources: List of references
- Approval: Usually Matron or Policy and Procedure Committee

Summary

- Procedure for the implementation of each operational standard described Managerial structure for nurses prepared and job description indicated

Session 1.3: Implementation Checklist and Indicators/Handout

Session objectives

After completing this session, the trainee will be able to

- Develop checklist for monitoring and evaluation
- Identify in addition, indicators for implementation

1.3.1 Assessment Tool for Operational Standards

- In order to determine if the Operational Standards of Nursing /Midwifery care standards have been met by the hospital an assessment tool has been developed which describes criteria for the attainment of a Standard and a method of assessment. This tool can be used by hospital management or by an external body such as the RHB or FMOH to measure attainment of each Operational Standard.

1.3.2 Implementation Checklist

- The following Table can be used as a tool to record whether the main recommendations outlined above have been implemented by the hospital. This tool is not meant to measure attainment of each Operational Standard, but rather to provide a checklist to record implementation activities.

Table 1. Nursing/Midwifery Care Standard Checklist

		Y	N
1.	There is a system for coordinating and managing nursing staff.		
2.	Job descriptions for nursing positions have been developed.		
3.	A nursing workforce plan has been developed.		
4.	The hospital's nurse staff requirements are defined in the nursing workforce		
5.	Nurse to patient ratios for each service area are defined in the nursing		
6.	There is a written policy for the nursing process.		
7.	Nurses complete nursing admission assessments for inpatients.		
8.	Nurses complete a nursing care plan for inpatients.		
9.	There are written guidelines for nursing verbal and written communication.		
10.	There are written guidelines for medication administration.		
11.	There is an established nursing/midwifery care practice audit program.		
12.	Nurses implement regular nursing/midwifery hours (eight)' shift.		
13.	Nurses conduct nursing care based on hourly rounds*.		
14.	There is a central medication room or cabinet.		
15.	There is a centralized nursing/midwifery station set-up in each ward.		

***Hourly rounding** can be defined as "a systematic, proactive nursing intervention designed to anticipate and address the needs of hospitalized patients."

1.3.3 Nursing/Midwifery Care Standards' Indicators

In addition, the following indicators should be monitored on a regular basis to assess the effectiveness/outcomes of implementation of the recommendations provided in this module.

Table 2. Nursing and Midwifery service standards process indicator

Quality statements	Quality measures	score	Remark/verification criteria's
Nursing and midwifery service standard 1: Each ward has all the necessary facilities, equipment and supplies needed to provide a quality nursing service			
NMS1.1 well equipped nursing station is established in each ward	Nurses' stations should have visibility of patients and of circulation paths.	1	
	The nurse station has organized and efficient chart filing systems in to a shelf	1	
	Should have dressing room/corner with personal lockable locker for all of the nurses working in the ward	1	
	The nursing /midwifery station has Enough space to accommodate • Computers with printer and internet access • Telephones • Shelf for ➢ Reference books, guidelines and policies ➢ Patient cards and different formats • Table • Comfortable chair • Access to clean drinking water • Hot plates/electrical hot pot	2	0 if all available except functional computer and telephone 2 if all available
	medical equipments for nursing diagnosis or intervention use – see annex	2	0 if two or more are missed 1 if only one missed 2 if all available
	Medication Preparation Areas with • Small under counter refrigerator. • Hand washing sink with disinfectant.	1	0 if either refrigerator or functional hand washing sink is not available 1 if both are available
	Nursing guidelines are availed • Nursing process • Nursing communication • Safe drug administration	1	0 if one of them is not available

NMS1.2 Medication stores are available for each ward or room	Central or room cabinet for medication store based on the patient bed number	2	Give 0 if any drug or supply is at bedside despite the presence of central or room cabinet
NMS1.3 Skill lab is established	the hospital has skill laboratory for staff and student nurses and all the necessary teaching aids are available – see annex	2	0 if two or more missed 1 if only one missed 2 if all present
Nursing and midwifery service standard 2: The hospital has functional Nursing midwifery management			
NMS2.1 The hospital has a Matron/ Nursing midwifery director and functional nursing/midwifery management	Matron/ nursing director is a member of SMT	1	0 if letter is available but the matron or nurse director is not regularly participate in SMT meeting
	The nursing management has annual operational plan	1	DOCUMENT REVIEW
	Induction or orientation is given for all newly recruited nurses/midwives Regular refreshment training is given for all nurses/midwives at least quarterly	5	DOCUMENT REVIEW Verify if it was done for all in the previous quarter / last month for new ones
NMS2.2 The nursing/midwifery management conducts QI projects for identified nursing midwifery service quality gaps	Nursing management conducts monthly nursing management meeting	2	DOCUMENT REVIEW Verify if it was done last month
	Nursing midwifery round team established and made at least once nursing round a day	22	See minutes of each working day last month and 1 for each day
	Nursing management develops action plan for identified gaps in each meeting	2	DOCUMENT REVIEW Verify if it was done last month
	Nursing management implemented the action plan developed	2	
Nursing and midwifery service standard 3: Quality nursing midwifery service is ensured for all patients			
NMS3.1 comprehensive nursing midwifery assessment is done for all patients	There is written evidence of a compilation of data based on Gorden's functional model including • demographic details • Health Perceptions-Health Management	10	CHART REVIEW

	Pattern • Nutritional-Metabolic Pattern • Elimination Pattern • Activity-Exercise Pattern • Cognitive-Perceptual Pattern • Sleep-Rest Pattern • Self-Perception and Self-Concept Pattern • Roles and Relationships Pattern • Sexuality-Reproductive Pattern • Coping and Stress Tolerance Pattern • Values and Belief Pattern		
	Nursing assessment is completed within 8 hours patient's arrival	10	Each ward should be handovering register between runners bring admitted patients from liaison office and nurses in the ward. Time of arrival of patient should be registered and the nurse and runner both has to sign on it. The absence of a handovering register or untimed nursing assessment will make the score 0
	All entries in the nursing process should be legible, dated and signed	10	CHART REVIEW
NMS3.2 correct nursing midwifery diagnosis is made for all patients	The formulated actual and/ or potential nursing diagnosis go with the nursing assessment (subjective and objective data) • Problem, Etiology and Signs(PES) for actual problem and • Problem and Etiology (PE) for potential or risk nursing diagnosis)	10	CHART REVIEW
	Nursing diagnosis is listed based	10	CHART REVIEW

	on their priority		
	The nurses/midwifes formulated nursing diagnosis based on revised NANDA list.	10	CHART REVIEW
	The expected goal/outcomes for each nursing diagnosis are SMART	10	CHART REVIEW
	The expected goal/outcome are consistent with nursing diagnosis	10	CHART REVIEW
	The nursing intervention/nursing order are clear, understandable and consistent with expected goal/outcome	10	CHART REVIEW
	The nursing interventions are prioritized	10	CHART REVIEW
NMS3.3 nursing midwifery interventions are implemented	The interventions are implemented/recorded according to the treatment plan	10	CHART REVIEW
	Counseling/information given to the patient is recorded according to plan	10	CHART REVIEW
NMS3.4 nursing midwifery evaluation is done after each intervention	The outcome measured at the end of the nursing intervention (all changes of subjective and objective markers are reviewed and documented on the progress shit)	10	CHART REVIEW
	The nursing plan is revised based on clients health status change	10	CHART REVIEW
	The outcome measured at the end of the nursing intervention (all changes of subjective and objective markers are reviewed and documented on the progress shit)	10	CHART REVIEW
NMS3.5 proper communication system is established b/n nurses and nurses/physicians	All physician order contains, • Name of patient • Date and time • Drug name • Drug dose, frequency, duration of treatment • Root of administration • Name and signature of physician	10 0 if one bullet is absent or incorrect	CHART REVIEW
	The physician written orders are	10	CHART REVIEW

	dated & timed, and signed by nurse when transcribed and administered		
	Verbal orders are signed by 2 nurses	10	CHART REVIEW
	Verbal orders are signed by physician within 24 hours	10	CHART REVIEW
	There is nursing round for each shift?	10	CHART REVIEW
	Does the hospital provide complete uniforms for nurses/midwives and do nurses/midwives comply with the institutions dress code?	10	Observation and document review
	Are nurses /midwives in complete uniform at all times at working place	10	Observation
	Patient records conform to the following requirements: • Legible • Dated • Name and signed after each entry/attendance • Errors crossed with a single line and errors initialed • Patient's name and medical record number on each page • Abbreviations are contained within a locally agreed glossary	10 0 if one bullet is absent or incorrect	
NMS3.6 All nursing and other formats are put in logical sequence	Formats are put in the client chart in logical sequence (V/S sheet, Input output monitor, physician assessment form, nursing assessment form, nursing diagnosis form, nursing care plan form, nursing intervention and medication administration form, nursing progress/evaluation form, discharge form)	10	CHART REVIEW
Nursing and midwifery service standard 4: Patient centered nursing midwifery service is given to all patients			
NMS4.1 All patients are involved in the plan of care	There is a system to involve all patients when changes to nursing/midwifery services are proposed	10	CLIENT INTERVIEW

	All patients are provided with information about arrangements for first contact	10	CLIENT INTERVIEW
	All patients are informed about: • access to services • how to make a complaint • consent to treatment • discharge planning	10	CLIENT INTERVIEW
NMS4.2 All patients were approached with dignity and respect, addressed by name and encouraged to ask questions	During treatment sessions, patients are introduced the name of the nurse or midwifes responsible for his/her care and all patients are addressed by their name	10	CLIENT INTERVIEW
	Staffs are polite and considerate	10	CLIENT INTERVIEW
	All patients are given all the privacy they need	10	CLIENT INTERVIEW
	All patients are given the chance to ask questions	10	CLIENT INTERVIEW
NMS4.3 All patients are informed of treatment outcomes and discharge plan	All patients felt involved in deciding about their treatment plan (informed consent) and all are told about what they could achieve at the end of their treatment	10	CLIENT INTERVIEW
	the results of the assessments/procedures are explained to all patients	10	CLIENT INTERVIEW
	If patients are left alone during treatment session, they are told how to call for help	10	CLIENT INTERVIEW
	During discharge, all patients felt involved in the plans for their discharge and given appointment instruction	10	CLIENT INTERVIEW
	During discharge, all patients are given enough advance warning for their discharge and all the plans for their discharge went smoothly	10	CLIENT INTERVIEW

Table 3. Nursing/Midwifery Care Standards outcome Indicators

S/N	Indicators	Formula	Frequency	Comment
1.	Pressure sore incident rate	Number of pressure sores/number of admissions*100	Quarterly	HMIS
2.	Attrition rate of nursing staff	Total number of nurses leaving/total number of nurses at beginning of reporting period * 100	Quarterly	HMIS
3.	Attrition rate of midwifery staff	Total number of midwives leaving/total number of nurses at beginning of	Quarterly	HMIS
4.	a) Cumulative number of nursing staff who received in service training b) % of nursing staff who received in service training	a) Total number of nursing staff with in-service training from the beginning of year to the end of reporting period b) Cumulative number of nursing staff who received training/ Total number of	Quarterly	HMIS
5.	a) Cumulative number of midwifery staff who received in service training b) % of midwifery staff who received in service training	a) Total number of midwifery staff with in-service training from the beginning of year to the end of reporting period b) Cumulative number of midwifery staff who received training/ Total	Quarterly	HMIS
6.	In patient satisfaction survey : % of respondents who answer 'always or usually' to the following questions: a) During this health facility stay, how often did nurses treat you with courtesy and respect? b) During this health facility stay, how	Total number of inpatients who respond 'always or usually' to the questions listed/ Total number of inpatients respondents*100	Biannual	Survey tool

7.	Healthcare acquired infection rate	Total number of patients with an infection arising >48 hours after admission during reporting period /total number of admissions during reporting period *100	Quarterly	
8.	Surgical site Infection	a. Total number and percentage of patients with elective Caesarean section who developed post op wound infection b. total number and percentage of patients with clean surgical procedure who developed surgical site infection	Quarterly Quarterly	

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Module -II Nursing Ethics

Module -II Nursing Ethics

Module Description

This module is designed to equip trainees with the required knowledge, attitude and practice regarding essential components of the nursing ethics. The course will address the principles of nursing ethics, nursing values, and ethical dilemmas, legal issues in nursing, ethical decision-making and professional code of ethics. The course will also enable nurses to provide quality nursing care by influencing their attitude positively.

Module Objective:

Up on completion of this module the trainees will be able to demonstrate ethical principles and use appropriate ethical decision-making approaches.

Enabling objectives:

After completing this module, the trainees will be able to:

- Describe ethics
- Describe ethical principles
- Discuss ideal nursing ethical competencies
- Describe elements ethical dilemma and distress
- Apply Ethical decision-making models to solve ethical dilemmas
- Discuss legal issues in relation to the nursing practice
- Demonstrate sound ethical decision making ability
- Describe code of ethics

Session outline

Session-1: Introduction to Nursing Ethics

Session 2: Nursing Ethical principles

Session 3: Nursing Values

Session 4: Ethical Dilemmas and Ethical distress in Nursing

Session 5: Ethical Decision Making in the Nursing Practice

Session 6: Legal Aspects of the Nursing Practice

Session 7: Nursing Code of Ethics

Session 2.1. Introduction to Nursing Ethics

Session Objectives

- Define Nursing Ethics

> **Activity 2.1: Probing question**
>
> **What is Ethics?**

Definition:

The word ethics is derived from the Greek word "ethos", which means custom or guiding beliefs. Ethics determines the characteristics of a profession and is also called as a "code of conduct". Nursing ethics provides the professional standards for nursing activities, which protect the nurses and the patients from legal and ethical issues.

Ethics- Rules of conduct recognized in respect to a particular class of human actions or a particular group.

Ethics (sometimes called morals or moral philosophy):

- is concerned with fundamental principles of right and wrong and what people ought to do
- inform our judgments and values and help individuals decide on how to act

Guidance on acting ethically is informed by accepted ethical theories, principles and frameworks.

The International Council of Nurses Code of Ethics is grouped into four distinct areas. These four distinct areas define the responsibilities of the individual nurse and nursing as a whole. The four areas are: to promote health, to prevent illness, to restore health, and to alleviate suffering. Nursing also embraces human rights and provides care without regard to conditions of race or culture. In nursing, the patient may be an individual, a family, or a community (ICN).

A theme common to the ANA (2001) and ICN (2006) code is a focus on the importance of compassionate patient care aimed at alleviating suffering.

The American Nurses Association wrote the Code of Ethics for Nurses in order to serve the following purposes:

- As a statement of the ethical obligations and duties of every person who chooses to enter the profession of nursing.
- To act as the nonnegotiable standard of ethics
- To serve as an expression of the understanding on nursing's commitment to society.

Summary

Ethics is rules of conduct recognized in respect to a particular class of human actions or a particular group. It is concerned with fundamental principles of right and wrong and what people ought to do. Ethics inform our judgments and values and help individuals decide on how to act

Session 2.2: Ethical Principles

Session Objectives

- Identify principles of nursing
- Describe different principles of nursing

Ethical principles provide criteria on which to base judgments in relation to ethical theories. Ethical principles include:

Activity: 2.2.1

State Principles of Ethics You Know

Beneficence – doing or promoting good.

- Compassion; taking positive action to help others; desire to do good; core principle of our patient advocacy.
- Beneficence is doing or active promotion of good. This is done by:
  - Providing health benefits to the clients.
  - Balancing the benefits and risks of harm.
  - Considering how a client can be best helped.

Example: *An elderly patient falls at home and has a fractured hip. In the emergency room, the nurse acts to provide pain medication as soon as possible in an act of beneficence.*

Non-maleficence - to do no harm

- Avoidance of harm or hurt; core of medical oath and nursing ethics.
- Often in modern times, non-maleficence extends to making sure you are doing no harm in the beneficent act of using technology to extend life or in using experimental treatments that have not been well tested.
- Avoiding deliberate harm, risk of harm that occurs during the performance of nursing actions.
- Considering the degree of risk permissible.

- Determining whether the use of technological advances provides benefits that outweigh risks.

***Example**: When this elderly person above received pain medication (an act of beneficence) there are complications that could arise. Practitioners recognize that using a narcotic may cause confusion. When obtaining the consent for her hip surgery, we want to make certain that the patient is alert enough to understand the risks and benefits of the procedure. We must balance the beneficence of providing the medication quickly with the possible maleficence of obtaining consent when patient does not have the capacity to make the decision for surgery.*

Autonomy

- The third ethical principle, autonomy, means that individuals have a right to self-determination, that is, to make decisions about their lives without interference from others. What are some of the ethical issues to be raised when applying this principle to interstate nursing practice?
- Respecting a client's rights, values and choices is synonymous to respecting a person's autonomy. Informed consent is a method that promotes and respects a person's autonomy. For a client to make an autonomous decision and action, he or she must be offered enough information and options to make up his or her mind free of coercion or external and internal influences. In clinical settings, this is promoted by proving informed consent to the client.

***Example:** In clinical situations nurses respect a patient's autonomy, where the patient is allowed the freedom of choice regarding treatment, such as in deciding whether he/she wishes to be intubated during an exacerbation of COPD, or deciding when he/she wishes to forgo further dialysis. If a patient lacks capacity for such a decision and has an advance directive, the person who has the durable power of attorney can make the decision.*

Justice

- Derived from the work of John Rawls, this principle refers to an equal and fair distribution of resources, based on analysis of benefits and burdens of decision. Justice implies that all citizens have an equal right to the goods distributed, regardless of what they have contributed or who they are.

- Justice is the promotion of equity or fairness in every situation a nurse encounters. The following nursing implications promote justice:

    - Ensuring fair allocation of resources. (example: appropriate staffing or mix of staff to all clients)
    - Determining the order in which clients should be treated. (example: priority treatments for the clients in pain)

Example: *A hospital organization wishes to donate low or no-cost pediatric dental services to the community. There are openings for 45 children per month. Justice requires a fair method that is free from bias, to determine who will receive these services.*

Veracity – duty to tell the truth

- It requires the health care provider to tell the truth and not intentionally deceive or mislead clients. After decision is made, the nurse should be truthful to the patient. Tell him the decision and why they chose it. Sometimes nurses can give false Reassurance, or tell the patient something different just to shut the patient up or spare the patient from worrying too much.

Fidelity- duty to keep promises

- This principle requires loyalty, fairness, truthfulness, advocacy, and dedication to our patients. It involves an agreement to keep our promises. Fidelity refers to the concept of keeping a commitment and is based upon the virtue of caring.

    Example: *A patient asks the nurse not to reveal the fact that she is dying or give her diagnosis to his family. The nurse asks why she does not want her family advised. The patient explains that her family is very emotional and has stated they would do everything to keep her alive, even if it required long-term mechanical ventilation. The patient has explained multiple times that she does not want mechanical ventilation. The nurse recognizes that keeping of this information in confidence, while supporting the family, is an example of exercising fidelity.*

Privacy and Confidentiality

- The fifth ethical principle relates to privacy and confidentiality. Privacy belongs to each person and, as such, it cannot be taken away from that person unless he/she wishes to share it. Confidentiality, on the other hand, means that the information shared with other

persons will not be spread abroad and will be used only for the purposes intended. A patient's sharing of private information imposes a duty of confidentiality on health care providers. That duty means providers will share information only on a need-to-know basis.

Paternalism

- Healthcare professionals make decisions about diagnosis, therapy, and prognosis for the patient. Based upon the health care professional's belief about what is in the best interest of the patient, he/she chooses to reveal or withhold patient information in these three important arenas. This principle is heavily laden as an application of power over the patient.
- Described as a dominant attitude of one over another --- providers who were expected to make the best decision for the patient. Some of the nurses who has been with the facility for a long time expressed their opinions, which was "We follow the rule, let the physician make the decision, We follow his order" This type of ethical principle can be tricky sometimes. Because some physicians decisions/orders aren't always the right decision.

  Example: *Patient has repeatedly voiced fear over receiving a diagnosis of lung cancer, as he believes this is a death sentence. His primary care physician decides not to reveal the diagnosis to the patient after he says he would kill himself if he had lung cancer.*

To practice in an ethically sound professional manner it is necessary to balance ethical considerations, with professional values and relevant legislation. The essence of ethical practice at all levels involves an individual, or team identifying what the legal, ethical and professional standards required are and how these can be caring and compassionately applied to the challenges of clinical practice.

Activity 2.2.2 Case Studies

Read the following case studies in group and answer the question that follows it

Case Study 2.2.1

An ill-appearing 2-years-old with fever and stiff neck appears to have meningitis. His parents refuse a lumbar puncture on the grounds that they have heard spinal taps are extremely dangerous and painful.

Discussion Questions:

a. What is the ethical issue?

b. What should you do?

Case Study 2.2.2

The nurses in a critical care unit had been under a great deal of stress from very ill patients, a high census, and frequent staff illnesses during a 2-week period. On one particular evening, two nurses recognized that they were developing the symptoms of an upper respiratory infection that had been affecting other members of the staff. Because they had three post-op patients needing one-on-one care and were receiving another admission from the emergency room, the nurses solicited medication from the house staff in order to suppress their symptoms and "keep going." Although they were able to remain working on the unit and not contribute to an already critical staffing situation, they recognized that they might be causing harm by communicating their illnesses to already vulnerable patients and by risking making mistakes while under the influence of medications (antihistamines).

The two nurses contemplated the alternatives. They were convinced that the additional risk to the patients was quite small, and they believed that the patients were in real need of the one-on-one care that could only be provided if they remained on duty. They concluded that, on balance, the good they could do exceeded the risk of harm, but they wondered: Is there a special obligation for health professionals to avoid harm?

Discussion Questions:

a. What is the ethical issue?
b. What should you do?

Case Study 2.2.3

After reviewing the needs of all patients on a medical /surgical nursing care unit, night nurse Martha decides that she must set priorities for her time among four needy patients. One,

Mrs. Aster, is an 83-year-old woman with a cerebrovascular accident who is semi-comatose and inevitably dying but who needs suctioning every 15 to 20 minutes. The second, Mr. Bewketu, 47 years old, was admitted with gastrointestinal bleeding and has already had several bloody stools. The third, 52-year-old Mr. Haillu, is a recently diagnosed diabetic with unstable blood sugar levels receiving insulin per IV and requiring frequent vital sign checks. The fourth, 35-year-old Mr. Mersha, is a patient who learned today that he has inoperable cancer with metastasis to the spine. He has been suicidal in the past.e Nurse realizes that these patients have different needs.

Discussion Questions:

a. What is the ethical issue?
b. What should you do?

Case Study 2.2.4

The night-shift nurse, pages the resident on call when a newly admitted female patient (for observation following a car accident, age 46, history of asthma) develops anxiety, wheezing, increased blood pressure, and tachycardia. By the time the sleepy and somewhat disoriented resident comes to the unit, the patient has severe shortness of breath. The Nurse has alerted the ICU and is prepared to intubate the patient. The resident takes over and decides to do a hasty tracheotomy before transporting the patient to the ICU. While doing the tracheotomy, he severs a major blood vessel, and the patient loses a great deal of blood. A trach tube is put in place, however, and the patient is quickly prepared for transportation to the ICU. At this point, The Nurse realizes that the portable oxygen tank does not seem to be functioning properly. The patient remains oxygen deprived and is brought to the ICU. The patient never gains consciousness and dies 6 hours later. The death is not related to injuries from the car accident.

Discussion Questions: a. What is the ethical issue?

b. What should you do?

Case Study 2.2.5

Nurse Alem and Martha have been colleagues for a long time—they have worked together at the same hospital for 6 years. Since obtaining a divorce, however, Martha personality has changed. She often makes silly comments or giggles at inappropriate times. At other times, Martha is very irritable and resorts to taking medication for her "nerves." Nurse Alem suspects that her friend is developing a drug dependency. Her suspicion is confirmed one day when Martha asks Alem to work for her while she sleeps off the effects of some medication. Martha acknowledges that she has been taking cocaine but asks Alem not to tell other nurses about the nature of her problem. Alem promises not to tell.

The next day, however, Alem finds Martha asleep in a chair in an empty room when she should be taking care of a patient. Does Alem have an obligation to break the promise she made to Martha in order to protect their patients from unsatisfactory levels of nursing care? How much respect for confidentiality can one expect from a fellow nurse?

Discussion Questions: a. What is the ethical issue?

b. What should you do?

Summary

Ethical principles provide criteria on which to base judgments in relation to ethical theories. Ethical principles include: Beneficence, Non-maleficence, Autonomy, Justice, Veracity, Fidelity, Privacy and Confidentiality and Paternalism

Session 2.3. Nursing values and moral values

Session Objectives:

- Explain nursing values
- Discuss ideal nursing ethical competencies

Activity 2.3.1 : Point of reflection

- Why do you think being a nurse is important, worthwhile and worth striving for?
- What do you think the nurse should value most and why?
- Have you ever felt you are maintaining these values? If not why and what should be done to maintain these values?

Definition of nursing values

Nursing care is usually provided at an individual level, involving both task aspect and a relational aspect. The person in need of nursing care may require support, guidance and active help with something (objective aspect), which, in addition, must be provided in an agreeable manner (relational aspect).

Nurses provide appropriate nursing care based on the values they have selected. These values form a framework to evaluate their activities influencing their goals, strategies, and function. These values can also be counted as a resource for nurses' conduct toward clinical ethical competency and their confrontation with contemporary ethical concerns.

Values are unwritten standards, ideals, or concepts that give meaning to a person's life and that often serve as a guide for making decisions and setting priorities in daily life. Values are viewed as "what is important, worthwhile and worth striving for" and made who we are as individuals. How individual personal values are protected is impacted by the society, culture, morals and beliefs (Horton et al 2007). Values are related and overlapping. It is important to work toward keeping in mind all values in the code at all times for all people in order to uphold the dignity of all.

Values are also beliefs that are considered to be socially and personally desirable and therefore are recognized as being important in organizations. If there is any conflict between personal

values and organization values, nurses can be challenged and tend not to follow a directive or requirement with which they disagree. Societal, organizational and personal values all influence the way people operate in large institutions.

Value could be explicated in terms of degrees between polar opposites such as, for example, socially useful/useless, prestigious/low-status, fulfilling/unfulfilling, skillful/unskilled, respected/disrespected, opportunities for advancement/dead-end, requiring certain (named) virtues/not requiring certain (named) virtues, supported/unsupported, autonomous/dependent and so forth.

The term *professional nursing values* refers to the attitudes, beliefs, and priorities of nurses that ultimately functions as a guide and motivation in interactions with patients, colleagues, and other professionals (Leners, Roehrs, Piccone, 2006). They are the guiding beliefs and principles that influence your work behaviour. Professional nursing values, while individually held, are shared among nurses, so that a duty to self that is jeopardized in the work setting for one nurse may by circumstances apply to all nurses in that setting. Healthcare professionals need an awareness of their values and an understanding of how those values influence their behaviour and its impact on humanistic care.

Ideal Nursing Ethical Competencies

Activity 2.3.2 : Point of reflection

1. What are the characteristics of an ideal nurse?
2. To what extent nurses are applying these characteristics?

The ethical competencies identified to characterize a well-defined, ideal nurse comprise 10 competencies divided into 3 major categories:

1. Moral integrity: i. Honesty ii. Truthfulness and truth telling, iii. Benevolence iv. Wisdom and v. Moral courage;	**2. Communication:** i. Mindfulness and ii. Effective listening; and **3. Concern:** i. Advocacy ii. Power and iii. Culturally sensitive care

Moral Integrity

Moral Integrity

"State of being, acting like, and becoming a certain kind of person. This person is honest, trustworthy, consistently doing the right thing and standing up for what is right despite the consequences" (Laabs's, 2011).

- Moral integrity is the quality and wholeness of character, it is necessary to realize full human flourishing.
- People with moral integrity follow a moral compass and usually they do not vary by appeals to act immorally.
- People with moral integrity:
  - ✓ Pursue a moral purpose in life,
  - ✓ Understand their moral obligations in the community, and

✓ Are committed to following through regardless of constraints imposed on them by their workplace policies.

- Nurses of good character consistently use their intellectual ability and moral propensity accompanied by pragmatic application to execute good and right actions.
- A person with moral integrity manifests
  - i. Honesty
  - ii. Truthfulness and truth telling,
  - iii. Benevolence,

iv. Wisdom, and

v. Moral courage.

i. Honesty

- Nurses perceived honesty as a virtue related to facts, metaphors, ethics, and communication, and they perceived truth telling as a palpable feature in trusting relationships.
- Honesty, in simple terms, is being "real, genuine, authentic, and bona fide" (Bennett, 1993)
- Honesty is a well thought out and rehearsed behaviour that represents commitment and integrity.
- Nurses must
  - ✓ Stay true to their word.
  - ✓ Stay committed to their promises to patients and
  - ✓ Follow through with appropriate behaviours, such as returning to patients' hospital rooms as promised to help them with certain tasks.
- Honesty is also about being honest with one's self
- Nurses need to establish a routine checkpoint system of ongoing self-evaluation to retain and improve honesty in actions and relationships with patients and others.

ii. Truthfulness and truth telling

Activity 2.3.3 : Point of reflection

- Are there ever circumstances when nurses should be morally excused from telling the truth to their patients?

- **Truthfulness is,**
  - ✓ The intermediate state between imposture (excessiveness) and self-deprecation (deficiency).
  - ✓ Being genuine in all words and deeds and is never false or phony.
- A truthful person speaks in a way that symbolizes who the person really is.
- Truth telling in the healthcare environment, means nurses are usually ethically obligated to tell the truth and are not intentionally to deceive or mislead patients

Activity 2.3.4 : Point of reflection

- Are there ever circumstances when nurses should be morally excused from telling the truth to their patients?

- Some reasons nurses or physicians might avoid telling the full truth include the following:
  - They are trying to protect patients from sad and heart-breaking news,
  - They do not know the facts, or
  - They state what they know to be untrue about the situation rather than admit everything they know to be true.

Activity 2.3.5: Point of reflection

Case study 2.3.1

In one rural hospital you are the nurse caring for a woman with low socioeconomic status scheduled for a hysterectomy because of uterine cancer. The community knows her surgeon as having a bad surgical record in general, but especially in performing hysterectomies. The woman previously heard gossip to this effect and asks you about it before her surgery because she is apprehensive about using the surgeon. You know at least one legal suit has been filed against him because you personally know the woman involved in a case of a botched hysterectomy.

- Discuss these options and any other ideas you may have regarding this case. As a nurse who wants to be committed to an ethical nursing practice, what actions might you consider in this difficult circumstance? Be as objective as possible.

iii. Benevolence

- Benevolence is a "morally valuable character trait, or virtue, of being disposed to act to benefit others" (Beauchamp, 2013, Part 1, para. 2).
- Some people believe benevolence surpasses the act of compassion.

- Nurses who use benevolence as a central motivating factor do not just perform acts of kindness in a haphazard fashion when the opportunity arises; they seek out ways to perform acts of kindness rather than only recognizing ways to do good

Benevolence

Altruistic, kind-hearted, caring, courteous, and warm-hearted are characterizations of a benevolent person; also, in definitions of compassionate care, kindness and benevolence, among others, are common descriptors.

iv. Wisdom

- It requires calculated intellectual ability, contemplation, deliberation, and efforts to achieve a worthy goal.
- Wisdom is an excellence of genuine quality that develops with intellectual accomplishment, and practical expertise (Broadie, 2002).
- Nurses must have the feature of intellectual accomplishment and the proclivity to seek the right and the good

v. Moral Courage

- Nurses with moral courage stand up for or act upon ethical principles to do what is right, even when those actions entail constraints or forces to do otherwise.
- If nurses have the courage to do what they believe is the right thing in a particular situation, they make a personal sacrifice by possibly standing alone, but they will feel a sense of peace in their decision.
- If nurses are in risky ethical situations, they need moral courage to act according to their core values, beliefs, or moral conscience.
- For nurses to act with moral courage means they choose the ethically right decision, even when under intense pressure by administrators, co-workers, and physicians.
- Examples of having moral courage are:
  - Confronting or reporting a peer who is stealing and using drugs at work;

- Confronting a physician who ordered questionable treatments not within the reasonable standard of care;
- Confronting an administrator regarding unsafe practices or staffing patterns;
- Standing against peers who are planning an emotionally hurtful action toward another peer; and
- Reporting another nurse for exploitation of a patient or family member, such as when a nurse posts a picture or a story of a patient on a social networking site.

Concern

- The competency of concern means that nurses feel a sense of responsibility to think about the scope of care important for their patients; sometimes a sense of worrying about the health or illness of patients prompts nurses to action.

i. Advocacy

- A general definition of advocacy is pleading in favour of or supporting a case, person, group, or cause, but many variations on the definition of advocacy exist.
- Three central characteristics of patient advocacy related to professional nursing ethics are: in their concept analysis:
  - Safeguarding patients' autonomy
  - Acting on behalf of patients
  - Championing social justice in the provision of health care (Jezewski, 2006)
- Nurses are to be advocates for patients and their rights; for public and community social justice areas of health care, policy, and economics; and for each other.
- Barriers to nursing advocacy (Hanks, 2007)
  - Conflicts of interest between the nurse's moral obligation to the patient and the nurse's sense of duty to the institution
  - Institutional constraints
  - Lack of education and time
  - Threats of punishment
  - Gender-specific, historical, critical social barrier related to nurses' expectations of a subservient duty to medical doctors.

ii. Power

- Nurses with power have the ability to influence persons, groups, or communities.
- Because nurses participate in and direct activities involving patient care, they are in powerful positions to improve quality in patient care and oversee professional nursing practice standards.
- As nurses integrate and use their power in a "collaborative, interdisciplinary effort focused solely on the patients and families that the nurse and care team serve and with whom they partner" (Ponte et al., 2007).

Properties of a powerful professional practice

- ❖ Acknowledge their unique role in the provision of patient- and family-centered care.
- ❖ Commit to continuous learning through education, skill development, and evidence based practice.
- ❖ Demonstrate professional comportment [manner in which one conducts oneself] and recognize the critical nature of presence.
- ❖ Value collaboration and partner effectively with colleagues in nursing and other disciplines.
- ❖ Actively position themselves to influence decisions and resource allocation.
- ❖ Strive to develop an impeccable character: to be inspirational, compassionate, and have a credible, sought-after perspective (the antithesis of power as a coercive strategy).
- ❖ Recognize that the role of a nurse leader is to pave the way for nurses' voices to be heard and to help novice nurses develop into powerful professionals.
- ❖ Evaluate the power of nursing and the nursing department in organizations they enter by assessing the organization's mission and values and its commitment to enhancing the power of diverse perspectives.

Source: Quoted from Ponte, P. R., Glazer, G., Dann, E., McCollum, K., Gross, A., Tyrell, R. . . . Washington, D. (2007). The power of professional nursing practice—an essential element of patient and family centered care. *The Online Journal of Issues in Nursing, 12*(1)

iii. Culturally Sensitive Care

- Culturally sensitive care means nurses must first have a basic knowledge of culturally diverse customs and then demonstrate constructive attitudes based on learned knowledge (Spector, 2012).
- Cultural competence is the adaptation of care in a manner that is consistent with the culture of the client and is therefore a conscious process and nonlinear. (Purnell, 2002, p. 193)
- The following cultural assessment is an easy and quick approach based on ASK (Awareness, Sensitivity, And Knowledge):
  1. What is the patient's ethnic affiliation?
  2. Who are the patient's major support persons and where do they live?
  3. With whom should we speak about the patient's health or illness?
  4. What are the patient's primary and secondary languages, and speaking and reading abilities?
  5. What is the patient's economic situation? Is income adequate to meet the patient's and family's need? (Lipson & Dibble, 2005)

Summary

Values are viewed as "what is important, worthwhile and worth striving for" and made who we are as individuals. Values are also beliefs that are considered to be socially and personally desirable and therefore are recognized as being important in organizations.

The term *professional nursing values* refers to the attitudes, beliefs, and priorities of nurses that ultimately functions as a guide and motivation in interactions with patients, colleagues, and other professionals.

Session 2.4. Ethical Dilemma and Ethical Distress in Nursing

Session objectives

- Describe elements of ethical dilemma and distress
- Apply Ethical decision-making models to solve ethical dilemmas and distress

2.3.1. Ethical dilemmas

Activity 2.4.1: Point of reflection

1. Have you ever felt difficulty to choose between two or more options that will affect the outcome of the patient you care for?
2. Have you sometimes withhold information from a patient or his families because of fear of its adverse effect?
3. Have you ever felt frustration because all possible options have both positive and negative consequences?

Ethical dilemmas is situations arising when equally compelling ethical reasons both for and against a particular course of action are recognized in which the appropriate choice in the situation is unclear and a decision must be made

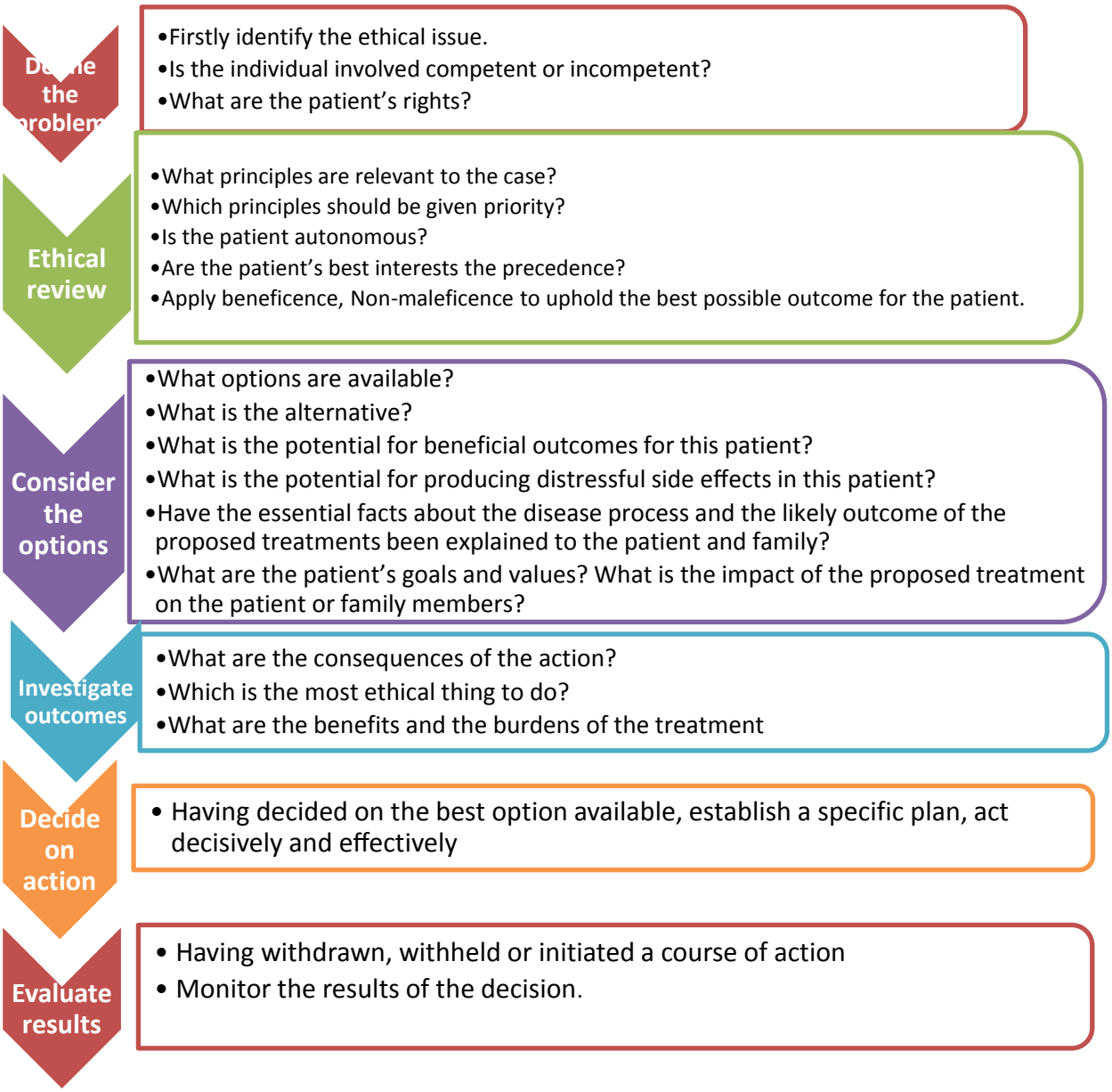
It is a situation in which a person must choose between two options that will affect the outcome of the case. Although each option can be justified as "good," both have pros and cons. Therefore, when one option is selected or implemented, it creates uncertainty in the outcome of the case (Butts & Rich, 2013).

Exercising moral accountability means the nurse will make a reasoned judgment about what is right and will act accordingly. An individual nurse's determination of what is right may or may not be the same decision that others, including those to whom the nurse is accountable, believe is the right decision.

In fact, many ethical dilemmas are regular occurrences in the clinical setting. Many ethical dilemmas arise related to situations such as inadequate staffing protection of patients' rights, unethical practices of health care professionals, end-of-life decision making, and breeches in confidentiality (Ulrich et al, 2010).

The ethical decision-making process provides a method for nurses to answer key questions about ethical dilemmas and to organize their thinking in a more logical and sequential manner.

The DECIDE model to achieve morally and ethically sound decisions., as described by Thompson et al. (2003), constitutes the following process shown in Table 7.3.


Define the problem
•Firstly identify the ethical issue.
•Is the individual involved competent or incompetent?
•What are the patient's rights?
Ethical review
•What principles are relevant to the case?
•Which principles should be given priority?
•Is the patient autonomous?
•Are the patient's best interests the precedence?
•Apply beneficence, Non-maleficence to uphold the best possible outcome for the patient.
Consider the options
•What options are available?
•What is the alternative?
•What is the potential for beneficial outcomes for this patient?
•What is the potential for producing distressful side effects in this patient?
•Have the essential facts about the disease process and the likely outcome of the proposed treatments been explained to the patient and family?
•What are the patient's goals and values? What is the impact of the proposed treatment on the patient or family members?
Investigate outcomes
•What are the consequences of the action?
•Which is the most ethical thing to do?
•What are the benefits and the burdens of the treatment
Decide on action
• Having decided on the best option available, establish a specific plan, act decisively and effectively
Evaluate results
• Having withdrawn, withheld or initiated a course of action
• Monitor the results of the decision.

Activity 2.4.2: Point of reflection

Reflect on a situation that commonly recurs in your practice setting that creates ethical dilemma for you and your staff. Then think through the following questions.

1. Is the ethical dilemma truly a situation where there are more than one options and you face difficulty to choose one? To what degree does the situation the interest of different parties (families, other professionals) complicate the scenario?
2. What was your final decision and what was its consequence? Was your decision effective and what would be done differently if not? What would need to change to resolve ethical dilemma and is such change possible?

Ethical/Moral distress

Activity 2.4.3: Point of reflection

- Have you ever felt like you knew the best thing to be done for a patient but felt that you could not do it?
- Have you sometimes wanted to "break the rules" because there were policies and procedures that prevented you from doing what you thought was best in a situation?
- Have you ever felt frustration because you sensed that the patient's voice wasn't being heard when decisions were being made about care?

- When what we think we would do differs from what we think we should do (i.e., the ethically right decision/course of action) either our moral agency is deficient, moral distress is present or some combination of deficient moral agency and moral distress are operative.

  Moral/ethical distress is an emotion that occurs when nurses have identified and know what right response is called for, but institutional or other constraints make it almost impossible to pursue the right course of action (Jameton, 1984).

- The constraints may include
  - ✓ Legal rules,
  - ✓ Institutional policies,
  - ✓ Lack of decision-making authority, and
  - ✓ Lack of recognition of the individual's moral agency.

- Nurses may experience moral distress as they analyze a situation; they may not always be able to articulate the ethical components but will describe feeling that something "is not right."
- When experienced, moral distress has situational, cognitive, action, and feeling dimensions, as well as short- and long-term effects. It results in :
  - ✓ Significant physical and emotional stress, which contributes to nurses' feelings of loss of integrity and dissatisfaction with their work environment.
  - ✓ It affects relationships with patients and others and can affect the quality, quantity, and cost of nursing care.
- Groups of people who work together in situations that cause distress may experience
  - ✓ Poor communication,
  - ✓ Lack of trust,
  - ✓ High turnover rates,
  - ✓ Defensiveness, and
  - ✓ Lack of collaboration across disciplines.
- An environment of good communication and respect for others is essential for decreasing the likelihood of experiencing moral distress
- Moral distress is linked to
  - ➢ Incompetent or poor care,
  - ➢ Unsafe or inadequate staffing,
  - ➢ Overwork,
  - ➢ Cost constraints,
  - ➢ Low job satisfaction
  - ➢ Nurses turnover
  - ➢ Ineffective policy,
  - ➢ Futile care,
  - ➢ Unsuccessful advocacy,
  - ➢ The current definition of brain death,
  - ➢ Objectification of patients, and
  - ➢ Unrealistic hope

The American Association of Critical-Care Nurses (AACN) ethics work group developed a call-to-action plan titled Four A's to Rise Above Moral Distress (2004) as a guide to identify and analyze moral distress:

1. **Ask** appropriate questions to become aware that moral distress is present.
2. **Affirm** your distress and commitment to take care of yourself and address moral distress.
3. **Assess** sources of your moral distress to prepare for an action plan.

4. **Act to** implement strategies for changes to preserve your integrity and authenticity.

Activity 2.4.4: Point of reflection

Reflect on a situation that commonly recurs in your practice setting that creates moral distress for you and your staff. Then think through the following questions.

1) Is the moral distress truly a situation where individuals know what is right to do but are prevented from doing so because of variables beyond their control? To what degree does deficient individual or corporate moral agency complicate the scenario?

2) Another way to think about the preceding question, is leaving this unit or hospital the only way to resolve the distress? What would need to change to resolve the distress and is such change possible? What would it take to bring about needed change and who might facilitate such changes?

Activity 2.4.5: Case studies

Read the following case studies and answer questions that follow it

Case study 2.4.1

Nurse Mekonin works in home health care nursing. She visits a gentleman, Mr. Dinka, who had a stroke. His son and daughter check on him and run shops for him, but he lives alone and eats frozen microwave dinners. His appearance and his home are unkempt and disheveled. When checking his medication, Nurse Mekonin discovers that he has nearly full bottles of antihypertensive and anticoagulant medications. He said he sometimes forgets whether he has taken them and figures it is better to skip them than take a double dose. Despite pillboxes, schedules, and other reminders, he does not regularly take his medication. His blood pressure is 230/150. Nurse Hunt begins to call the physician to report her findings and Mr. Dinka asks her not to, saying he does not want any more medication, hospitalization, or therapy. He wants to be left alone.

Case study 2.4.2

The Patient Stephanie is a 39-year-old female with a history of intravenous drug abuse and HIV/AIDS, with a most recent CD4 count of 9/mL, who presented to the Emergency Department with acute onset of upper abdominal pain and bright red hematemesis since the morning of admission. She reported noticing easy bruising and gum bleeding over the past several weeks, but no overt blood loss until the current episode. She also had an increasingly poor appetite and a 20-pound weight loss over the last two months.

The medical team consulted the GI and hematology services, and ordered Stephanie to be nil per os (nothing by mouth) and to receive IV fluids, transfusion of red blood cells for her anemia, and platelets in an attempt to stop further blood loss. When the team attempted to obtain informed consent for the transfusion of blood products, Stephanie agreed to transfusion of red blood cells, but refused to accept transfusion of platelets. The team explained to Stephanie that the units of platelets were necessary to help prevent further bleeding, but she still refused to allow them. When pressed for her reasoning behind the decision, she stated "because that's what I want," and wouldn't clarify the matter any further.

Case study 2.4.3

The Nurse Expected to Go Along with the Doctor's Deception

Martha is registered nurse (RN) and the nurse manager, walks onto an oncology unit. Alem, a bedside nurse, comes up to her and screams, "I've had it! Dr. Lema. is telling Mr. Walde family that all is well and ordering another round of chemo and everyone except Mr. Walde and his family know that he is dying! Ms. Martha knows that Dr. Lema has a reputation for not knowing the limitations of medicine and for inappropriately treating those who are actively dying with life-sustaining medical technology. The words hospice and palliative care just do not seem to be in his lexicon—not to mention "dying". Unfortunately, Dr. Lema has a huge practice (and generates beaucoup bucks for the hospital) and his patients seem to like his cheerful presence.

Earlier efforts to get him to change his practice have been unfruitful. Alem, the nurse who just screamed, has been a passionate patient advocate, but you have noticed recently that her efforts to advocate for patients have been subdued. This time she tells you in no uncertain terms that she does not want to care for any of Dr. Lema patients— which would be a scheduling nightmare.

Case study 2.4.4

Acting in the doctor's interests

'I felt part of the whole conspiracy' Mr Robel was an 82-year-old who had had emergency abdominal surgery. During surgery, he had breathing difficulties, which necessitated the insertion of a mini-tracheostomy tube. On his return to the ward, his condition was very poor and it was decided that he should not be resuscitated in the event of an arrest. Later that evening I noticed that one of the sutures anchoring the tracheostomy tube was missing and I repeatedly asked the doctor to come and replace it. Later, when attending Mr Robel. I saw that the tube was missing. The doctor came to the ward and an X-ray revealed that the tube was lying in the patient's right bronchus. The medical team decided to perform a bronchoscopy, but to do so needed consent. They called the man's son and told him a further investigation was essential and naturally, he gave his consent.

During the procedure Mr Robel. arrested and was resuscitated after which he was transferred to the intensive care unit. After 24 hours, he was returned to the ward and died a few hours later. This patient was kept alive to save the houseman and his son was totally unaware of the risks or exactly why his father had to go to theatre. I knew what was happening, but I felt powerless to say anything. When Mr Robel. died, I was unable to comfort his son as I felt part of the whole conspiracy.

Summary

Ethical dilemmas is situations arising when equally compelling ethical reasons both for and against a particular course of action are recognized in which the appropriate choice in the situation is unclear and a decision must be made. The DECIDE model helps to achieve morally and ethically sound decisions.

Moral/ethical distress is an emotion that occurs when nurses have identified and know what right response is called for, but institutional or other constraints make it almost impossible to pursue the right course of action

Session 2.5: Ethical decision making in the Nursing practice

Session objectives

At the end of this session, participants will be able to:

- Identify appropriate ethical decision making procedures
- Demonstrate sound ethical decision making ability

> **Activity 2.5.1: Point of reflection**
>
> 1. What is ethically sound decision with respect to the nursing practice?
> 2. What ethical concerns have you been faced during your nursing practice?

Introduction

Clinical situations that raise ethical questions are a challenge to navigate. Often, there are multiple clinical facts to consider. In addition, patient values and preferences and the concerns and values of family must be taken into account. In some cases a decision is needed quickly. Ideally, when faced with these difficult clinical situations, we would use a systematic approach that ensures success in reaching an ethical decision or recommendation.

The four quadrants (topics) approach

- The four topics method was developed to provide clinicians with a framework for sorting through and focusing on specific aspects of clinical ethics cases and for connecting the circumstances of a case to their underlying ethical principles. Each topic—medical indications, patient preferences, quality of life, and contextual features—represents a set of specific questions to be considered in working through the case (see the table below).

MEDICAL INDICATIONS	PATIENT PREFERENCES
Beneficence and Nonmaleficence • What is the patient's medical problem? History? Diagnosis? Prognosis? • Is the problem acute? Chronic? Critical? Emergent? Reversible? • What are the goals of treatment? • What are the probabilities of success? • What are the plans in case of therapeutic failure? • In sum, how can the patient benefit by medical and nursing care, and how can harm be avoided?	**Respect for Patient Autonomy** • Is the patient mentally capable and legally competent? Is there evidence of capacity? • If competent, what is the patient stating about preferences for treatment? • Has the patient been informed of benefits and risks, understood this information, and given consent? • If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision making? • Has the patient expressed prior preferences (eg, advance directives)? • Is the patient unwilling or unable to cooperate with medical treatment? If so, why? • In sum, is the patient's right to choose being respected to the extent possible in ethics and law?
QUALITY OF LIFE	**CONTEXTUAL FEATURES**
Beneficence, Nonmaleficence, and Respect for Patient Autonomy • What are the prospects, with or without treatment, for a return to normal life? • What physical, mental, and social deficits is the patient likely to experience if treatment succeeds? • Are there biases that might prejudice the provider's evaluation of the patient's quality of life? • Is the patient's present or future condition such that his or her continued life might be judged as undesirable? • Is there any plan and rationale to forgo treatment? • Are there plans for comfort and palliative care?	**Loyalty and Fairness** • Are there family issues that might influence treatment decisions? • Are there provider (physician, nurse) issues that might influence treatment decisions? • Are there financial and economic factors? • Are there religious or cultural factors? • Are there limits on confidentiality? • Are there problems of allocation of resources? • How does the law affect treatment decisions? • Is clinical research or teaching involved? • Is there any conflict of interest on the part of the providers or the institution?

Activity 2.5.2: Case studies

Case study 2.5.1

Purpose: the purpose of this case scenario is to enable participants to solve ethical issues by applying the four topic approach.

Instruction: First, read the case scenario for 2-3 minutes individually and then work in groups to analyze the case using the for topic/quadrant approach. Finally, reflect the decision of the group.

A 76 year old male admitted to a large teaching hospital. He was diagnosed 6 months ago with metastatic cancer which has spread from his lungs and liver to his GI tract and bones. His physician had decided that further chemotherapy would be useless and ordered for the patient to be kept on comfort measures and pain medication. A continuous morphine-sulphate IV drip was delivered to help control the pain; however, it helped him little. A friendly and happy person by nature, as the cancer spread, the patient would cry out in pain and ask the nurses not to move him. The nurses has told him the benefits of the position change and the all the potential risks of immobility. Being over 1.7 meter tall and underweight, his bony prominences became reddened and sore. He would shout so loudly when he was turned that the nurses wondered whether they were hurting him or helping him. It has been clearly stated that all bed ridden patients must be turned to another position every two hours unless contraindicated because of medical condition. What shall be done? Should the nurses continue turning the patient every 2 hours or stop the patient's movement?

Session 2.6: Legal Aspects of the Nursing Practice

Session objectives

At the end of this session, participants will be able to:

- describe general legal concepts of nursing
- discuss legal issues in relation to the nursing practice

Activity 2.6.1 Case study

Case study 2.6.1

Purpose: the purpose of this case scenario is to enable participants reflect their opinion about legal issues in nursing.

Instruction: Read the case study individually for 2-3 minutes and then discuss the issue with the participant next to you. Finally, reflect your opinion to the large group.

An actress develops stage IV non-Hodgkin's lymphoma. The health care team informs her that neither surgery nor local radiation will be appropriate. She agrees to undergo combination chemotherapy. No one from the team informed her about the potential adverse effects of the chemotherapy since there is no alternative. The usual and the recommended dose of chemotherapy are given and the patient loses her hair and develops neuropathy from the vincristine. She is not able to work because of her appearance. She open file on the court.

Discussion questions

a. What do you think the most likely outcome of the charge?
b. What is the legal issue?

General legal concepts of nursing

Law

Law can be defined as those rules made by humans who regulated social conduct in a formally prescribed and legally binding manner. Laws are based upon concerns for fairness and justice.

Law governs the relationship of private individuals with government and with each other.

Types of law

1. **Public law:** it deals with an individual's relationship to the state.
    - Sources include constitutional, administrative and criminal

    1.1. **Constitutional law:** set of basic laws that defines the powers of the government
    - Nurse maintain rights as individual

    1.2. **Administrative law:** developed by groups who are appointed to governmental administrative agencies (e.g. nurse practice act)

    1.3. **Criminal law:** acts or offences against the welfare or safety of the public (e.g. criminal code)
2. **Civil law:** it deals with crimes against a person or persons

    2.1. **Contract law:** the enforcement of agreements among private individuals (e.g. employment contracts)

    2.2. **Tort law:** the enforcement of duties & rights among independent of contractual agreements. It is a civil wrong committed on a person or property stemming from either a direct invasion of some legal right of the person, infraction of some public duty, or the violation of some private obligation by which damages accrue to the person.

    Examples of tort law include
    - Negligence and malpractice
    - Assault & Battery
    - Invasion of privacy
    - Defamation

- Fraud

Functions of law in nursing

1. It provides a framework for establishing which nursing actions in the care of client are legal
2. It differentiates the nurses' responsibilities from those of other health professionals
3. It helps the boundaries of independent nursing action
4. It assists in maintaining a standard of nursing practice by making nurses accountable under the law

Activity 2.6.2 Case study

Case study 2.6.2

Purpose: the purpose of this case scenario is to enable participants reflect their opinion about legal issues in nursing.

Instruction: Read the case study individually for 2-3 minutes and then discuss the issue with the participant next to you. Finally, reflect your opinion to the large group.

A 70 years old woman admitted to a hospital with gastroenteritis and dehydration. There is no indications in the chart of her having dizziness. She also does not inform the nurses of her dizziness. She asks to be brought to the bathroom. She is left alone on the toilet when she becomes lightheaded, faints, hits her head against a wall and sustaining a laceration. The patient and the family opens file on the court.

a. What do you think the most likely outcome of the charge?
b. What is the legal issue?

Negligence and malpractice

- **Malpractice** refers to the behaviour of a professional person's wrongful conduct, improper discharge of professional duties, or failure to meet the standards of acceptable care which result in harm to another person.
- **Negligence (breach of duty)** is the failure of an individual to provide care that a reasonable person would ordinarily use in a similar circumstance.

Assault and Battery

- Assault is the intentional & unlawful offer to touch a person in an offensive, insulting or physically intimidating manner.
- Battery is the touching of another person without the person's consent

Selected legal aspects of nursing practice

1. **Informed consent:** it is an agreement by a client to accept a course of treatment or a procedure after being fully informed of it.
   - Consents are either express or implied. Express consent should be oral or written. If the procedure is more invasive and/or the potential for risk to the client is great, a written permission is needed.
   - Implied consent exists when the client's nonverbal behaviour indicates agreement such as in positioning their bodies for an injection or when their vital signs are recorded.
   - Obtaining informed consent for specific medical or surgical procedure is the responsibility of the person who performs the procedure.
   - Information to be given during informed consent:
     - Diagnosis or condition that requires treatment
     - Purpose of treatment
     - What the client can expect to feel or experience
     - The intended benefits of the procedure
     - Possible risks
     - Advantages and disadvantages of alternatives to treatment (including no treatment)
   - Major elements of informed consent
     - The consent must be voluntary
     - The consent must be given by a client who is capable and competent to understand
     - The client must be given enough information to be the ultimate decision maker
2. **Delegation:** it is the transfer of responsibility for the performance of an activity from person to another while retaining accountability for the outcome.

- When delegation is to occur, the nurse needs to determine the answers for the following questions:
  - Does the Nurse practice act (if any) permit delegation?
  - Is there a list of procedure a nurse can delegate?
  - Are there guidelines explaining the nurse's responsibilities when delegating?

3. **Violence, Abuse, and Neglect**
   - Violent behaviour can include domestic violence, human abuse, and sexual abuse
   - Neglect is the absence of care necessary to maintain the health and safety of a client nurses are in position to identify and assess cases of violence
   - When an injury appears to be present resulting from abuse, neglect, or exploitation, the nurse must report the situation to the appropriate authority.

Legal responsibilities in nursing

1. **Common-sense precautions**
   - Follow accepted procedures. Protect from possible lawsuits by always performing procedures as taught and as outlined in the procedure manual of the healthcare facility.
   - If these policies are incorrect or inadequate, work to improve them through the proper channels.
2. **Be competent in practice**
   - Always responsible for own behaviour. Refuse to perform procedures for which have not been prepared.
   - Ignorance is not a legal defence.
   - Neither will lack of sleep or overwork be accepted as a legal reason for carelessness about safety measures or mistakes.
3. **Ask for assistance**
   - Always ask for help if unsure about how to perform a procedure.
   - Do not assume responsibilities beyond those of level
   - Admitting that do not know how to perform a procedure is always better than attempting to do it and injuring someone.

- Question any physician's order that do not understand, cannot read, or in which believe an error exists

4. **Document well**
   - The health record is the written and legal evidence of treatment.
   - The record is to reflect facts only, not personal judgements.
   - Careful and accurate documentation is vital for each client's welfare.
   - Careful documentation is perhaps the most important thing can do protect against an unjustified lawsuit.
   - If do not document a treatment or medication, legally the measure is considered no to have been done.
5. **Do not give legal advice to clients**
   - The laws governing personal and property rights of an individual are many and complex. Never attempt to advise a client on legal rights or financial matters.
6. **Do not accept gifts**
   - Accepting gifts from the client is unwise for several reasons. Some clients are considered vulnerable adults (e.g. mentally ill, retarded, or confused individuals).
   - Moreover, exchange of gifts could compromise professional position, and could be accused of coercing the client.

Examples of healthcare related laws in Ethiopia (handout)

1. The revised penal code (Proclamation No.414/2004)

Article 69: Professional Duty

An act done in the exercise of a professional duty is not liable to punishment when it is in accordance with the accepted practice of the profession and the doer does not commit any grave professional fault.

Article 520: Mismanagement of hazardous wastes and other materials

Whoever:

a) fails to manage hazardous wastes or materials in accordance with the relevant laws; or

b) fails to label hazardous wastes or materials; or

c) unlawfully transfers hazardous wastes,

Is punishable with fine not exceeding five thousand birr, or rigorous imprisonment not exceeding three years, or with both.

Article 537: Refusal to provide medical assistant

Any doctor, pharmacist, dentist, veterinary surgeon, midwife or nurse, or any other person lawfully entitled to render professional attention and care, who, contrary to his duty and without just cause refuses to provide his services in a case of serious need, whether from indifference, selfishness, cupidity, hatred or contempt or any other similar motive, is punishable with fine, or, where the crime is repeated, with simple imprisonment not exceeding six months.

Article 559: Injuries cause by negligence

(1) Whoever, by criminal negligence, causes another to suffer common injury to person or to health is punishable with simple imprisonment not exceeding six months, or fine not exceeding one thousand birr.

2. FMHACA directive (Proclamation No. 661/2009)

Article 33: Requirement of professional license

1) No person shall practice as a health professional without having obtained a professional practice license issued by the appropriate organization.

Article 34: Standards of care and scope of practice

- Any health professional shall practice his profession in accordance with the standards of healthcare and scope of professional practice set by the executive organization.

Article 35: Code of conduct

- Any health professional shall perform his professional duties in accordance with the relevant code of ethics

Article 36: Duty to report

1) Any health professional or any other person who is aware of the existence of professional malpractice shall report the same to the appropriate regulatory organization.

Article 37: Information of patients and obligation of health institutions

1) Any health professional shall fully record personal health information generated during each encounter with a patient within a health institution
2) Any health institution shall have the duty to ensure that the records of personal health information referred to sub-article (1) of this article are kept and maintained properly.
3) Any personal information of a patient shall be confidential unless it is requested for a legitimate purpose authorized by law.

Session 2.7: Nursing code of Ethics (Handout)

Session objectives

At the end of this session, participants will be able to:

- Explain the nursing code of ethics

Probing question
What is nursing code of ethics?

Introduction

A code of ethics stands as a central and necessary mark of a profession. It functions as a general guide for the profession's members and as a social contract with the public that it serves.

Nurses' professional code of Ethics

1. The nurse practices with compassion and respect for the inherent dignity, worth, and personal attributes of every person, without prejudice.

   1.1 Respect for human dignity

   - A fundamental principle that underlies all nursing practice is respect for the inherent dignity, worth, and human rights of all individuals.
   - Nurses consider the needs and respect the values of each person in every professional relationship and setting; they lead in the development of changes in public and health policies that support this duty.

   1.2 Relationships with Patients

   - Nurses establish relationships of trust and provide nursing services according to need, setting aside any bias or prejudice.
   - When planning patient, family and population centered care, factors such as lifestyle, culture, value system, religious or spiritual beliefs, social support system and primary language shall be considered.

- Such considerations must promote health, address problems and respect patient decisions. This respect for patient decisions does not require that the nurse agree with or support all patient choices.

1.3 The Nature of Health

- Nurses respect the dignity and rights of all human beings regardless of the factors contributing to the health status.
- The worth of a person is not affected by disease, disability, functional status, or proximity to death.
- Nurses assess, diagnose, plan, intervene, and evaluate patient care in accord with individual patient needs and values.
- Respect is extended to all who require and receive nursing care whether in the promotion of health, prevention of illness, restoration of health, alleviation of suffering, and provision of supportive care to those who are dying.

1.4 The Right to self-determination

- Respect for human dignity requires the recognition of specific patient rights, in particular, the right of self-determination.
- Patients have the moral and legal right to determine what will be done with their own person; to be given accurate, complete, and understandable information in a manner that facilitates an informed decision; to be assisted with weighing the benefits, burdens, and available options in their treatment, including the choice of no treatment; to accept, refuse, or terminate treatment without deceit, undue influence, duress, coercion, or prejudice; and to be given necessary support throughout the decision-making and treatment process.
- Nurses include patients or surrogate decision-makers in discussions, provide referrals to other resources as indicated, identify options, and address problems end of life and should be actively involved in related research, education, practice, and policy development.

1.5 Relationships with Colleagues and Others

- Respect for persons extends to all individuals with whom the nurse interacts.

- Nurses maintain professional, respectful and caring relationships with colleagues and are committed to fair treatment, integrity-preserving compromise, and the resolution of conflicts.
- In every role, the nurse creates a moral environment and culture of civility and kindness, treating others, colleagues, employees, co-workers, and students with dignity and respect. This standard of conduct includes an affirmative duty to act to prevent harm.

2. **The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population.**

2.1 Primacy of the Patient's Interests

- The nurse's primary commitment is to the recipients of nursing and healthcare services—the patient—whether individuals, families, groups, communities, or populations.
- Any plan of care must reflect the fundamental commitment of nursing to the uniqueness, worth and dignity of the patient.
- Addressing patient interests requires recognition of the patient's place within the family and other relationships. When the patient's wishes are in conflict with others, nurses help to resolve the conflict. Where conflict persists, the nurse's commitment remains to the identified patient.

2.2 Conflict of Interest for Nurses

- Conflicts of interest may arise in any domain of nursing activity including clinical practice, administration, education, consultation and research.
- Nurses must examine the conflicts arising between their own personal and professional values and the values and interests of others including those who are also responsible for patient care and healthcare decisions, and perhaps patients themselves.
- Nurses address these conflicts in ways that ensure patient safety and promote the patient's best interests while preserving the professional integrity of the nurse and supporting interdisciplinary collaboration.
- Changes in healthcare financing and delivery systems may create conflict between economic self-interest and professional integrity. Bonuses, sanctions, and

incentives tied to financial targets may present such conflict. Any perceived or actual conflict of interest should be disclosed to all relevant parties and, if indicated, nurses should withdraw from further participation.

2.3 Collaboration

- The complexity of healthcare requires effort that has the strong support and active participation of all health professions.
- Nurses should actively foster collaborative planning to provide high quality, patient-specific health care.
- Nurses are responsible for articulating, representing and preserving the unique contribution of nursing to patient care and the nursing scope of practice. The relationship with other health professions also needs to be clearly articulated, represented and preserved.

2.4 Professional Boundaries

- The nature of nursing work is inherently personal.
- Within their professional role, nurses recognize and maintain appropriate personal relationship boundaries.
- Professional relationships are therapeutic in nature yet at times remaining within professional boundaries can be tested.
- In all communications and actions nurses are responsible for maintaining professional boundaries and for seeking the assistance of peers or supervisors in managing difficult situations or taking appropriate steps to remove themselves from the situation.

3. **The nurse promotes, advocates for, and protects the rights, health and safety of the patient.**

3.1 Protection of the Rights of Privacy and Confidentiality

- Privacy is the right to control access to and disclosure or nondisclosure of information pertaining to oneself, and to control the circumstances, timing, and extent to which information might be disclosed.
- The need for health care does not justify unwanted or unwarranted intrusion into people's lives.

- Nurses safeguard the individual's, families', and community's right to privacy. The nurse advocates for an environment that provides sufficient physical privacy, including privacy for discussions of a personal nature.
- Nurses also participate in the maintenance of and policies and practices that protect both personal and clinical information at institutional and societal levels.
- Confidentiality pertains to the nondisclosure of personal information that has been communicated within the nurse–patient relationship.
- Central to that relationship is an element of trust and an expectation that personal information will not be divulged without consent.
- The nurse has a duty to maintain confidentiality of all patient information, both personal and clinical in the work setting and off duty in all venues, including social media or any other means.

3.2 Protection of Human Participants in Research

- Stemming from the right to autonomy or self-determination, individuals have the right to choose whether or not to participate in research as a human subject.
- Participants or legal surrogates must receive sufficient and materially relevant information to make informed decisions and to understand that they have the right to decline to participate or to withdraw at any time without fear of adverse consequences or reprisal.

3.3 Performance Standards and Review Mechanisms

- Professional nursing is a process of education and formation that involves the ongoing acquisition and development of the knowledge, skills, dispositions, practice experiences, commitment, relational maturity, and personal integrity essential for professional practice.
- Nurse educators must ensure that basic competence and commitment to professional practice exist prior to entry into practice.
- Nurse managers and executives similarly ensure that nurses have the required knowledge, skills, and dispositions to perform clinical responsibilities requiring preparation beyond the basic academic programs. In this way nurses— individually, collectively and as a profession—are responsible and accountable for nursing practice and professional behavior.

3.4 Professional Competence in Nursing Practice

- Nurses must lead in the development of policies and review mechanisms to promote patient health and safety, reduce errors, and create a culture of excellence.
- When errors occur, nurses must follow institutional guidelines in reporting errors to the appropriate authority and ensure responsible disclosure of errors to patients.

3.5 Protecting Patient Health and Safety by Action on Questionable Practice

- Nurses must be alert to and take appropriate action in instances of incompetent, unethical, illegal, or impaired practice or any actions that place the rights or best interests of the patient in jeopardy.

3.6 Patient Protection and Impaired Practice

- Nurses must protect the patient, the public, and the profession from potential harm when a colleague's practice appears to be impaired.
- When another's practice appears to be impaired, the nurse's duty is to take action to protect patients and to ensure that the impaired individual receives assistance.

4. **The nurse has authority, accountability, and responsibility for nursing practice, makes decisions, and takes action consistent with the obligation to provide optimal care.**

4.1 Authority, Accountability, and Responsibility

- Nurses bear primary responsibility for the nursing care that their patients and clients receive and are accountable for their own practice.
- Nursing practice includes independent direct nursing care activities, care as ordered by an authorized healthcare provider, delegation of nursing interventions, evaluation of interventions, and other responsibilities such as teaching, research, and administration.
- In each instance, nurses have the authority and retain accountability and responsibility for the quality of practice and for compliance with state nurse practice acts, and standards of care.

4.2 Accountability for Nursing Judgments, Decisions, and Actions

- In order to be accountable, nurses act under a code of ethical conduct that includes adherence to the scope and standards of nursing practice and such moral principles as fidelity, gratitude, and respect for the dignity, worth, and self-determination of patients.

- Nurses are accountable for judgments made and actions taken in the course of nursing practice, irrespective of other providers' directives or institutional policies.
- Systems and technologies that assist in clinical practice are adjunct to, not replacements for, the nurse's knowledge and skill.
- The nurse retains accountability and responsibility for nursing practice even in instances of system or technological failure.

4.3 Responsibility for Nursing Judgments, Decisions and Actions

- Nurses are accountable for their judgments, decisions, and actions; but, in compromising circumstances, responsibility may be borne by both the nurse and the institution.
- Nurses accept or reject specific role demands and assignments based on their education, knowledge, competence, experience, and assessment of patient safety.
- Nurses have a responsibility to define, implement, and maintain standards of professional practice.
- Nurses must plan, establish, implement, and evaluate review mechanisms to safeguard patients and nurses. These include peer review processes, credentialing processes, and quality improvement initiatives.
- Nurses are responsible for assessing their own competence. When the needs of the patient are beyond the qualifications or competencies of the nurse, consultation and collaboration must be sought from qualified nurses, other health professionals, or other appropriate resources.

4.4 Delegation of Nursing Activities or Tasks

- Nurses are accountable and responsible for the assignment or delegation of nursing activities. Such assignment or delegation must be consistent with institutional policy, and nursing standards of practice.
- Nurses must make reasonable effort to assess individual competence when delegating selected nursing activities. This assessment includes the evaluation of the knowledge, skill, and experience of the individual to whom the care is assigned; the complexity of the assigned tasks; and the nursing care needs of the patient.

- Nurses are responsible for monitoring the activities and evaluating the quality and outcomes of the care provided by other healthcare workers to whom they have delegated tasks.
- Nurses may not delegate responsibilities such as assessment and evaluation; they may delegate interventions.

5. **The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.**

5.1 Duty to Self and Others

- Moral respect accords moral worth and dignity to all human beings regardless of their personal attributes or life situation. Such respect extends to oneself as well: the same duties that we owe to others we owe to ourselves.
- Self-regarding duties primarily concern one self and include promotion of health and safety, preservation of wholeness of character and integrity, maintenance of competence, and continuation of personal and professional growth.

5.2 Promotion of Personal Health, Safety, and Well-Being

- As professionals who assess, intervene, evaluate, protect, promote, educate, and conduct research for the health and safety of others and society, nurses have a duty to take the same care for their own health and safety.
- Nurses should model the same health maintenance and health promotion measures that they teach and research, seek health care when needed, and avoid taking unnecessary risks to health or safety in the course of their customary professional and personal activities.
- A healthy diet and exercise, maintenance of family and personal relationships, adequate leisure and recreation, attention to spiritual or religious needs, and satisfying work must be held in balance to promote and maintain the health and well-being of the nurse.

5.3 5.3 Wholeness of Character

- Nurses have both personal and professional identities that are integrated and embrace the values of the profession, merging them with personal values.

- Wholeness of character pertains to all professional relationships with patients or clients.
- When nurses are asked for a personal opinion, they are generally free to express an informed personal opinion as long as this maintains appropriate professional and moral boundaries and preserves the voluntariness of the patient.
- It is essential to be aware of the potential for undue influence attached to the nurse's professional role.
- Nurses assist others to clarify values in reaching informed decisions, always avoiding coercion, manipulation, and unintended influence.
- When nurses care for those whose personal, condition, attributes, lifestyle, or situations are stigmatized, or encounter a conflict with their own personal beliefs, nurses still render respectful and competent care.

5.4 Preservation of Integrity

- Personal integrity is an aspect of wholeness of character; its maintenance is a self regarding duty.

5.5 Maintenance of Competence and Professional Growth

- Maintenance of competence and professional growth involve the control of one's own conduct in a way that is primarily self-regarding.
- Competence affects one's self-respect, self-esteem, and the meaningfulness of work.
- Nurses must maintain competence and strive for excellence in their nursing practice, whatever the role or setting.
- Nurses are responsible for developing criteria for evaluation of practice and for using those criteria in both peer and self-assessment.
- To achieve the highest standards, nurses must evaluate their own performance and participate in substantive peer review.
- Continual professional growth, particularly in knowledge and skill, requires a commitment to lifelong learning.

5.6 Personal Growth

- Nursing care addresses the whole person as an integrated being; nurses should also apply this principle to themselves.

- Activities that broaden nurses' understanding of the world and of themselves affect their understanding of patients; those that increase and broaden nurses' understanding of nursing's science and art, values, ethics, and policies also affect the nurse's self-understanding.
- Thus, in continuity with nursing ethics' historic and enduring emphasis, nurses are encouraged to read broadly, continue life-long learning, engage in personal study, seek financial security, participate in a wide range of social advocacy and civic activities, and to pursue leisure and recreational activities that are enriching.

6. **The nurse, through individual and collective action, establishes, maintains, and improves the moral environment of the work setting and the conditions of employment, conducive to quality health care**.

6.1 The environment and moral virtue and value

- Virtues are universal, learned, and habituated attributes of moral character that predispose persons to meet their moral obligations; that is, *to do* what is right.
- There is a presumption and expectation that we will commonly see virtues such as integrity, respect, temperance, and industry in all those whom we encounter.
- Virtues are what we are *to be* and make for a morally "good person".
- There are more particular attributes of moral character, not expected of everyone, that are expected of nurses. These include knowledge, skill, wisdom, patience, compassion, honesty, and courage. These attributes describe what the nurse is to be as a morally "good nurse".
- Nurses must create, maintain, and contribute to morally good environments that enable nurses to be virtuous. Such a moral milieu fosters mutual respect, communication, transparency, moral equality, kindness, prudence, generosity, dignity, and caring.

6.2 The Environment and Ethical Obligation

- Virtues focus on what is good and bad in whom we are *to be* as moral persons; obligations focus on *right and wrong* or what we are *to do* as moral agents.
- Obligations are often specified in terms of principles such as beneficence or doing good; non maleficence or doing no harm; justice or treating people fairly; reparations, or making amends for harm; fidelity, and respect for persons.

- Nurses, in all roles, must create, maintain, and contribute to practice environments that support nurses and others in the fulfillment of their ethical obligations.
- Environmental factors include all that contribute to working conditions. These include but are not limited to: clear policies and procedures that set out professional ethical expectations for nurses; uniform knowledge of *The Code of Ethics for Nurses with Interpretive Statements*; and associated ethical position statements.

6.3 Responsibility for the Healthcare Environment

- Nurses are responsible for contributing to a moral environment that demands respectful interactions among colleagues, mutual peer support, and open identification of difficult issues that includes on-going formation of staff in ethical problem solving.

7. **The nurse, whether in research, practice, education, or administration, contributes to the advancement of the profession through research and scholarly inquiry, professional standards development, and generation of nursing and health policies.**

7.1 Contributions through Research and Scholarly Inquiry

- All nurses must participate in the advancement of the profession through knowledge development, evaluation, dissemination, and application to practice.
- Knowledge development relies chiefly, though not exclusively, upon research and scholarly inquiry.
- Nurses engage in scholarly inquiry in order to expand the body of knowledge that forms and advances the theory and practice of the discipline in all its spheres.

7.2 Contributions through Developing Maintaining, and Implementing Professional Practice Standards

- Practice standards must be developed by nurses and grounded in nursing's ethical commitments and body of knowledge.
- These standards must also reflect nursing's responsibility to society.

7.3 Contributions through Nursing and Health Policy Development

- Nurses must lead, serve, and mentor on institutional or agency policy committees within the practice setting.
- Nurse educators have a particular responsibility to foster and develop students' commitment to professional and civic values and to informed perspectives on nursing and healthcare policy.

8. **The nurse collaborates with other health professionals and the public to protect and promote human rights, health diplomacy, and health initiatives.**

8.1 Health is a Universal Right

- The nursing profession holds that health is a universal human right and that the need for nursing is universal.
- The right to health is a fundamental right to a universal minimum standard of health to which all individuals are entitled. Such a right has economic, political, social, and cultural dimensions.

8.2 Collaboration for Health, Human Rights, and Health Diplomacy

- The nursing profession commits to advancing the health, welfare, and safety of all.
- This nursing commitment reflects the intent to achieve and sustain health as a means to the common good so that individuals and communities here and abroad can develop to their fullest potential and live with dignity.

8.3 Obligation to Advance Health and Human Rights

- Through community organizations and groups, nurses educate the public; facilitate informed choice; identify conditions and circumstances that contribute to illness, injury and disease; foster healthy life styles; and participate in institutional and legislative efforts to protect and promote health.
- Nurses collaborate to address barriers to health, such as poverty, homelessness, unsafe living conditions, abuse and violence, and lack of access by engaging in open discussion, education, public debate and legislative action.
- Nurses must recognize that health care is provided to culturally diverse populations in this country and across the globe.

9. **The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy.**

9.1 Articulation of Values

- Their professional associations and organizations represent individual nurses. These groups give united voice to the profession.
- It is the responsibility of a profession collectively to communicate, affirm, and promote shared values both within the profession and to the public.
- The profession's organizations communicate to the public the values that nursing considers central to the promotion or restoration of health, prevention of illness, and alleviation of suffering.
- Through professional organizations, the nursing profession must reaffirm and strengthen nursing values and ideals so that when those values are challenged, adherence is steadfast and unwavering.

9.2 Integrity of the Profession

- The profession's integrity is strongest when its values and ethics are evident in all professional and organizational relationships.
- Nursing must continually emphasize the values of justice, fairness, and caring within the national and global nursing communities, in order to promote health in all sectors of the population.
- Together, nurses must bring about the improvement of all facets of nursing, fostering and assisting in the education of professional nurses in developing regions across the globe.
- The values and ethics of the profession must be evident in all professional relationships whether interorganizational, or international.

9.3 Integrating Social Justice

- Nurses must be vigilant and take action to influence legislators, governmental agencies, non-governmental organizations, and international bodies in all related health affairs for addressing the social determinants of health.

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MODULE III: COMMUNICATION IN NURSING

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Description of the module

This module is designed to enable the trainees to be competent communicators during nursing and midwifery care practice. Trainees will be able to use a wide range of effective communication strategies and skills which are necessary to establish interpersonal relationship with physicians and nursing staffs, clients, and their families.

Module objective: After completion of this module the trainee will be able to:

- Utilize client cantered effective communication

Learning Objectives

After completion of this module the trainee will be able to:

- Discuss communication and its significance in nursing
- Explain the benefits of communication
- Describe elements of the communication process
- Discuss barriers to effective communication
- Describe the therapeutic communication skills
- Integrate effective communication skills into clinical practice.
- Manage documentation according to national protocols

Session 3.1. Basics of communication

Session objectives

At the end of this session the participants will be able to:

- Discuss communication and its significance in nursing
- Explain the benefits of communication
- Describe elements of the communication process
- Describe modes of communication
- Analyze characteristics of an therapeutic communication
- Describe the therapeutic communication skills
- Discuss barriers to therapeutic communication
- Describe the 7 C's of communication

3.1 An overview of communication and its significance in nursing

Activity 3.1. Think pair share

- **With whom and how do nurses communicate every day?**
- **Instruction:** Think individually on the above question for 1 minute and then discuss the issue with the participant next to you. Finally, reflect your opinion to the large group.

Communication is process of transferring, sharing or exchanging **verbal (overt)** and **nonverbal (covert)** messages, feelings and ideas thereby people create a relationship by interacting with each other. It should be accurate, timely and effective. Quality of patient care depends on the caregiver's ability to communicate with patient and with colleagues

Communication is a complex process of sending and receiving verbal and non-verbal messages, it allows the exchange of information, feelings, needs, and preferences and it uses source/sender and receiver encode and decode message in a cyclic pattern as communication channels.

Communication is fundamental to all nursing and interpersonal relationships. Nurses can use this dynamic and interactive process to motivate, influence, educate, facilitate mutual support, and acquire essential information necessary for survival, growth and an overall sense of well-

being. It is essential for nurses to develop and maintain competent communication and interpersonal skills.

3.1.1 Benefits of Communication

Activity 3.2: Group discussion

Be in group and discuss on benefits of communication within 2 minutes

Communication in nursing has the following benefits:

- It greatly contributes to the ability to provide patients with individualized care. Nurses who take the time to understand the unique challenges and concerns of their patients will be better prepared to advocate on their behalf and properly address issues as they arise. This greater focus on communication frequently leads to better patient outcomes as well.
- Patients who feel like they are receiving all of the nurse's attention during an interaction are more likely to disclose the true extent of their feelings and symptoms much quicker. Patients may also feel more satisfaction with their care if the nurse provides them with undivided attention.
- Interpersonal communication can satisfy the innate needs of the patient as outlined in Maslow's hierarchy of needs. Those needs include the feelings of safety, love and confidence, all of which are important during a patient's treatment and recovery.
- Communication in nursing not only benefits the patients, but the nurses as well. Nurses who communicate well with their coworkers tend to witness an improvement in morale as well as job satisfaction. High turnover rates, increased stress, and lower morale and job satisfaction are among the negative effects of poor workplace communication.

3.1.2 Elements of the communication process

There are many models of communication. The commonly used communication model comprises six elements:

1. The referent
2. The source-encoder

3. The message
4. The channel
5. The receiver-decoder
6. Feedback

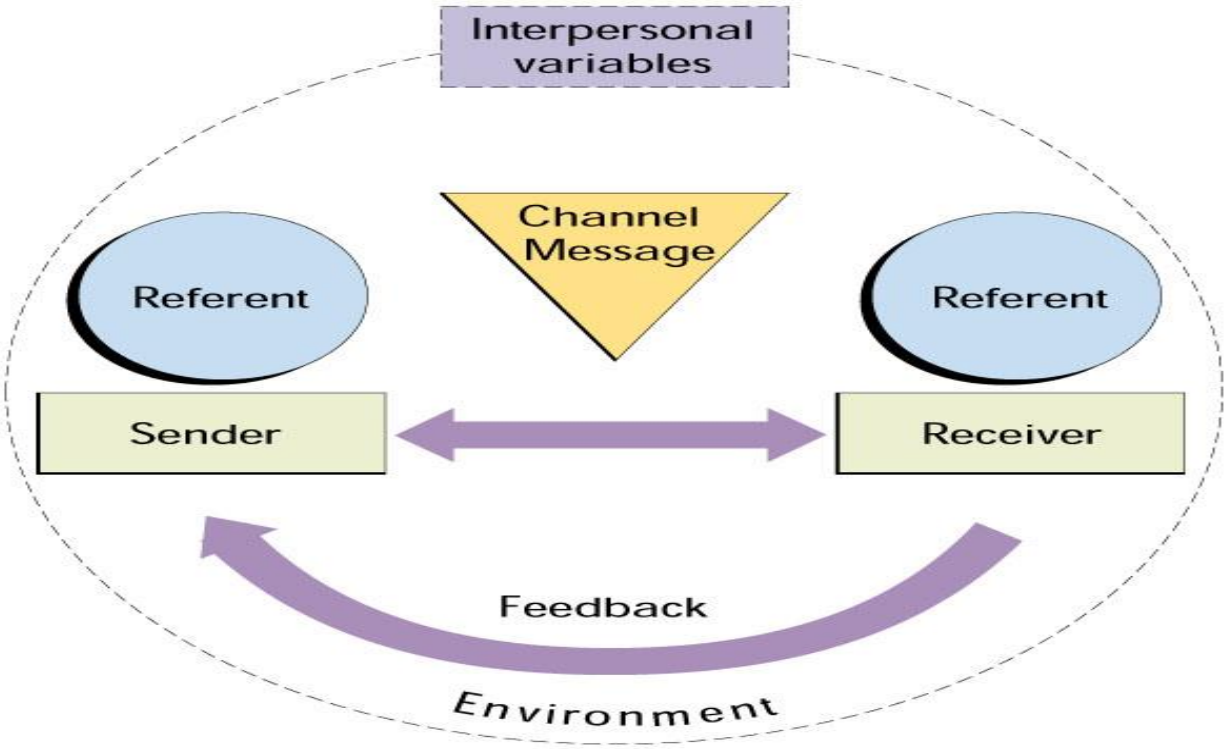

Figure 22-1 Communication as active process between sender and receiver.

- Every encounter we have with another person, whether spontaneous or deliberate, begins with an idea-a reason for engaging in a verbal exchange. The model must begin with what idea, referent. Referent mental images within a person who desires to convey those images to another
    - ✓ ideas, thoughts, pictures, and emotions
    - ✓ Encoding : translation of image into symbol
- **Encoding:** the process of translating images into symbols *that receivers can* understand.
    - ✓ Symbols often are **words, pictures, sounds, or sense information (e.g., touch or smell).**

- ✓ Only through symbols can the mental images of a sender have meaning for others.

A referent may be one of "a wide range of objects, situations ideas, or experiences" Any one of these items or a combination of them prompts the source- encoder to initiate action in order to convey the message engendered by the referent.

The *source-encoder/sender is* a term that describes one person who communicates with another. Sender initiates the process of communication by generating a message .Our ability to form, use and understand the messages we transmit is continually influenced by numerous factors, it include our communication skills, our attitudes, our levels of knowledge, and our sociocultural system. These factors are never static; indeed they are always changing, always being modified as we change and are modified by the events that surround us. Whenever we act in the role of the source-encoder we must consider these influences in order to understand not only our own communication, but also the communicative behavior of others.

Our ability to transmit the experiences we encounter is limited if we do not poses the ability to encode them in a form recognizable by others. The vocal mechanisms used in speech, the motor skills used in writing, and the language peculiar to a specific culture are encoding skills possessed to some degree by every human being. Similarly, the use of gestures and other nonverbal behaviors is an encoding ability that often bridges the verbal gaps encountered by people who speak different languages.

The ideas and experiences we have, as the source-encoder is, at this stage, still intangible. To make them come alive we must change that intangible invention into an actual physical product, which in the communication model is labeled the *message*.

All of us are aware that a message does not just appear. Every day we deliver messages of varying kinds and lengths as if we actually knew what operations were involved. In order to convey a message, we must arrange it so that it has some resemblance of recognizable order. In the English language, this requirement is filled by the sentence because it is a series of words in connected speech or writing forming the grammatically complete expression of a single thought. The order established through sentences is the *message code*. Whatever the code is – a sentence, picture or music – its expression becomes the *message content*. Finally, a message can be sent unless consideration is given to the manner in which we convey the

desired message *treatment. Message treatment* is the decision made in selecting and arranging both codes and content.

Channel

- Ways to transmit or communicate the message to a receiver.
- Once decisions have been made on the codes and contents of message, we must route the message across a channel.
- Common channels : visual channel : sight

  Auditory channel

  Kinesthetic channel: physical sensation mediated by touch

Because the cannel in the model involves the senses of hearing, seeing, touching, smelling and tasting, the sensory channel selected must be appropriate to the message we wish to convey. The receiver-decoder is one of the last links in our communication model. Behind this label is the person to whom the message is directed, that other individual who has been influenced by the same factors of communication, knowledge, attitudes, and socio cultural systems as we have been. Since no two people perceive an event or share their perceptions of that event in the same way, it is crucial to any verbal interaction that the receiver-decoder understands what we *mean* to convey. Our intent is not enough. We must aim for precision in our communication. The success with which we convey our thoughts determines how they will be absorbed and translated by the receiver – decoder. Then the receiver provides some form of *feedback*, which allows us to determine the success or failure of our communication efforts.

Decoding: interpretation of symbol in to mental image

- Receivers must **sense and interpret** the symbols and then decode the information back into images, emotions, and thoughts that make sense to them.
- When messages are decoded exactly as the sender has intended, the images of the sender and the images of the receiver match, and effective communication occurs.

3.1.3 Modes of communication

Nurses communicate with clients often and in various ways. Two types of communication are verbal communication (using words) and nonverbal communication (using facial expressions, actions, and body position). Verbal communication is sometimes differentiated from oral communication. Effective communication occurs when words and actions convey the same message (congruency).

Verbal Communication

Verbal communication is sharing information through the written or spoken word. Nurses use verbal communication extensively. They converse with clients, write care plans, document information and assessments, input data into the electronic record, and give oral or written change-of-shift reports.

Nonverbal Communication

Nonverbal communication is sharing information without using words or language. **Nonverbal communication** expresses emotions and attitudes, as well as enhancing what is being expressed verbally. **Nonverbal communication** is one component of body language and is sometimes more powerful in conveying a message than is verbal communication. If verbal and nonverbal messages are not congruent, the receiver usually believes the nonverbal cues. **If the body language and verbal cues are not congruent**, confusion occurs.

For example, Mr. H., a young diabetic client, begins clenching and unclenching his fists when the nurse asks about his sexual activity. He says, "Everything is fine," through gritted teeth. Later, when he trusts the nurse more, he admits that he has been impotent for the past 6 months. Often, body language provides more powerful clues than verbal language because it points to the person's true feelings.

Messages expressed through body posture and movements, gestures, facial expressions, and other forms of nonverbal behavior provide cues or suggestions to a person's true feelings or beliefs. This study of body movements and posture, facial expressions, and gestures is referred to as kinesics. The nurse must be aware, however, that nonverbal behavior has different

meanings for different people and in different situations. The nurse must be cautious when interpreting nonverbal cues. It is important to check with clients before making assumptions about the meaning of their body language. Remember, **Nonverbal communication** includes factors such as clothing, body ornamentation, body shape and size, and gestures.

Key Concept Be sure that your verbal and nonverbal communications give a congruent message to clients. When verbal and nonverbal messages conflict (are not congruent), others are most likely to believe the nonverbal message.

Key Concept In general, verbal communication is used to communicate information. Nonverbal communication conveys feelings and attitudes. Nonverbal communication occurs whether we want it to or not.

3.1.4 Therapeutic communication

One of the main ways nurses establish trust with patients is through communication. Because nurses are likely to have the most direct contact with patients, effective nurse-patient communication is critical. Nurses can utilize proven therapeutic communication techniques that promote quality care.

What is therapeutic communication?

Therapeutic communication is an application of the process of communication to promote the well-being of the client**.** Can be verbal or non verbal.

Therapeutic communication is a collection of techniques that prioritize the physical, mental, and emotional well-being of patients. Nurses provide patients with support and information while maintaining a level of professional distance and objectivity. With therapeutic communication.

The therapeutic relationship includes the following:

- Developing the nurse–patient relationship based upon partnership, intimacy and reciprocity.
- Manipulating the environment – from the macro organizational level, through to the meso patient environment level to the micro environment and the physical features that impact on the well-being of the patient.

- Teaching – involving patient education and information.
- Providing comfort – physical and non-physical care.
- Adopting complementary health practices – these are creative approaches to healing that are incorporated into nursing care.
- Utilizing tested physical interventions – incorporating intuitive approaches to care that can be supported by inductive research approaches.

Stages of therapeutic relationship formation

A. Orientation phase

During this phase, the nurse engages the patient, and the patient is able to ask questions and receive explanations and information. This stage helps the patient develop trust and is where first impressions about the nurse and health care system begin to evolve.

B. **Identification phase**

The patient and nurse begin to work together. These interactions provide the basis for understanding, trust and acceptance as the patient becomes an active participant in treatment.

C. Exploitation phase

The patient takes advantages of all services offered, exploiting the nurse-patient relationship to address treatment goals.

D. Resolution phase

As a result of effective communication, the patient's needs are met, and he or she moves toward full independence. The patient no longer needs help, and the relationship ends.

Characteristics of an effective nurse patient relationship

- Intellectual and emotional bond between nurse and patient
- Respects patient as an individual
- Respects patient's confidentiality
- Focuses on patient's well-being
- Based on mutual trust, respect and acceptance

Therapeutic Communication techniques/skills

Activity 3

1.1.1 Make a list of all the therapeutic communication technique you can think of and categorize these into skills that:

- Assist in keeping the focus on the patient and/or carer'.
- Demonstrate listening.
- Assist with information giving.

It is important that nurses have skills that keep the focus of communication on the patient, that demonstrate active listening and assist with information giving. Refer to Box 1 to examples of communication skills that are integral to nursing.

Skills that assist in keeping the focus on the patient and/or carer:

- Looking and listening for cues.
- Asking open questions. For example: 'How are you?'
- Asking open directive questions. For example: 'How are you since I last saw you?'
- Asking open questions about feelings.
- Exploring cues. For example: 'You said you are not with it, can you tell me more about that?'
- Using pauses and silence.
- Using minimal prompts.
- Screening. For example: asking the question 'Is there something else?' before continuing with the discussion.
- Clarifying. For example: asking the question 'You said you are not with it, from what you say, it sounds like it is hard to concentrate?'

Skills that demonstrate listening

- Reflecting.
- Acknowledging.

- Summarizing.
- Empathizing.
- Paraphrasing.
- Checking.

Skills that assist with information giving

- Checking what information the person knows already.
- Giving small amounts of information at a time, using clear terms and avoiding jargon.
- Avoiding detail unless it is requested – do not assume people want to know.
- Checking understanding using an open question. For example: 'I've gone through some difficult information, what sense have you made of it?'
- Pausing and waiting for a response to what you have said before moving on.
- Checking, with sensitivity, the effect of the information you have given on the patient or carer. For example: 'There has been a lot of information to take in today, how are you feeling?'

Barriers to therapeutic communication

Activity 4

Working with a colleague, discuss and list the barriers to effective communication. One person could consider the barriers from the healthcare professional's point of view and one from the patient and/or carer's point of view.

Barriers to **therapeutic** communication are factors that hinder good communication. By having a conscious awareness of the potential barriers to **therapeutic** communication it is possible for the nurse to manage and minimize the effect of these barriers in the caring environment.

Barriers to **therapeutic** communication are broadly categorized into patient and carer barriers and health care professional barriers.

Patient and care provider (family and significant others) barriers:

- Environment – noise, lack of privacy, no control over who is present or not present (staff or relatives).

- Fear and anxiety – related to being judged, being weak, or breaking down and crying.
- Other barriers – difficulty explaining feelings (no emotional language to explain feelings), being strong for someone else, or communication cues being blocked by healthcare professionals.

Health care professional barriers:

- Environment – high workload, lack of time, lack of support, staff conflict, lack of privacy or lack of referral pathway.
- Fear and anxiety – related to making the patient more distressed by talking and/or asking difficult questions.
- Other barriers – not having the skills or strategies to cope with difficult reactions, questions and/or emotions. Thinking 'it is not my role', and 'the patient is bound to be upset'.

- **Video show** on therapeutic and non-therapeutic relationship.)

Box 1 – Definitions and examples of therapeutic communication skills

Skills to keep the consultation patient-focused:

Empathizing

Saying something to show you appreciate (not understand or sympathise) how the other person seems to be feeling. For example: 'Everything has happened so fast, no wonder you are finding it difficult to take in.'

Making educated guesses

Seeing or hearing something (cues) that gives you a hint about how the person is feeling. For example: 'You are telling me you know what is going to happen, but you look a little confused.'

Looking and listening for cues

Cues are hints and can be words, gestures or body language. Noticing verbal and non-verbal cues is important to understanding the patient's needs.

Psychological focus

Recognizing and responding to emotions, feelings and concerns. Patients appreciate healthcare professionals asking about their feelings.

Using pauses and silence

Pauses and silence provide a slower pace and will help the person to engage in the conversation and give them time to think what they want to say.

Using minimal prompts

Small, encouraging words and gestures, for example, nodding or saying 'go on'.

Negotiating

Negotiating and asking permission. For example: 'Would it be okay to talk about what is worrying you?'

Active listening: acknowledging

Showing a response to what you are noticing or hearing. For example: 'I can see you are very upset about this.'

Active listening: summarizing

A clear way to prove you have heard all the cues, concerns or questions. For example: 'So what you told me you are concerned about is the treatment, your husband and how long you may need to be off work.'

Reflecting

Reflecting is a helpful way to pick up a cue. Reflection can also function like a question, but is easier for the person to respond. Reflect back to the patient or relative their own words, or use your own words to check that you understand. For example: 'You have been thinking, what will happen… [pause].'

3.1.14 The 7 Cs of Communication: A Checklist for Clear Communication

According to the 7 Cs, communication needs to be:

- Clear.
- Concise.
- Concrete.
- Correct.
- Coherent.
- Complete.
- Courteous.

In this article, we look at each of the 7 Cs of Communication, and we'll illustrate each element with both good and bad examples.

1. Clear

When writing or speaking to someone, be clear about your goal or message. What is your purpose in communicating with this person? If you are not sure, then your audience won't be sure either.

To be clear, try to summarize the number of ideas in each sentence. Make sure that it's easy for your reader to understand your meaning. People shouldn't have to "read between the lines" to understand what you are trying to say.

Bad Example

Hi Yidenek,

I wanted to write you a quick note about Tigist, who's working in your case team. She's a great asset and I'd like to talk to you about her when you have time.

Best

Yeko

What is this email about? Well, we're not sure. First, if there are multiple Tigist's in Yidenek's case team, Yidenek won't know who Yeko is talking about.

Next, what is Tigist doing, specifically, that is so great? We don't know that either. It's so vague that Yidenek will definitely have to write back for more information.

Last, what is the purpose of this email? Does Yeko simply want to have an idle chat about Tigist, or is there some more specific goal here? There's no sense of purpose to this message, so it's quite confusing.

Let's see how we could change this email to make it clear.

Good Example

Hi Yidenek,

I wanted to write you a quick note about Tigist Menale, who's working in your case team. In recent weeks, she's helped our case team in understanding the nursing care of a TB patient on her own time.

We've now got a patient with open TB, and her knowledge and skills would prove invaluable. Could we please have her transferred to our case team to help with the holistic nursing management of TB patients? I'd appreciate speaking with you about this. When is best to call you to discuss this further?

Best wishes,

Yeko

This second message is much clearer, because the reader has the information he needs to take action.

Concise

When you're concise in your communication, you stick to the point and keep it brief. Your audience doesn't want to read six sentences when you could communicate your message in three.

- Are there any adjectives or "filler words" that you can delete? You can often eliminate words like "for instance," "you see," "definitely," "kind of," "literally," "basically," or "I mean."
- Are there any unnecessary sentences?

- Have you repeated the point several times, in different ways?

Bad Example

Hi Salem,

I wanted to touch base with you about the patient we discussed this morning. I really think that our assessment and nursing diagnosis are definitely wrong. I think that could make a big difference, and it would help the patient and his relatives.

For instance, if we both asses his needs, as well as plan his nursing care needs, then the family members that we want to understand his condition are going to remember our his needs. The impact will just be greater.

What do you think?

Adey

This email is too long! There's repetition, and there's plenty of "filler" taking up space.

Good Example

Watch what happens when we're concise and take out the filler words:

Hi Salem,
I wanted to quickly discuss the RTA patient, Ato Asres, we discussed this morning. Our assessment and nursing diagnosis were wrong/ did not reflect his nursing care needs.
We need to involve both the patient and his relatives in the nursing process in order for them to fully contribute, understand his condition, treatment regime and the part they have to play in caring for him.

This would promote Asres' compliance with his care and enable them to understand how to prevent recurrence of his condition.

What do you think?
Adey

2. Concrete

When your message is concrete, then your audience has a clear picture of what you're telling them. There are details (but not too many!) and vivid facts, and there's laser-like focus.

Bad Example

Consider this patient/public notice:

"The needs you"

A statement like this is confusing. There's no passion, no vivid detail, nothing that creates emotion, and nothing that tells patients/public why they need them. This message isn't concrete enough to make a difference.

Good Example

What would you do or like to see change if you're the owner of this hospital? Have you got any ideas or something to offer to make this hospital a place you consider a good hospital? Yes you do! For example, you can speak or write to us on how we can make things better here. Why not volunteer some of time to help hospital staff in many areas of your choice? With your help in whatever capacity will make this hospital a centre of excellence and give a sense of ownership and pride! People will stay less days/time in the hospital and More lives will be saved! Think and Act Now!

This notice is better because there are vivid images. Patients/Public can picture the hospital becoming a centre of excellence- and who could argue with that? And mentioning that people will stay less days/time in the hospital is appealing and concrete to everybody. The notice has come alive through these details.

3. Correct

When your communication is correct, it fits your patient's needs, and correct communication is also error-free communication.

- Do the technical terms that you use fit your patient's level of education and knowledge?
- Have you checked your writing for grammatical errors? Remember, spell checkers won't catch everything.

Bad Example

Hi Senait,

Thanks so much for meeting me at lunch today! I enjoyed our conservation, and I'm looking forward to moving ahead on our case team project. I'm sure that the two-weak deadline won't be an issue.

Thanks again, and I'll speak to you soon!

Best,

Eriteria Alem

- Are all names and titles spelled correctly?

If you read that example fast, then you might not have caught any errors. But on closer inspection, you'll find two. Can you see them? The first mistake is that the writer accidentally typed "conservation" instead of "conversation". This common error can happen when you are typing too fast. The other error is using "weak" instead of "week". Again spell checkers won't catch word errors like this, which is why it is so important to proofread everything.

4. Coherent

When your communication is coherent, it is logical. All points are connected to the main topic, and the tone and flow of the text is consistent.

As you can see in the example below, this email doesn't communicate its point very well. Where is Bethlehem's feedback on Rael's report? She started to mention it, but then she changed the topic to talk about Friday's meeting.

Bad Example

Rahel,

I wanted to write you a quick note about the incident report you wrote last week. I gave it to Sr. Bicha to proof, and she wanted to make sure you knew about the case team we're having this Friday. We'll be drafting incident reporting guidelines.

Thanks,

Bethlehem

Good Example

I wanted to write you a quick note about the incident report you wrote last week. I gave it to Sr. Bicha to proof, and she let me know that there are a few changes that you'll need to make. She'll email you her detailed comments later this afternoon.

Thanks,

Notice that in the good example, Bethlehem does not mention Friday's meeting. This is because the meeting reminder should be in an entirely separate email. This way, Rael can delete the report feedback email after she makes her changes, but save the email about the meeting as her reminder to attend. Each email has only one main topic.

5. Complete

In a complete message, the audience has everything they need to be informed and, if applicable, take action.

- Does your message include a "call to action", so that your audience clearly knows what you want them to do?
- Have you included all relevant information - contact names, dates, times, locations, and so on?

Bad Example

Hi everyone,

I just wanted to send you all a reminder about the case team meeting we're having tomorrow!

See you then,

Genet

This message is incomplete, for obvious reasons. What meeting? When is it? Where? Genet has left her team without the necessary information.

Good Example

Hi everyone,

I just wanted to remind you about tomorrow's case team meeting on the hospital reform nursing implementation guidelines. The meeting will be at 10:00 a.m. in the hospital conference room. Please let me know if you can't attend.

See you then,

6. Courteous

Courteous communication is friendly, open, and honest. There are no hidden insults or passive-aggressive tones. You keep your reader's viewpoint in mind, and you're empathetic to their needs.

Bad Example

Haile,

I wanted to let you know that I don't appreciate how your case team always monopolizes the discussion at our monthly hospital staff meetings. I have a lot of projects, and I really need time to get my team's progress discussed as well. So far, thanks to your case team, I haven't been able to do that. Can you make sure they make time for me and my team next month?

Thanks,

Kassaye

Well, that is hardly courteous! Messages like this can start office wide feuds. And this email does nothing but create bad feelings, and lower productivity and morale. A little bit of courtesy, even in difficult situations, can go a long way.

Good Example

Hi Haile,

I wanted to write you a quick note to ask a favour. During our monthly hospital staff meetings, your people do an excellent job of highlighting their progress. But this uses some of the time available for my team to highlight theirs. I'd really appreciate it if you could give my team a little extra time each week to cover their progress reports.

Thanks so much, and please let me know if there's anything I can do for you!

Best,

Kassaye

What a difference! This email is courteous and friendly, and it has little chance of spreading bad feelings around the office.

Variations

There are a few variations of the 7 Cs of Communication:

- **Credible** - Does your message improve or highlight your credibility? This is especially important when communicating with an audience that doesn't know much about you.
- **Creative** - Does your message communicate creatively? Creative communication helps keep your audience engaged.

Key Points

Most of us communicate every day. The better we communicate, the more credibility we'll have with our clients, our bosses, and our colleagues.

Use the 7 Cs of Communication as a checklist each time you communicate. By doing this, you'll stay clear, concise, concrete, correct, coherent, complete, and courteous.

Session 3.2 Documentation and reporting

Session objectives

At the end of this session the participants will be able to:

- Define reporting and documentation
- Explain type of nursing record documentation
- Identify basic components of patient chart
- Describe types of verbal communication/ reporting
- Analyze characteristics of good recording
- Discuss medication management
- Identify factors associated with medication errors
- Describe characteristics of medication errors

Reporting and Documenting

Reporting is an oral, written, or computer account of patient status. It can be done between members of health care system. Report should be clear, concise, and comprehensive.

Documentation is permanent record of patient information and care and serves the following purpose:

Purpose:

- To communicate
- As a legal document
- For research and Statistical analysis
- For education
- For audit and quality assurance, and
- Planning client care

Characteristics of documentation

- Brief
- Factual
- Concise
- Objective
- Descriptive

- Comprehensive
- Legally prudent
- Appropriate/relevant

Nursing Record Documentation

A. Written Communication

Patient care record/chart contains the following basic components

- Admission sheet
- Medical History and Physical Examination (Physician)
- Physician's order sheet
- Physician's progress notes
- Nurse's notes: care plan, progress notes, discharge planning, etc.
- Special records/reports: referrals, x-ray and laboratory results, medication and vital sign sheets, I&O, IVF administration, etc.
- Discharge Summary

The following items are used by nurses to document a patient's course of treatment. It is the nurse's responsibility to ensure that a patient's medical record is complete, containing all the necessary forms in the proper sequence. The forms are intended to guide the entire medical team and to become a permanent record maintained in the patient's medical record:

1) *Clinical forms:* Nurses must record patient data and findings on clinical forms that include:

- Routine Observation Sheet
- Intravenous Fluid Administration Record,
- Fluid Balance Chart
- Medication Administration Record

It is the nurse's responsibility to chart on the appropriate form and to make sure that the information is timely and accurate.

2) *Nursing Process Forms: Nurses should record all steps in the nursing process on the appropriate forms :(* ***ANNEX 6)***

- Nursing Admission Assessment Form
- Nursing Problem Statement List
- Nursing Care Plan

- Nursing Patient Progress Report

Verbal Communication

1) ***Nurse-to-Nurse Report:*** During a shift change, the off-going nurse should verbally report to the on-coming nurse concerning the status of each patient using a standard format. The report consists of a general synopsis of the patient, any significant events during the shift, as well as a progress report of the work completed. Updates should be provided on IV administration, tests done or pending, abnormal laboratory findings, and general patient progress.

Follow the format below for performing nurse-to-nurse shift report.

- Patient name
- Patient age
- Reason for Seeking Care/Chief complaint
- Patient diagnosis: present all current diagnoses
- Current IVs
- Tests completed or pending
- Abnormal lab findings: do not report normal findings
- Events during the shift: synopsis of what occurred during the shift
- Patient progress: description of patient's response to any treatment or events that occurred during the nurse's shift, including the patient's progression towards discharge

2) ***Nurse to Junior Nurse Report:*** At the start of each shift, the nurse is responsible for reporting to the junior nurse regarding patient(s) under his/her care. Specific care information related to bathing, ambulating, eating, toileting, and other similar concerns should be discussed. A written checklist of tasks to be completed should be given to the junior nurse/health assistant/student.

Use the following format for performing a nurse to junior nurse/health assistant/student report. It is important that the assigned tasks are specific to ensure that the junior nurse/health assistant/student is able to accomplish them during their shift.

a) ***Vital Signs:*** Describe the frequency required for assessing a patient's vital signs. Is it necessary to assess them:

- Once a shift,
- Twice a shift,
- Every hour, or
- Other unique needs.

b) ***Bathing***: Describe the level of assistance the patient requires for bathing and changing linens. Is the level:

- Complete assistance during both bath and bed linen changing,
- Required assistance when bringing bathing materials to the patient who must remain in the bed while linens are changed,
- Required assistance when bringing bathing materials to the patient who is capable of getting out of the bed while the linens are changed, or
- No assistance necessary because the patient is independent during bathing and the patient is capable of getting out of bed while the linens are changed.

c) ***Activity***: Describe the activity level of the patient as follows:

- Bed rest: how often does the patient need to be turned?
- Out of bed (OOB) walking: is the patient OOB at will or does he/she need assistance? If assistance is required, please inform the aide of the frequency of OOB.
- Out of bed (OOB) to chair: what is the level of assistance required to get OOB to a chair? If assistance is required, please inform the aide of the frequency that this should occur and for how long.

d) ***Toileting:*** Describe the level and type of assistance the patient requires to perform the following (if applicable):

- Out of bed to the bathroom,
- Offer the bedpan to the patient every _____ (amount of time),
- Patient uses the urinal,
- Patient has a Foley catheter, and/or
- All patient output should be recorded and communicated.

e) ***Diet:*** Describe the patient's type of diet and the assistance they require:

- Set up the food only,
- Set up and cut the food,

- Feed the patient, and/or
- Record all input.

f) ***Safety:*** Describe how often the aide needs to make rounds on the patient.

3) Nurse – to – Physician Reporting

Whenever a patient's status changes, the physician should be informed. The status should be reported in an objective manner, allowing for the physician's recommendation(s). Any physician's order should then be documented in the medical record by the nurse as a verbal order. Verbal orders from a physician to a nurse must be told to 2 nurses simultaneously in order to ensure that instructions are clearly understood and verifiable. The transcribed order should be signed by the physician within 24 hours.

Physician orders

Physicians provide both written and verbal forms of communication in order to direct a patient's care. It is the nurse's responsibility to ensure that a physician's orders and plan for a patient's care are put into action.

Physician's orders should be recorded by the physician on a physician order Sheet. When the order is carried out this should be documented on the order sheet, including the date and time that the order was carried out, and the signature of the person confirming that the order has been completed.

Physician's order must contain the following elements:

- Date and time
- Full name of the medication
- Dosage
- Concentration – amount and type of diluent
- Duration
- Time and frequency
- Route
- Physician signature

All physician orders, even verbal orders, must be documented.

Any/all verbal orders from a physician must be given to two (2) nurses simultaneously in order to ensure verbal instructions are clearly understood and verifiable. The physician should be clear about which nurse (of the two) is to implement his/her verbal orders. Once received,

the order is immediately transcribed into the Physician Order Sheet by the implementing nurse. The nurse who is writing the order completes the transcription by writing "*verbal order given by (the name of the physician)/the nurse's signature."* All verbal orders are to be reviewed and co-signed by the physician within twenty-four (24) hours.

Characteristics of Good Recording

- Brevity – concise, complete sentences required, start with a ***C****apital* letter and end with a *period.*
- Use black ink pen
- Accuracy – must be objective
- Appropriateness
- Completeness and chronology/timing
- Use of standard terminology
- Confidentiality
- Signed – sign with full name (in script) and status; i.e. Haimonot Geremew R. N.
- In case of ERROR: draw a horizontal line through the error, write the word "error" above the line, sign
- Legal awareness
- Legible
- No abbreviations except those accepted in the medical/clinical field (OD, BID, TID, etc)
- Horizontal line drawn to fill up partial line

Methods of documentation

Problem Oriented Medical Records (POMR)

POMR is a structured method of documentation that emphasizes client problems (look example. The method is based on the nursing process and facilitates communication of client needs.

The POMR is composed of a data -base, a numbered problem list, and progress notes referred to as **SOAP** notes. The advantages of POMR charting method include the following:

a. Gives emphasis to clients' perception of their problems
b. Requires continuous evaluation and revisions of care plan.
c. Provides greater continuity of care among health care team members.

d. Enhances effective communication among health care team members.
e. Increases efficiency in gathering data.
f. Provides easy to read information in chronological order.
g. Reinforces use of the nursing process.

With POMR format, the list of problems is filled in an easily accessible location and referred to frequently. New problems are added as identified. After a problem has been resolved, the date of resolution is recorded and a line is drawn through the problem and its number on the problem sheet. After a problem list is developed, succeeding record entries (such as in the progress notes) are coded by the problem number.

Problem	Date	Problem	Resolved
~~1.~~	~~4/7/2002~~	~~Diarrhea~~	12/7/2002
2.	4/8/2002	Anxiety related to Inexperience with	
3.	4/9/2002	Post-operative routines.	
4.	4/9/2002	Pain related to incisional edema and movement of right arm	
		Altered body image	

Progress notes follow a SOAP format including SOAPE, SOAPIE, and SOAPIER notes. These are acronyms for subjective data (S), objective data (O), assessment (A) and plan (P). Some also use intervention (I), evaluation (E), and response (R).

S- Includes subjective data from the client. **O-** Objective data that can be observed or measured. **A-** is a conclusion from the subjective and objective data. Assessment is and interpretation of the client's condition or level of progress. It is a statement of the status of the diagnosis or problem. It determines whether the problem has been resolved or if further care is required.

P- Depending on the assessment of the situation, the health care member maintains or revises the previous plan of care. Plans may include specific orders or interventions designed to manage the client's problem and goals and expected outcomes of care.

PIE- is an acronym for problem, intervention, and evaluation. The **PIE NOTE** differs from soap notes because the narrative does not include assessment data and the format requires nurses to evaluate client outcomes.

P- Problem or nursing diagnosis applicable to client

I- Interventions or actions taken

E- Evaluation outcomes of nursing interventions and client response to nursing therapies.

S- "I am worried about what it will be like after surgery."
O- Client asking frequent questions about surgery. First surgery experience. Wife present expresses concern.
A- Anxiety related to knowledge deficit of surgery experience.
P- Explain routine preoperative preparation. Demonstrate and explain deep breathing exercises. Provide explanation and booklet on postoperative care
E- Expresses eagerness to learn as much as possible. B. Gebre, RN

P	Anxiety related to knowledge deficit of surgery manifested by frequent questions and first time surgery.
I	Explained normal preoperative preparations for surgery. Demonstrated deep breathing exercises. Provided booklet to client on postoperative care.
E	Able to demonstrate exercises correctly. Needs review of postoperative nursing routines. B. Gebre, RN

Examples of Progress notes written in SOAPE and PIE formats

Focus Charting- (Lampe 1988)

Focus charting structures progress notes according to the focus of the note. Examples include a sign or symptom, a condition, a nursing diagnosis, behaviour, a significant event or an acute change in the patient condition. Each note includes data, actions, and client's response (DAR) for the particular client situation.

*Wro. Hanna has developed a fever, 39degree C, 2-days following surgery***.** The nurse has auscultated lung sounds and found crackles in the right lower lobe. The client has difficulty coughing as a result of incisional pain. The nurse repositioned the client, began instruction on deep breathing exercises.

Focus Note

D- *Temp. 39degree C. Lungs auscultated with crackles over R. lower lobe*

A- *Repositioned client and instructed on deep breathing. Ordered Spirometer*

R- *Client has difficulty coughing as a result of incisional pain*

-

Medicines' Management

It is the nurse's responsibility to safely administer the medications to a patient as ordered by the physician. Nurses should be aware of the desired outcome, dosage, preparation and side effects of each prescribed medication.

Medication storage

The nurse is responsible to ensure that all medications and medical supplies are stored either in the central or room cabinet designed for this purpose. Drugs and supplies should not be kept at bedside. Furthermore, it is the responsibility of the nurse to administer all drugs prescribed for the patient. Drug administration should not be delegated to the family or any care givers as long as the patient is in the hospital..

Transcribing the Order:

Medication orders are transcribed by the nurse from the physician order sheet to the Medication Administration Record. The nurse will document that the order has been transcribed by putting a signature next to the order.

The nurse is responsible for questioning the physician regarding any medication order or element of an order that is in his/her judgment an error. The perceived error may be in the drug ordered, dosage, route, time and/or frequency to be given.

Administration of Medications

The following steps should be followed by the nurse when administering medications. Two processes are outlined which differ based on whether the medication is stored at the patient's bedside or in a central cabinet. There are three distinct steps to administering medications: preparation, administration and documentation. Each step requires safety checks to ensure that the right drug is given to the right patient.

1. Preparation

Medications at the Bedside

- The nurse brings the Medication Administration Record to the patient's bedside.
- The nurse checks the prescribed medication from the patient's bedside to the Medication Administration Record *three times* to ensure that it is the proper medication:
- When reaching for the container of medication,

- Immediately prior to the pouring the medication, and
- When returning the container to its proper location.

Medications in a Cabinet

- The nurse brings the Medication Administration Record to the cabinet.
- The nurse checks the prescribed medication from the cabinet to Medication Administration Record three times to ensure that it is the proper medication:
- When reaching for the container of medication,
- Immediately prior to the pouring the medication, and
- When returning the container to its proper location.
- Medications should be prepared one patient at a time. Each medication for a single patient should be organized into a group for that individual patient, prior to dispensing medications for another patient.
- When medications are to be given to more than one patient, the medication cup/container should be clearly marked with each bed number.
- Before administering medication, the nurse should cross-reference the bed number (on cup/container) with the bed number and name listed on the Medication Administration Record.

2. Administration

- The nurse who prepares the medication should always be the nurse who administers the medication.
- During administration, medications should never be out of the sight of the administering nurse.
- It is the nurse's responsibility to confirm that they are giving the correct drug to the correct patient. When the nurse arrives at the patient's bedside, the nurse must confirm using two methods that the patient is properly identified.
- Check the name on the Medication Administration Record with the patient's posted name.
- Ask **the patient to repeat their name.**
- Once the correct patient is verified, administer the medication. If it is an oral medication do not leave it for the patient to take later. The nurse needs to observe all

medications being taken to assure that the medication has been adequately administered.

- If a patient refuses a medication, the physician should be notified and it should be clearly documented in the medical record.

3. Documentation*:*

Immediately following the administration of a patient's medication, the nurse who administered the medication must document on the Medication Administration Record that the medication has been given. The nurse must document the time that each drug was given and then sign and initial the record.

Medication Errors

Patient safety is fundamental to quality nursing and health care[1] and medication errors are the leading cause of death and disability[2]. There is a recognition and consensus that patient safety as primarily a nursing responsibility[3] because nurses take a central role in patient safety and as a result, there is a danger that errors can be attributed to nurses rather than to system failures. However, evidence shows that nursing vigilance protects patients against unsafe practices. For example, nurses were responsible for intercepting 86% of all medication errors made by physicians, pharmacists and others before the error occurred[4] and medicines management is, therefore, a multidisciplinary responsibility.

Why do medication errors happen?

Every step in patient care involves a potential for error and some degree of risk to patient safety. In a study of prescribing errors[5], the most common factors associated with errors included:

- Using the wrong drug name, dosage form, or abbreviation;
- Mistakes on calculating dosage;
- Atypical or unusual and critical dosage.

Types of Possible Medication Errors

Types	Contributing Factors	Causes
extra dose	Distractions	performance deficit
improper dose/quantity	workload increase	procedure/protocol

		not followed
omission error	inexperienced staff	knowledge deficit
prescribing error	shift change	inaccurate or lack of documentation
unauthorized drug	agency/temporary staff	confusing communication
wrong administration	no 24 hour pharmacy	inaccurate or omitted transcription
Technique	insufficient staffing	computer entry
wrong dosage form	emergency situation	drug distribution system
wrong drug preparation	cross coverage	inadequate system safeguards
wrong patient	code situation	illegible or unclear handwriting
wrong route	no access to patient	
wrong time	Information	

(Source: Ruth M. Kleinpell, Nursing Spectrum, February 2001. Vol. 2 No. 2. p.39)

Medication errors are preventable, although reducing the error rate significantly will require multiple interventions and close collaboration between the health team and management.

Types of medication errors

- Omission errors
- Improper dose
- Unauthorized drug errors
- Wrong time error
- Types of medication error…
- Deteriorated drug error
- Wrong dosage form error
- Wrong drug preparation error
- Wrong administration technique
- Monitoring errors

1. Omission error

- Failure to administer an ordered dose to a patient before the next scheduled dose is considered.
- Omission is not an error
    - If there is any medical reason
    - When patient cannot take anything by mouth(NPO) prior to a procedure or

- Patient refuses to take them

3. **Improper dose**

   It occurs when a patient is given a dose that is greater(extra dose error) or less than the prescribed dose.

Cause: absence of documentation

- Inaccurate measurement of an oral liquid is also an improper dose error.

- Un authorized error

Administration of a medication to a patient without proper authorisation by the prescribers categorized as an unauthorised drug error

4. **Deteriorated drug error**

   Medications that are dispensed or administered beyond their expiration date may have lost potency or less effective or ineffective

5. **Wrong time error**

   - Timing of administration is critical to the effectiveness of medications
   - Maintaining an adequate blood level of drug is required for effectiveness
   - Administering doses too early or too late may effect the drug serum level and consequently the efficacy of the drug

6. **Wrong dosage form error**

   - Doses administered or dispensed in a different form from that ordered by the prescriber are classified as wrong dosage form errors
   - Depending on the state law and health care facility guidelines, dosage forms changes may be acceptable to accommodate particular patient needs

   For example:

   Dispensing a liquid formulation without specific prescription to a patient who has difficulty swallowing tablets might be an acceptable dosage form change

7. **Wrong drug preparation error**

   Drugs requiring reconstitution, (adding liquid to powdered drug), dilution or special preparation prior to dispensing or administration of drug

8. **Wrong administration technique**

   Doses that are administered using an inappropriate procedure or incorrect technique are categorized as wrong administration technique errors

A subcutaneous injection that is given too deep. An I.V drug that is allowed to infuse via gravity instead of using an I.V pump. Instilling the eye drops in the wrong eye is another example

9. **Monitoring errors**

Monitoring errors result from inadequate drug therapy review. Prescribing an anti hypertensive agent which lowers blood pressure, and failing to check blood pressure

Error reporting and learning

A good way to learn from medication errors is to establish a reporting system, as voluntary reporting of adverse events provides data that leads to improved patient safety. However, because of the "blame and shame" approach in health system, there is generally underreporting and what is reported is often the tip of the iceberg. A useful approach to use is the *critical incident analysis*. This analysis examines adverse events to understand where the system broke down, why the incident occurred, and the circumstances surrounding the incident . Analyzing critical incidents, whether or not the event actually leads to a bad outcome, provides an understanding of the conditions that produced an actual error or the risk of error as well as the contributing factors.

Feedback and dissemination of information can create an awareness of errors that occur in the system and improve system design to reduce or eliminate medication errors. Health care organizations and health professionals should be encouraged to participate in voluntary reporting systems as an important component of their commitment to patient safety.

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Module IV: Nursing Process

Module IV: Nursing Process

Module description

This module is designed to enable trainees to apply nursing process as a framework to provide quality individualized and holistic nursing care. This module covers all components of nursing process including nursing assessment, nursing diagnosis, outcome identification, nursing plan of care, nursing implementation and evaluation.

Module objective

After completing this module the trainees will be able to effectively carry out the nursing process through assessment of patients, formulation of nursing diagnoses, set-patient centered outcomes, develop individualized plan of care, carry out nursing interventions and evaluate outcomes.

Enabling objectives

After completing this module, the trainees will be able to

- Conduct comprehensive assessment of client
- Formulate nursing diagnoses
- Develop holistic nursing care plan
- Carry out nursing instructions
- Evaluate effectiveness and efficiency of nursing care

Module content

The module has seven sessions:

Session 4.1. Introduction to nursing process

Session 4.2. Nursing Assessment

Session 4.3. Nursing diagnosis

Session 4.4. Planning: Outcome Criteria/Identification

Session 4.5. Planning: Nursing Intervention

Session 4.6. Nursing Implementation

Session 4.7. Evaluation

Session 4.1. Introduction to nursing process

Session Description

This session highlights basics nursing process, which is the tool and methodology of the provision of nursing care.

Enabling objectives

By the end of this session, trainees will be able to:

- Define concepts of nursing
- Describe nursing process
- Identify the six steps of nursing process
- Explain the characteristics nursing process
- Explain benefits of using the nursing process
- Compare nursing process with medical process

Basic nursing concepts

Nursing is a profession that ensures the successful implementation of interventions that welcome and nurture life, promotes or restores health, enables the means to a peaceful, dignified, and pain-free death. American nurses association defined nursing as, the diagnosis and treatment of human responses to actual and potential health problems or illness (***ANA, 1995***).

Nurse, is a person who is trained and experienced in nursing profession and interested in care of sick/well person; has completed a program of basic, generalized nursing education and is authorized by the appropriate regulatory authority to practice nursing (ICN 1987).

What is the Nursing process and why do we use it?

The nursing process is an organized and systematic process of giving goal oriented, individualized and humanistic nursing care that is both effective and efficient. It is organized and systematic in that it consists of six sequential and interrelated steps: assessment, diagnosis, outcome identification, planning, implementation, and evaluation. Nursing process is based on the assumptions that professional nursing practice is interpersonal in nature and professional nurses view human beings as holistic, thereby acknowledging that mind and body

are not separated but function as a whole. People respond as whole beings. What happens in one part of the mind or body affects the person as a whole entity.

Given these two assumptions, it would be impossible for a nurse to view a client/patient as "the hysterectomy in room 201" or "the paranoid in bed 2". The woman who has experienced a hysterectomy may have physiological, spiritual, and psychological health problems, i.e., physiological and psychological adjustments due to induced menopause, and spiritual adjustments if her life style includes a religious orientation related to childbearing. Or the person with symptoms of paranoia may refuse to eat, causing physiological changes related to malnutrition. These two assumptions, that nursing is interpersonal in nature and that professional nurses view human beings as holistic, give guidance and direction to the use of the nursing process.

In nursing, the client/patient may be an individual, family, or community and the nursing process has been adapted for use with each type of client/patient.

In order to use the nursing process effectively, nurses need to understand and apply appropriate concept and theories from nursing, from the biological, physical, and behavioral sciences, and from the humanities, in order to provide a rationale for decision-making, judgments, interpersonal relationships, and actions9. These concepts and theories provide the framework for nursing care.

Historical Perspective and Steps of Nursing Process

In 1955 Lydia Hall, mention the term nursing process for the first time where she introduced three steps of nursing process: observation, administration of care and validation. Further, in the late 1950th Johnson and in the early 1960th Orlando and Wiedenbach, introduced three steps of nursing process that include assessment, planning, and evaluation.

In the late 1960th Yura and Walsh identified four steps in the nursing process: assessment, planning, implementation, and evaluation. By 1974 the North American Nursing Diagnosis Association (NANDA), nursing diagnosis was added as a separate and distinct step in the nursing process. Prior to this, nursing diagnosis had been included as a natural conclusion to the first step, assessment. Latter in 1991 ANA included outcome identification as a specific part of the planning phase making the nursing process five steps: assessment, diagnosis,

outcome identification and planning, implementation, and evaluation (1). Currently the nursing process consists of six phases (or steps): assessment, diagnosis, planning outcomes, planning interventions, implementation, and evaluation as shown on Fig 1(2).

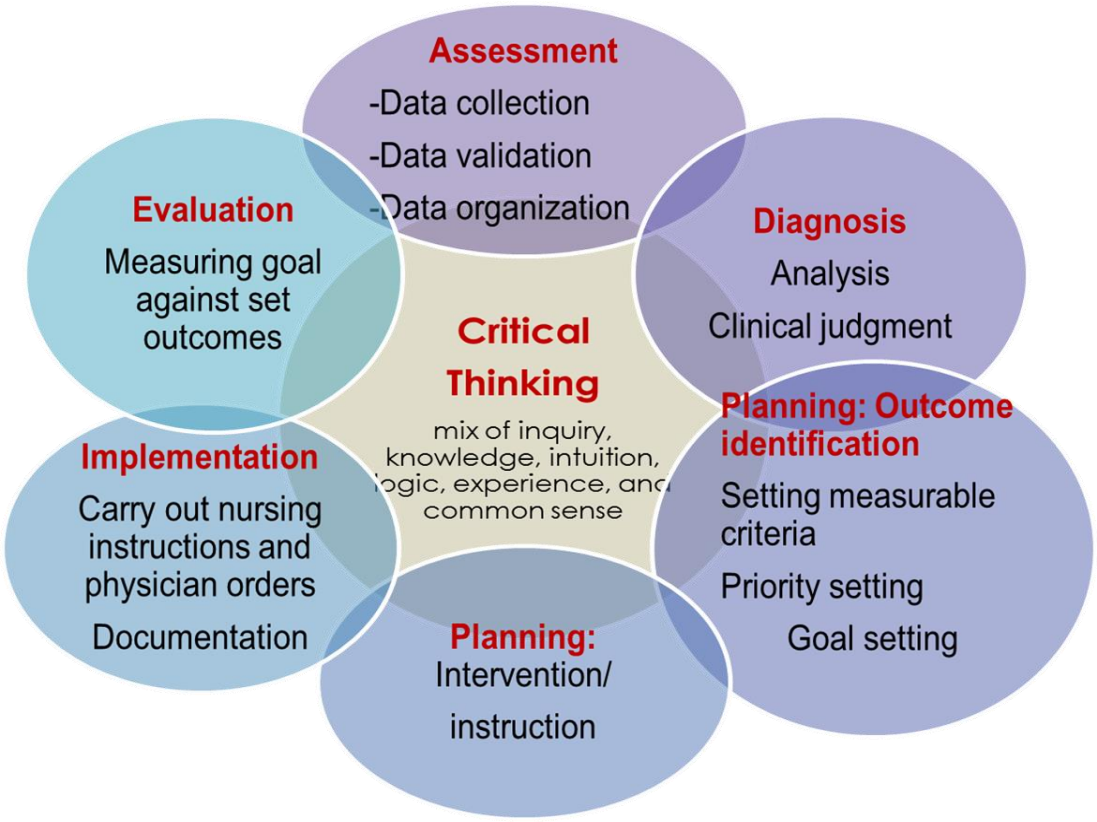


Fig 1: The six steps of nursing process

Critical thinking

Critical thinking is the concept central to nursing process. It is the process that allows nurses to see the big picture (envision the overall perspective) instead of focusing only on details.

It is reasonable reflective thinking that is focused on deciding what to believe or do. Every day, nurses make decisions that are derived through critical thinking. Making clinical judgments relies on critical thinking.

Characteristics of critical thinkers:

- Open-minded and curious
- Consciously work in a planning mode
- Proactive instead of reactive
- Flexible
- Organized

Critical Thinking Skills

Interpretation: Categorize, decode sentences, clarify meanings

Analysis: Examine ideas, identify and analyze arguments

Influence: Query evidence, conjecture alternatives, and draw conclusions

Explanation: State results, justify procedures, present arguments

Evaluation: Assess claims, assess arguments

Characteristics of Nursing Process

Internalizing of the phases of nursing process mentioned above, one could well understand what the characteristics of this entire process are.

1. ***Cyclic and dynamic:*** it is a continuous process throughout the stages of illness and treatment that ends with the cease of the illness.
2. ***Goal directed and Client oriented:*** The nursing process is intended to treat the patient and is in the best interest of the patient.
3. ***Interpersonal and Collaborative***: This goes to explain the amount of interaction that might be necessary between nurses, patients of similar illnesses and the health care team. It might involve group therapy and / or family counseling.
4. ***Universally applicable***: This process is universally standard and applicable in any setting and for all kinds of clients regardless of their age, type of illness and other conditions. It is like a common nursing language with common nursing terminology followed universally.
5. ***Scientific and Systematic***: The nursing process is based on the objective format, viz., scientific format. Every symptom or sign is a result of a scientific fact that leads to scientific methods of treatment and follow-ups. It is systematic and goes from step to step as in the phases mentioned above. It is not based on mere instincts, but outlined within a framework of set parameters (3-5).

Benefits of the Nursing Process

- Ensures access to quality nursing care
- Ensures continuity of care
- Promotes involvement of clients in their own care
- Speed up diagnosis and treatment of actual and potential health problems, reducing the incidence of hospital stays;

- Has precise documentation that improve communication, to prevent errors, omissions, and unnecessary repetitions;
- Promotes flexibility and independent critical thinking;
- Tailors interventions for the individual responses (not just the disease);
- Helps nurses to gain satisfaction of getting results
- Helps nurses to practice within accepted legal frameworks
- Contributes to the development of nursing profession

Comparison of Nursing Process and Medical Process

Nursing Process	Medical Process
Deals with two types of health problems (1) Human response problems (2) Pathological problems	Deals mostly with problems with structure and function of organs or systems
Uses the six sequential steps which need to be followed strictly within the scope of nursing practice	Uses medical approach within the scope of medical practice
Considers the whole person, organ and system function , as well as, the person's response to organ/system malfunction	Mainly considers organ and system function
Focuses on teaching individuals or groups how to be independent on activities of daily living	Focuses on teaching about how diseases and trauma are treated
Involve individuals, their significant others, and with groups in nursing care provision	Mostly involved with individuals, sometimes with groups and families

Summary

Nursing process is a dynamic, systematic, cyclic, client centered and universal process that encompasses six sequential and interlinked steps (assessment, diagnosis, outcome identification, planning intervention, implementation, and evaluation) in providing individualized holistic nursing care.

Session 4.2. Nursing assessment

Session Description

This session is designed to equip trainees with knowledge and skills of patient assessment. The trainees will be well accustomed to the 11 Gordon's functional health patterns, which is holistic nursing assessment tool.

Session Objectives

At the end of this session, the trainees will be able to:

- Define nursing assessment
- Describe types of assessment
- Identify the four phases of assessment
- List the sources used for data collection
- Describe how data is collected
- Discriminate between subjective and objective data
- Use the 11 Gordon's functional health patterns as nursing assessment tool.
- Describe a method of organizing data that facilitates identifying information that should be used for nursing diagnosis

Introduction

Assessment can be defined as a *systematic collection* of subjective and objective data from patients /family/community *with the goal of making clinical judgment* about patient, family and the community.

Nursing assessment is ***not the duplicate medical assessments***, because nursing assessment focuses on the assessment patients' responses, whereas, the medical assessment targets to investigate pathologic conditions.

Purposes of undertaking nursing assessment

1. To establish baseline information on the client
2. To determine the client's normal function, abnormal function, risk for dysfunction and strengths
3. To provide data for nursing diagnosis

Types of Nursing Assessment

Types of Nursing Assessment

- ***Initial assessment***- this is performed on initial contact with the patient to gather information about all aspects of health status of the patient. This information is also called baseline data, which helps us show the progress of the patient with our care.
- ***Time lapsed assessment:*** *this type of assessment is done with the aim of comparison of client's current status to baseline obtained previously. It can be done with certain time interval like at 3^{r}, 6th, 1 year.*
- ***Focus assessment***- this is performed to gather detailed information about the status of a specific condition. It is an ongoing assessment.
- ***Emergency assessment:*** this is a type of assessment that is done at any time identify life-threatening conditions.

Phases of Assessment

Assessment is the first step of the nursing process that is done with the following phases:

- Collection of data (gathering information about the patient or client),
- Validating data (making sure the collected information is accurate),

Organizing data (clustering facts into groups of information that help you identify patterns of health or illness) and identifying patterns,

- Data interpretation
- Reporting and recording data (reporting and recording abnormalities to expedite treatment; recording assessment findings to communicate current status.

Collecting Data

Data collection begins when someone first enters the health care system and continues as long as there is a need for nursing care. The information gathered at this initial contact provides the basis for determining current health status and establishing an initial plan of care. The

information gathered on subsequent encounters tells you not only about current health status, but also about how the person is responding to the plan of care.

What sources do you need to gather the data?

I. Primary source—usual most reliable source
   - Patient/client

II. Secondary sources
   - Verbal and written consultations
   - Family, significant others
   - Records of diagnostic studies
   - Patient charts including nursing records
   - Relevant literatures

Identifying Subjective and Objective Data

Separating these two types of data aids critical thinking because each complements and clarifies the other.

Subjective Data	Objective Data
Relates to what the patient states about their state of health, feelings or perceptions	Is what the examiner observes and measures
Examples:	***Examples:***
• I feel sick • I have stomach ache • Nausea	• Pulse: Rate 100 bpm, strong and regular • Distended abdomen • Hemoglobin 9 g/dL

Exercise 2.1 Case study 1. Ato Hailu is 51 years old admitted 2 days ago with chest pain. The physician in charge ordered the following studies- ECG, and complete blood counts. He states "*I feel much better today, no more pain. It is a relief to get rid of discomfort*". You think he appears a little tired, and seems to be talking slowly and exhale noisily more often than you think. He denies being tired.

V/S: Tep 37oC, PR 74 bpm, RR 20 breaths pm, B/P 140/90 mmHg.

Draw subjective and objective data from the above case history

Exercise 2.2 Case studies 2:

- W/ro Alem Kebede, 28 years old woman was admitted with a **Medical Diagnosis** of Acute Gastroenteritis

Subjective: States…

- "I am weak and worried about my condition.", "My stool is very watery and frequent" and "I'm feeling very feverish"

Objective:

- Temp = 38.0 C (oral), Pulse = 110 per minute
- Respiration rate = 32 per minute,
- Decreased PaO2 , the nurse observed that the patient had diarrhea x 2-3 times of ½ cup per bout following admission
- ***Summarize subjective data from the above case history***

How data is collected?

Using these sources data should be generated through client interview, doing physical examination and reviewing charts for other diagnostic findings.

Interviewing

Interviewing is a ***planned communication*** or a conversation with a purpose of getting data from patient. For interviewing one need to have skill in ***obtaining history.***

Interview can be ***directive interview***, which is highly structured and elicits specific information or ***nondirective interview*** or rapport-building interview, in which the nurse allows the client to control the purpose, subject matter, and pacing.

Phases of interview

Effective interview has four phases:

I. **Preparatory phase /pre interaction phase:** this phase comes before the nurse meet the patient that involves pre collection of some information about the patient.

II. **Introductory phase/orientation phase:** this phase is a phase of establishing rapport with the patient through clarifying your role. This phase helps to alleviate patient anxiety.

III. **Maintenance phase /working phase:** this phase the at which the planned interview is undertaken

IV. **Concluding phase:** finalize the interview with concluding the session, for example by summarizing what have been collected and acknowledging the patient for his/her cooperation

Interview skills

For effective interview one need to can use the following skills

- **Questioning**: Using open-ended questions that cannot be answered with a simple "yes" or "no''
- **Facilitation**: "*Go on…I am listening*." (including non-verbal nodding)
- **Direction**: "*I understand that many things are bothering you…could we focus on the diarrhoea for just a minute?*"
- **Summarising**: "*So, from what I understand, you have had a lot of nausea and some cramping, you have taken all of the pills each day this week and you want some help with these symptoms…do I have it all right?*"

Techniques of Physical Examination

The health history provides subjective data for health assessment. The skills used for the physical examination include:

- Inspection;
- Palpation;
- Percussion and;
- Auscultation.

Inspection

Inspection is concentrated watching. Inspection begins the moment you first meet the individual and develop a "general assessment". Start the assessment of each body system with inspection.

Compare the right and left sides of the body. The two sides are nearly symmetric. Inspection requires good lighting, adequate exposure, and occasional use of certain instruments (otoscope, penlight, nasal and vaginal specula).

Palpation

Palpation follows and often confirms points you noted during inspection. Palpation applies your sense of touch to assess texture, temperature, moisture, organ location and size, as well as any swelling, vibration or pulsation, rigidity, crepitation, presence of lumps or masses, and presence of tenderness or pain.

Different parts of the hands are best suited for assessing different factors.

- **Fingertips-** best for skin texture, swelling, pulsation, and presence of lumps.
- **A grasping action of the fingers**- to detect the position, shape, and consistency of an organ or mass
- **The dorsa (backs) of hands and fingers**- best for determining temperature because the skin here is thinner than on the palms.
- **Base of the fingers (metacarpophalangeal joints)-** or ulna surface for vibration.

Start with light palpation to detect surface characteristics and to accustom the person to being touched. Then perform deeper palpation, by helping the person use deep breathing. Bimanual palpation requires the use of both of your hands to get certain organs, such as the kidneys, or uterus.

Percussion

Percussion is tapping the person's skin with short, sharp strokes in-order to assess underlying structures. The strokes yield a palpable vibration and a characteristics sound that shows the location, size and density of the underlying organ. Percussion has the following uses: -

1. Mapping out the location and size of an organ by exploring where the percussion notes changes - between the borders of an organ and its neighbors
2. Signaling the density (air, fluid, or solid) of a structure
3. Detecting an abnormal mass if it is fairly superficial. The percussion vibration penetrates about 5 cm deep. A deeper mass would give no change in percussion.
4. Eliciting pain if the underlying structure is inflamed, as with sinus areas or over kidney or appendix

Procedure

The stationary hand- Hyperextend the middle finger and place its distal portion, the phalanx and distal inter-phalangeal joint, firmly against the person's skin. Avoid to percuss the person's ribs and scapulae. Percussing over a bone yields no data because it always sounds "dull". Lift the rest of the stationary hand up off the person's skin.

The Striking Hand- Use the middle finger of your dominant hand as the striking finger. Spread your fingers and bounce your middle finger behind the nail bed. Flex the striking finger so that its tip, not the finger pad, makes contact.

Table 4. The Five Percussion Notes and Their Characteristics

Percussion Notes	Relative Intensity	Relative Pitch	Relative Duration	Example Location
Flatness	Soft	High	Short	Thigh
Dullness	Medium	Medium	Medium	Liver
Resonance	Loud	Low	Long	Normal lung
Hyperresonance	Very loud	lower	Longer	None normally
Tymany	Loud	High		Gastric air bubble or puffed-out check

Auscultation

Auscultation is listening to sounds produced because of flow of fluid and air. Auscultation can be done on organs like heart, blood vessels, the lungs, and abdomen. A stethoscope has two-end pieces- ***Diaphragm*** for high-pitched sounds such as breath, bowel, and normal heart sounds. Hold the diaphragm firmly enough against the person's skin. ***The bell end*** piece has a deep, hollow cup-like shape. It is best for soft, low- pitched sounds such as extra heart sounds or murmurs. Warm the end piece by rubbing it on your palm.

Equipment needed for physical examination

Items needed for screening physical examination includes: -

- ✓ Sphygmomanometer
- ✓ Stethoscope
- Flexible tape measure
- Reflex hammer

- ✓ Thermometer
- ✓ Flashlight
- ✓ Tuning fork
- ✓ Tongue depressor
- ✓ Lubricant

Sharp object (sterile needle)
Cotton balls
Bivalve vaginal speculum
Clean gloves

Validating Data

Validation of data is the process through which data are double-checked to make sure the collected data is accurate, consistent, factual, and complete**.** If you are not sure about the validity of the patient information, obtain more data rather than go on to identify problems based on incorrect or incomplete data that take you to an error in problem identification.

Data verification is done by examining the congruence between subjective and objective data. For example, a client might exhibit nonverbal expressions of pain (e.g., guarding a part of the body, facial grimacing) but verbally deny feeling pain.

Strategies for Validating Data

- Be aware that data that can be measured accurately can be accepted as factual (e.g. height, weight, laboratory study results)
- Keep in mind that data that someone else observes to be factual may or may not be true. When the information is critical, verify it by directly observing and interviewing the patient yourself.
- *Recheck your own data* (e.g. taking B/P in the opposite arm or 10 minutes later)
- *Look for factors that* may alter the accuracy of your data (e.g. check whether someone who has an elevated temperature and no other symptoms has just had a hot cup of tea).
- *Always double check information* that is extremely abnormal or inconsistent with patient cues. -e.g., repeat a diagnostic study that is extremely high or low.
- *Compare your subjective and objective data* to see if what the patient is stating is congruent with what you observe. E.g., compare actual pulse rate with perceptions of "racing heart".

Organizing (Clustering) Data

After data collection is completed and information is validated, the nurse organizes, or clusters, the information together in-order to identify areas of client strengths and weaknesses. This process is known as data clustering.

- Clustering assessment data according to human needs- For example, data that pertain to physiological needs; data that pertain to safety and security needs.
- Clustering assessment data according to functional health pattern (Gordon) – E.g., data that pertain to health perception, nutritional, elimination …
- Clustering data according to body systems- E.g., Respiratory system, cardiovascular system, gastrointestinal system …

Data interpretation

Data interpretation is important to identify cues and reach at inferences, which helps make clinical judgments about the client.

Identifying Cues and Making Inferences

- Subjective and objective data that you have identified act as cues. Cues are hints, or reminders, that prompt you to reach a conclusion about a patient needs. Example:

  Subjective Data *Patient states, "generalized body weakness following three days of passing loose stool in average four times a day"*

  Objective Data *Dry oral mucosa, PR: 120 bpm, BP: 80/50 mmHg, skin pinch going back slowly*

- The above data give you cues that may lead you to infer (conclusion) that the person is having dehydration. How you interpret or perceive a cue is called an inference. In this case you have made an inference about the generalized body weakness following passage of loose stool and has interpreted as probably having dehydration. Cues and correct inferences need observational skills, nursing knowledge and your clinical expertise.

Examples of cues with corresponding inferences

Cue	Inference
Letti states, " I have trouble in sleep that I frequently wake and couldn't sleep again"	Letti may have a sleep pattern disturbance

Recording and Reporting

Accurate and complete recording of assessment data are essential for communicating information to other health care team members.

The Eleven Gordon's Functional Health Patterns

Marjorie Gordon (1987) proposed functional health patterns as a guide for establishing a comprehensive nursing database. These 11 categories make possible a systematic and standardized approach to data collection, and enable the nurse to determine the following aspects of health and human function.

Patient Identifications

Patient identifications may include full name, MRN, age, sex, birth date, and unit/ward. In this part source of information, source of referral, date of admission and medical diagnoses, need to be included.

Pattern 1: Health Perception and Health Management

Data collection is focused on the person's perceived level of health and well-being, and on practices for maintaining health. Habits that may be detrimental to health are also evaluated, including smoking and alcohol or drug use. Actual or potential problems related to safety and health management may be identified as well as needs for modifications in the home or needs for continued care in the home.

Subjective data

- **Major reason for seeking health care:** addresses reason (s) for seeking health care or the major concern of the patient right now. It can be changed based on the condition of the patient as time goes.
- To determine the patients understanding about his/her current health status, his/her statement about reason of admission should also be sought.
- The statement of significant others about reason for admission may be sought as required in some cases like diabetes, psychiatric conditions, comatose patients, etc.
- Perceived health rating of the patient, on scale of 1 to 3 or other type of scale how the patient can rate his/her own health condition can be assessed. For example, general health can be rated as poor, fair or excellent on scale of three.

Substance use:

- Substances that are used by the patient need to be identified and be described by unit, amount taken, frequency and its effect on the patient if not taken.

- Subjectively assess patients for health maintenance practice like regular physical exercise, healthy eating, regular medical check-ups, history of last immunization and treatment adherence. Moreover, it is important to assess patient understand regarding the treatment/medicine he/she is taking by name, dose, frequency, how to take etc.

Objective data

- Under objective data, the health perception and health management of patients can be assessed by observing his/her general appearance and grooming condition.

Pattern 2: Nutrition and Metabolism

This pattern focuses on the pattern of food and fluid consumption relative to metabolic need. The adequacy of local nutrient supplies is evaluated. Actual or potential problems related to fluid balance, tissue integrity, and host defenses may be identified as well as problems with the gastrointestinal system.

Subjective data

- The subjective data need to address any change in the pattern food and fluid intake which could be in relation to major meals and snacks. Ask the patient if he/she is taking special diet because of illness like salt free diet. Gastro intestinal conditions like difficulty of chewing, dysphagia, sore tongue, sore gums/mouth, dental problem, food intolerance/preference, nausea and vomiting, appetite/ bulimia nervosa and use of anti-acids should also be assessed.
- Use of antacids, fever, cold/cold intolerance, abdominal pain and weight loss/gain

Objective data

- Objectively the nutritional and metabolic status can be assessed through anthropometric measurements that include weight, height, mid-upper arm circumference (MUAC), BMI and ideal body weight (IBW). BMI is calculated as weight in kg divided by height in meter square. IBW is calculated as follows:

IBW

- Males: IBW = 50 kg + 2.3 kg for each inch over 5 feet ± 10%
- Females: IBW = 45.5 kg + 2.3 kg for each inch over 5 feet ± 10%

Conversion

- 1lb = 0.454 kg
- 1ft = 0.31 m (5ft = 1.524m)
- 1ft = 12 in

Assess skin for

- Color changes like cyanosis, pallor, jaundice, petechiae, etc;
- Lesions:
    - primary lesions: macule, papule, nodule, vesicle, pustule, etc and
    - secondary lesions: scale and crust
- Texture: whether it is rough or smooth
- Moisture: dry like in case of dehydration, wet like in case hyperthyroidism
- Turgor: pinch the skin on abdomen and check whether it's going back immediately, slowly (with in second) or very slowly (took more than 1 and ½ a second)

Hair assessment

- Texture: whether it is rough or smooth
- Any scalp lesion
- Distribution: evenly distributed or loss of hair in certain scalp area like in case of alopecia
- Any color change

Nail assessment

- Color changes: look for any color changes like cyanosis, splinters, etc of nail, which is normally pink.
- Nail shape: check the nail angle which is normally less than 180^{o} with convex shape
- Texture: whether it is rough or smooth
- Tenderness: which is normally non-tender

Assess Oral Mucosa:

- Number of tooth: count the number of teeth and determine missing
- Oral Condition: Color changes, ulcers, white patches, nodules, dental carries, any foul/ bad odor, dryness
- Check gums for color, bleeding, patches
- Tongue: test buds, color, patches

Pattern 3: Elimination

This pattern is focused on excretory patterns (bowel, bladder, skin). Excretory problems such as incontinence, constipation, diarrhea, and urinary retention may be identified.

Subjective data

Bladder Habit

- Ask the patient for urinary frequency (voiding multiple times than usual) and nocturia (unusual increased frequency of voiding during the night)
- Color of urine: any change in color like redness in gross hematuria, cloudy in UTI, yellowish as in jaundice. Normally the color of urine is amber
- Amount per day: ask the patients whether it's increased or decreased or else if possible monitor intake and output
- Ask for classical manifestations of the other lower urinary tract manifestations like dysuria (pain/burning on voiding), urgency (desire to pass urine urgently), hesitancy (a delay between being ready to pass urine and the actual flow of urine)
- Ask for history of urinary incontinence (the inappropriate involuntary passage of urine, resulting in wetting) and urinary retention (inability to pass urine)

Bowel habit

- Like a bladder habit, ask for bowel habit of frequency, color (which is normally dark brown), consistency (whether formed, loose or watery) and amount of stool per day (whether increased or decreased than the usual). Ask also for pain on defecation, incontinence, constipation, history of colostomy/ileostomy.

Objective data

- Undertake abdominal examination with the order of inspection, auscultation, percussion, and palpation

Inspection

- Inspect the abdomen for the contour/shape of the abdomen whether it's round or flat (bulging bilaterally or unilaterally); any lesions; umbilicus (drainage, inverted/everted, redness, etc.), stria (a streak, line or thin band appearing on abdomen); vein (whether engorged and prominent) and abdominal movement with respiration.

Auscultation

- Auscultation provides important information about bowel motility. Listen to the abdomen before performing percussion or palpation, since these maneuvers may alter the frequency of bowel sounds.

- Listen for **bowel sounds** and note their frequency and character. Normal sounds consist of **clicks and gurgles**, occurring at an estimated frequency of 5 to 30 per minute.
- **procedure**
    1. Diaphragm of stethoscope are used
    2. Skin depressed to approximately 1 cm
    3. Listening in one spot is usually sufficient
    4. Listening for 15-20
    5. Bowel sounds ***cannot*** *be said to be* ***absent*** unless they are not heard after listening for **3-5 minutes**. (in all quadrants)

Abnormal Findings Related to Bowel Sounds

- Absent/hypoactive
    - Listen for 3-5 minutes
    - Bowel obstruction, peritonitis, paralytic ileus.
    - Low Potassium
    - Surgical manipulation
- Increased Bowel sounds/hyperactive
    - Increased motility of fluids
    - Diarrhea

Percussion

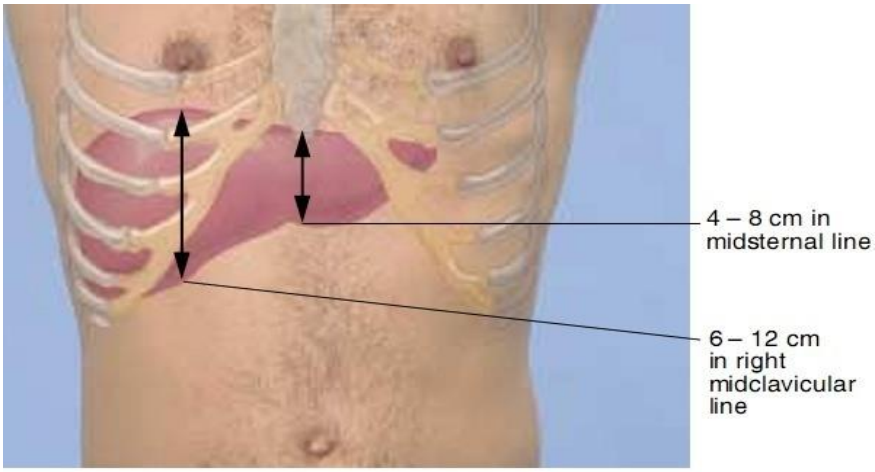
- Percussion helps you to assess the amount and distribution of gas in the abdomen and to identify possible masses that are solid or fluid filled.
- Percuss the abdomen lightly in all four quadrants to assess the distribution of tympani and dullness.

A protuberant abdomen that is tympanitic throughout suggests intestinal obstruction

- Using short tapings and percuss the abdomen for tympany (the normal sound noted over large part of the abdomen) and dullness (which indicates large fluid or mass in the abdomen). Percussion can also be used to determine organ sizes.

Liver percussion

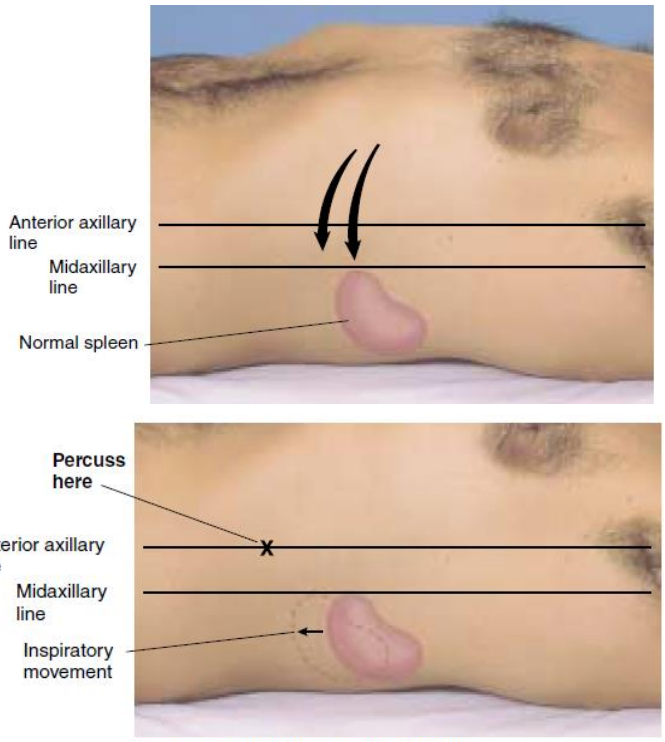
- In the right midclavicular line percuss from the lung resonance to liver dullness and mark. Then percuss from abdominal tympany to the liver dullness and make a mark. Then measure the distance between the two marks which should be normally 6-12 cm. In the midsternal line it's 4-8 cm.



NORMAL LIVER SPANS

Percussing the spleen

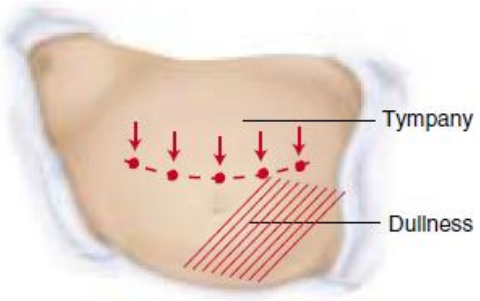
The spleenic dullness is located between 9th and 11th intercostal space just behind the left mid-axillary line and it's normally not wider than 7cm in adults. The tympanic sound of the spleen, which is the normal sound, is heard when percussing the lowest interspace of the left anterior axillary line and asking the person to take a deep breath. Normally tympany remains through a full inspiration. When the sound changes from tympany to a dull sound with full inspiration, it is abnormal. Splenomegally is common in malaria or hepatic cirrhosis.



NEGATIVE SPLENIC PERCUSSION SIGN

Test for shifting dullness

After mapping the borders of tympany and dullness, ask the patient to turn onto one side. Percuss and mark the borders again. In a person

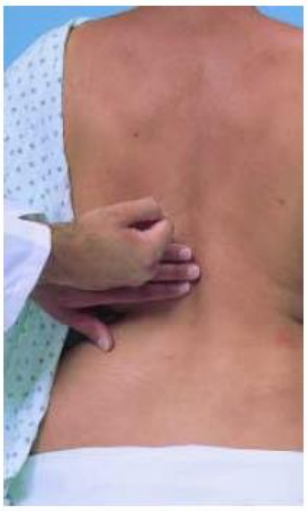


without ascites, the borders between tympany and dullness usually stay relatively constant.

Assessing Kidney Tenderness

Place the ball of one hand in the costovertebral angle (CVA) and strike it with the ulnar surface of your fist. Use enough force to cause a perceptible but painless jar or thud in a normal person.

- ↗ Pain with pressure or fist percussion suggests pyelonephritis, but may also have a musculoskeletal cause.



ASSESSING COSTOVERTEBRAL ANGLE TENDERNESS

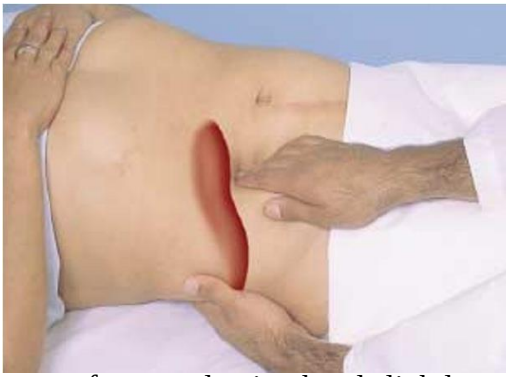
Palpation

- Gently palpate using the pad of fingers for tenderness and increased abdominal muscle resistance. Using deep palpation examines if there is large masses or enlarged organs.

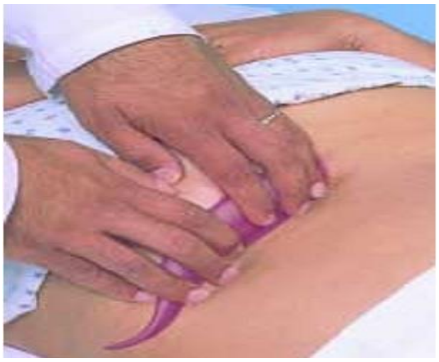
Techniques of liver palpation

Technique of liver palpation (1)

1. Place your left hand behind the patient, parallel to and supporting the right 11th and 12th ribs and adjacent soft tissues below
2. Press forward by the left hand
3. Place your right hand on the patient's right abdomen lateral to the rectus muscle, with the fingertips well below the lower border of liver dullness
4. Fingers can point up toward the patient's head or more oblique position
5. Then press gently in and up
6. Ask the patient to take a deep breath
7. Try to feel the liver edge as it comes down to meet your fingertips. If you feel it, lighten the pressure of your palpating hand slightly so that the liver can slip under your finger pads and you can feel its anterior surface
8. If palpable a normal liver is soft, sharp, and regular, with smooth and normal liver may be slightly tender



Technique of liver palpation (2): Hook method can also be used for the palpation of the liver.

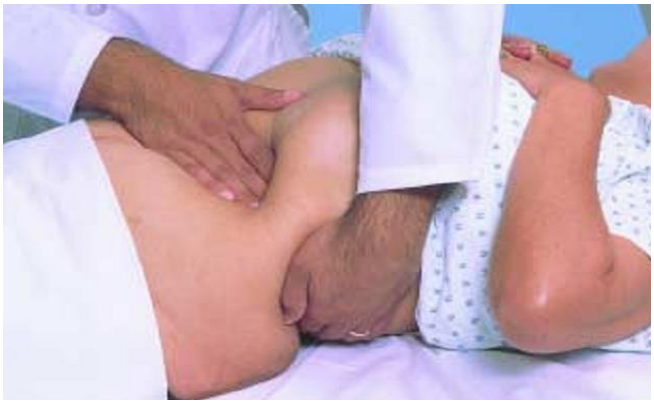


- ✓ Stand to the right of the patient's chest
- ✓ Place both hands, side by side, on the right abdomen below the border of liver dullness.
- ✓ Press in with your fingers and up toward the costal margin
- ✓ Ask the patient to take a deep breath.
- ✓ The liver edge is palpable with the finger pads of both hands

Spleen palpation

Technique of spleen palpation

- ✓ With your left hand support and press forward the lower left rib cage and adjacent soft tissue
- ✓ With right hand below the left costal margin, press in toward the spleen
- ✓ Ask the patient to take a deep breath
- ✓ Try to feel the tip or edge of the spleen as it comes down to meet your fingertips
- ✓ Note tenderness, assess the splenic contour, and measure the distance b/n the spleen's lowest point and the left costal margin



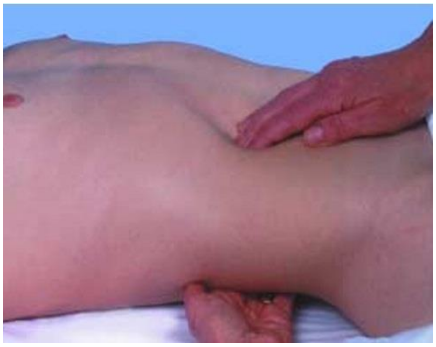
Repeat with the patient lying on the right side with legs somewhat flexed at hips and knees to bring the spleen forward and to the right into a palpable location

PALPATING THE SPLEEN—PATIENT LYING ON RIGHT SIDE

Palpation of Kidneys

- ✓ Kidneys are not usually palpable

Palpation Technique of the Left Kidney



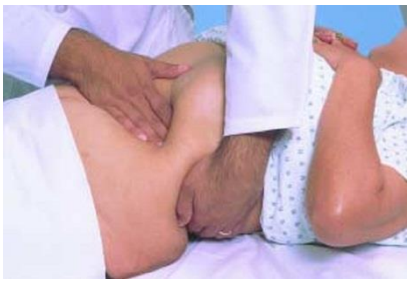
- ✓ Move to the patient's left side
- ✓ Place your right hand behind the patient just below and parallel to the 12th rib, with your fingertips just reaching the costovertebral angle (CVA)
- ✓ Lift, trying to displace the kidney anteriorly
- ✓ Place your left hand gently in left upper quadrant (LUQ), lateral and parallel to the rectus muscle
- ✓ Ask the patient to take a deep breath
- ✓ At the peak of inspiration, press your left hand firmly and deeply into the LUQ, just below the costal margin, and try to "capture" the kidney between your two hands.
- ✓ Ask the patient to breathe out and then to stop breathing briefly
- ✓ Slowly release the pressure of your left hand, feeling at the same time for the kidney to slide back into its expiratory position.
- ✓ If the kidney is palpable, describe its size, contour, and any tenderness

Palpation Technique of the Right Kidney

- ✓ To capture the right kidney, return to the patient's right side
- ✓ Use your left hand to lift from in back, and your right hand to feel deep in the RUQ
- ✓ Proceed as before (palpation of the left kidney)

Other method to palpate left kidney similar to feeling for the spleen

- ✓ With your left hand, reach over and around the patient to lift the left loin, and with your right hand feel deep in the left upper quadrant



- ✓ Ask the patient to take a deep breath, and feel for a mass
- ✓ A normal left kidney is rarely palpable

Rectal examination

- Rectal examination may be done as indicated
- Inspect the rectal mucosa for any lesions, fissure, color, visible masses.
- By using digital rectal examination (DRE) palpate the inside of the rectum giving attention to prostate in males. Check for any tenderness, roughness, and consistency of the prostate.

Pattern 4: Activity and Exercise

This pattern is focused on the activities of daily living requiring energy expenditure, including self-care activities, exercise, and leisure activities. The status of major body systems involved with activity and exercise are evaluated, including the respiratory, cardiovascular, and musculoskeletal systems.

Subjective data

- Assess the patients' level of dependency regarding daily living activities (ADL) on the scale of: fully independent, need assistance from device/others and fully dependent/unable to perform ADL. ADL include eating, bathing, dressing, toileting, bed mobility, transferring, ambulating, cooking, home maintenance and others.
- Ask the patient for dyspnea (laboured or difficult breathing), palpitations (unpleasant awareness of heart beat), chest pain (characterize by PQRST- **P**recipitating/aggravating, **Q**uality, **R**adiation, **S**everity/Site and **T**iming), stiffness of any part of the body, weakness, cough (characterize), hemoptysis, history of smoking, leisure activities and occupation. Effect of illness on activities should also be assessed.

Objective data

Vital signs

- For convince purpose all of vital signs should be included under the objective data of this pattern. Take pulse (with characteristics), temperature (by site), BP (on the right and

left side at three different positions lying, sitting, and standing) and respiration rate and depth.

When do we assess vital signs?

- During admission and discharge
- When there is change in client's condition
- When ordered by the physicians
- Before and after any interventions that affect vital signs

Blood pressure

- Is a force of blood exerted against the wall of blood vessels.

  Systolic BP: The maximum force exerted during contraction of the heart

  Diastolic BP: The maximum force exerted during contraction of the heart

Getting Ready To Measure Blood Pressure

- Ideally, ask the patient to avoid smoking or drinking caffeinated beverages for 30 minutes before the blood pressure is taken and to rest for at least 5 minutes.
- Check to make sure the examining room is quiet and comfortably warm.
- Make sure the arm selected is *free of clothing.* There should be no arteriovenous fistulas for dialysis, scarring from prior brachial artery cut downs, or signs of lymphedema (seen after axillary node dissection or radiation therapy).
- Palpate the brachial artery to confirm that it has a viable pulse.
- Position the arm so that the brachial artery, at the antecubital crease, is *at heart level*—roughly level with the 4th interspace at its junction with the sternum.
- If the patient is seated, rest the arm on a table a little above the patient's waist.
- Standing, try to support the patient's arm at the midchest level.

Nursing alert!

The following condition may result in falsely high blood pressure

- If the brachial artery is much below heart level.
- The patient's own effort to support the arm.
- A loose cuff or a bladder that balloons outside the cuff leads
- Cuffs those are too short or too narrow.
- Using a regular-size cuff on an obese arm.

Classification of blood pressure for adults ages 18 and older, with recommended follow-up (for persons not taking antihypertensive drugs and not acutely ill)

Category	***Systolic (mm Hg)***	***Diastolic(mm Hg)***	***Follow-up recommended***
Optimal	<120 and	<80	Recheck 2 years
Normal	<130 and	<85	Recheck 2 years
High normal	130–139 or	85–89	Recheck 1year
Hypertension			
Stage 1	140–159	90–99	Confirm within 2 months
Stage 2	160–179	100–109	Evaluate within 1 month
Stage 3	180 or higher	110 or higher	Evaluate immediately or within 1 week higher

Pulse

- Pulse is a wave of blood created by contraction of the left ventricle of the heart. It represents the **stroke volume** output or the amount of blood that enters the arteries with each ventricular contraction

Heart rate and rhythm

- By examining arterial pulses, you can count the rate of the heart and determine its rhythm, assess the amplitude and contour of the pulse wave, and sometimes detect obstructions to blood flow.

Heart Rate. The radial pulse is commonly used to assess the heart rate. With the pads of your index and middle fingers, compress the radial artery until a maximal pulsation is detected. If the rhythm is regular and the rate seems normal, count the rate for 15 seconds and multiply by 4. If the rate is unusually fast or slow, however, count it for 60 seconds.

Normal pulse rate for adults is between 60 and 100 beats per minute. **Bradycardia** is a heart rate less than 60 beats per minute in an adult. **Tachycardia** is a heart rate in excess of 100 beats per minute in an adult.

When the rhythm is irregular, the rate should be evaluated by cardiac auscultation, because beats that occur earlier than others may not be detected peripherally and the heart rate can thus be seriously underestimated.

Rhythm. To begin your assessment of rhythm, feel the radial pulse. If there are any irregularities, check the rhythm again by listening with your stethoscope at the cardiac apex. Is the rhythm regular or irregular? If irregular, try to identify a pattern: (1) Do early beats appear in a basically regular rhythm? (2) Does the irregularity vary consistently with respiration? (3) Is the rhythm totally irregular?

Assessment of the apical pulse is indicated for:

1. Clients whose peripheral pulse is irregular or unavailable.
2. Clients with known cardiovascular, pulmonary, and renal diseases.
3. Newborns, infants, and children up to 2 to 3 years old.

Respiration

Respiratory assessment is the measurement of the breathing pattern. Assessment of respirations provides clinical data regarding the pH of arterial blood

Observe the *rate, rhythm, depth,* and *effort of breathing.* Count the number of respirations in 1 minute either by visual inspection or by subtly listening over the patient's trachea with your stethoscope during your examination of the head and neck or chest.

Characteristics of Normal and Abnormal Breath Sounds

Eupnea refers to easy respirations with a normal rate of breaths per minute that are age-specific. **Bradypnea** is a respiratory rate of 12 or fewer breaths per minute. **Hypoventilation** is characterized by shallow respirations.

Tachypnea is a respiratory rate greater than 24 breaths per minute. **Hyperventilation** is characterized by deep, rapid respirations

NURSING ALERT
Positioning for Dyspneic Clients

Dyspneic clients should never be placed flat in bed; maintain them in a semi-Fowler's or Fowler's position. To facilitate maximal lung expansion place the client in a forward-leaning position over a padded, raised over bed table with arms and head resting on the table

Temperature

Body temperature is measured during the routine physical examination by using one of the instruments. Frequent monitoring is required for clients who have or are at risk for infection; for example, postoperative clients or those with suppressed white blood cell count. Accuracy of temperature measurement is essential because it guides nursing and medical decision making and interventions.

Sites

Although the physician may order a specific site to measure the temperature, nursing judgment usually determines the best site based on the client's age and physical and mental condition. Traditional sites for measuring the body's internal (core) temperature are oral (OT), rectal (RT), and axillary (AT), using either glass or electronic thermometers.

Oral and rectal temperature measurements are higher than axillary because the measuring device is in contact with the mucous membrane. Rectal measurements are higher than oral because of the seal created by the anal sphincter, which decreases contact with environmental air.

With the availability of electronic measuring devices, a glass thermometer should never be used for oral readings if there is danger that the client will bite and break the thermometer.

The axilla is commonly used as a site for infants and children with disabilities because it is the safest, even though least accurate, method. Axillary or rectal sites are used for clients who are uncooperative, comatose, or who have a nasogastric or feeding tube in place.

The average *oral temperature,* usually quoted at 37°C (98.6°F), fluctuates considerably. In the early morning hours it may fall as low as 35.8°C (96.4°F), and in the late afternoon or evening it may raise as high as 37.3°C (99.1°F). *Rectal temperatures* are *higher* than oral temperatures by an average of 0.4 to 0.5°C (0.7 to 0.9°F), but this difference is also quite variable.

(In contrast, *axillary temperatures* are *lower* than oral temperatures by approximately 1 degree, but take 5 to 10 minutes to register and are generally considered less accurate than other measurements.)

Fever or pyrexia refers to an elevated body temperature.

Hyperpyrexia refers to extreme elevation in temperature, above 41.1°C (106°F), while *hypothermia* refers to an abnormally low temperature, below 35°C (95°F) rectally.

Most patients prefer oral to rectal temperatures. However, taking oral temperatures is not recommended when patients are unconscious, restless, or unable to close their mouths. Temperature readings may be inaccurate and thermometers may be broken by unexpected movements of the patient's jaws.

- Rapid respiratory rates tend to increase the discrepancy between oral and rectal temperatures. In this situation, rectal temperatures are more reliable.

NURSING ALERT!
Temperature Measurement Sites

Rectal temperature measurement is contraindicated in clients with cardiovascular alterations because the thermometer may stimulate the vagus nerve and cause an irregular cardiac rhythm. It is also contraindicated in leukemia and rectal surgery clients because the insertion of the thermometer may traumatize the mucosa or incision line, causing bleeding.

I. Musculoskeletal System Examination

- Observe the patient for gait (steady or unsteady), any musculoskeletal deformity, swelling of the lower extremities and symmetry of the body. Ask the patient to perform active range of motions if cannot ask to perform passive range of motion. The major range of motions include not limited to flexion, extension, abduction, adduction, and internal and external rotation. Determine whether ROMs are decreased or normal to the joints.

Gait

Ask the patient to:

- Walk across the room or down the hall, then turn, and come back.
- Observe posture, balance, swinging of the arms, and movements of the legs.
- Normally balance is easy, the arms swing at the sides, and turns are accomplished smoothly.

↗ A gait lacking coordination (reeling & instability) is called ataxia

Determine muscle tone

Technique of muscle tone examination

- This can be assessed best by feeling the muscle's resistance to passive stretch.
- Take one hand with yours and, while supporting the elbow, flex and extend the patient's fingers, wrist, and elbow, and put the shoulder through a moderate range of motion.
- On each side, note muscle tone—the resistance offered to your movements
- If you suspect decreased resistance, hold the forearm and shake the hand loosely back and forth
- Normally the hand moves back and forth freely but is not completely floppy

- ↗ Decreased resistance may be caused by disease of the peripheral nervous system, cerebellar disease, or acute stages of spinal cord injury
- ↗ Marked floppiness indicates hypotonic or flaccid muscles
- ↗ Increased resistance that is worse at the extremes of the range is called spasticity. Resistance that persists throughout the range and in both directions is called lead-pipe rigidity.

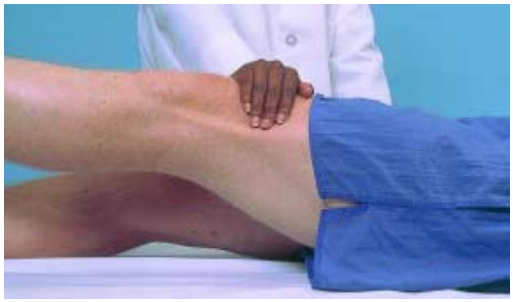
Muscle strength

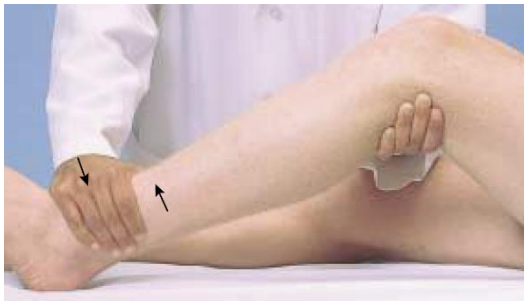
Muscle Strength Examination Technique

- Ask the patient to move actively against your resistance or to resist your movement
- If the muscles are too weak to overcome resistance, test them against gravity alone or with gravity eliminated

EXTENSION

FLEXION





Muscle strength is graded on a 0 to 5 scale:

0—No muscular contraction detected

1—A barely detectable flicker or trace of contraction

2—Active movement of the body part with gravity eliminated

3—Active movement against gravity

4—Active movement against gravity and some resistance

5—Active movement against full resistance without evident fatigue. This is normal muscle strength.

Decreased muscle strength

- Paresis: Impaired strength is called weakness
- Paralysis (plegia): Absence of strength
- Hemiparesis: Weakness of one half of the body
- Hemiplegia: Paralysis of one half of the body
- Paraplegia: Paralysis of the legs
- Quadriplegia: Paralysis of all four limbs

II. Respiratory system assessment

For respiratory assessment first do inspection, palpation, percussion, and auscultation of the posterior chest. With the same mechanism inspect, palpate, percuss, and auscultate the anterior chest.

The posterior chest:

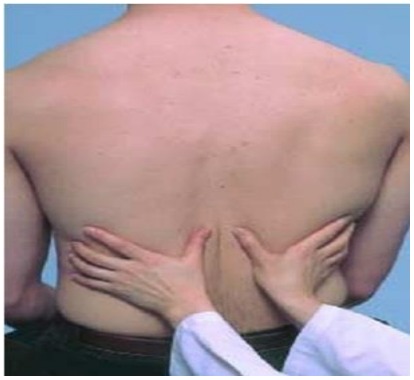
Inspect the posterior chest.

- Note the shape and configuration of the chest wall. The spinous processes should appear in a straight line. The thorax is symmetric. The scapulae are placed symmetrically.
- Shape of chest which should be normally the anteroposterior diameter is approximately half of the transverse diameter
- Antero-posterior = transverse diameter or “barrel chest “in chronic obstructive pulmonary disease.

Palpation

- Palpate the chest for tenderness, masses, lesions, respiratory excursion, and vocal fremitus

Testing chest expansion (Respiratory excursion)



Technique of respiratory excursion examination

- ❖ Thoracic expansion at 10th rib: place thumbs close to client's spine and spread hands over thorax
- ❖ Note divergence of thumbs, feel for range and symmetry of movement during deep inhalation and full exhalation

Cause of unilateral decrease or delay of respiratory excursion:

- ➢ Pleural effusion
- ➢ Lobar pneumonia
- ➢ Pneumothorax
- ➢ Unilateral bronchial obstruction

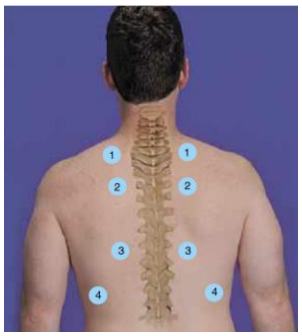
Cause of bilateral decrease or delay of respiratory excursion:

- ❖ When alveoli do not fully expand
  - ➢ Emphysema
  - ➢ Pleurisy

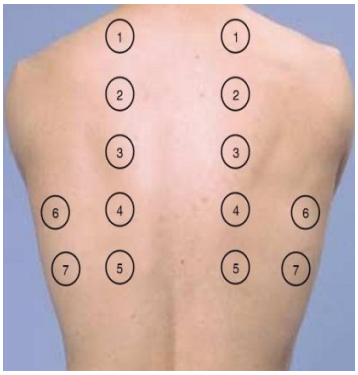
Tactile Fremitus

- Used to detect sound vibration generated by the larynx traveling distally along the bronchial tree

Technique



- Place ulnar aspect of your open hand at right apex of lung and place the hand at each location on the chest (as shown on pictures)
- Instruct client to say "99" or "1-1-1" or "44" in Amharic
- Use one hand or both
- Note areas of increased or decreased fremitus
- An increase in solid tissue per unit volume of lung will enhance fremitus
- An increase in air per unit volume of lung will impede sound



Percussion

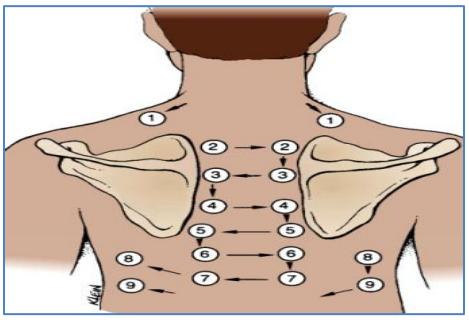
- Percuss between the scapulae of the posterior chest.
- Percussion Notes

❖ Have the patient keeps both arms crossed in front of the chest

❖ When percussing the lower posterior chest, stand somewhat to the side rather than directly behind the patient

❖ When comparing two areas, use the same percussion technique in both areas

❖ Learn to identify five percussion notes



Pathologic Examples

↗ Flatness may indicate large pleural effusion

↗ Dullness --fluid or solid tissue replaces air-containing lung or occupies the pleural space beneath percussing fingers.

- Examples include: lobar pneumonia, pleural effusion, hemothorax, empyema, fibrous tissue, or tumor

↗ Hyperresonance ➔ Emphysema, pneumothorax

↗ Tympany ➔ Large pneumothorax

Auscultation

Evaluate the presence and quality of normal breath sounds. The person is sitting, leaning forward slightly, with arms across the lap. Instruct the person to breath through the mouth, a little bit deeper than usual. Use the flat diaphragm end-piece of the stethoscope and hold it firmly on the person's chest wall. Listen to at least one full respiration in each location. Side to side comparison is most important.

While standing behind the person listen posterior from the apex at C7 to the base (around T10), and laterally from the axilla down to the seventh or eighth rib. Decreased or absent

breath sounds occur when the bronchial tree is obstructed by secretions or foreign body, in lungs such as pleurisy or pneumothorax.

- Auscultate between the scapulae of the posterior chest.
- Auscultation is used to assess airflow through the tracheobronchial tree
- Auscultation involves
  1. Listening to the sounds generated by breathing
  2. Listening for any adventitious (added) sounds
  3. If abnormalities are suspected, listening to the sounds of the patient's spoken or whispered voice as they are transmitted through the chest wall

Techniques of chest auscultation

- Listen to the chest anteriorly and laterally as the patient breathes deeply with mouth open
- Compare symmetric areas of the lungs
- Listen to the breath sounds, noting their intensity and identifying any variations from normal vesicular breathing
- Identify any adventitious sounds
- Listen for transmitted voice sounds

Breath Sounds (Lung Sounds)

- Are known by their normal location

	Duration of sounds	**Intensity of expiratory sound**	**Pitch of expiratory sound**	**Location where heard normally**
Vesicular	Inspiratory sounds last longer than expiratory ones	Soft	Relatively low	Over most of both lungs
Broncho-vesicular	Inspiratory and expiratory sounds are about equal	Intermediate	Intermediate	Often in the 1st and 2nd interspaces anteriorly and between scapulae
Bronchial	Expiratory sounds last longer than inspiratory ones	Loud	Relatively high	Over the manubrium, if heard at all
Tracheal	Inspiratory and expiratory sounds are about equal	Very loud	Relatively low	Over the trachea in the neck

Adventitious sounds and pathologic examples

Adventitious sounds	Pathologic examples
Crackles	Lung fibrosis, Early CHF, Chronic bronchitis, Asthma
Pleural Rub	Inflamed and roughened pleural surface
Stridor	Partial obstruction of the larynx or trachea
Wheezes	Asthma, Chronic bronchitis, COPD, CHF (cardiac asthma)

The Anterior Chest

Inspection

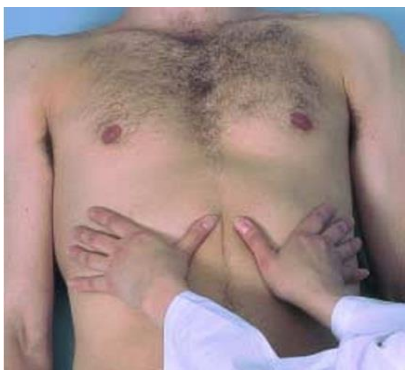
- Inspect the anterior chest for the shape, symmetry, facial expression, level of consciousness and quality of respiration.
- Shape of chest which should be normally the anteroposterior diameter is approximately half of the transverse diameter
- Respiratory rate and rhythm
  - ✓ Signs of respiratory difficulty: cyanosis signals hypoxia, use of accessory muscles, chest indrawing and clubbing of the nails

Abnormal: - Barrel chest, restlessness (hypoxia), noisy breathing (asthma), unequal chest expansion with pneumonia or obstruction, tachypnea or bradypnea.

Palpating the anterior chest

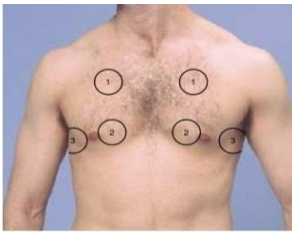
Palpate the symmetric expansion of the chest by placing your hands on the antero-lateral wall with thumbs along the coastal margins and pointing toward the xiphoid process. Ask the person to take deep breath and watch your thumbs move apart symmetrically, and note smooth chest expansion with your fingers.

Abnormal: - Failure in expansion occurs in pneumonia and palpable grating sensation with breathing indicates pleural fremitus.



Assess tactile fremitus- Begin palpating over the lung apex in the supra-clavicular areas. Compare vibrations from one side to the other as the person repeats " Arba-Arat". Note skin temperature and moisture.

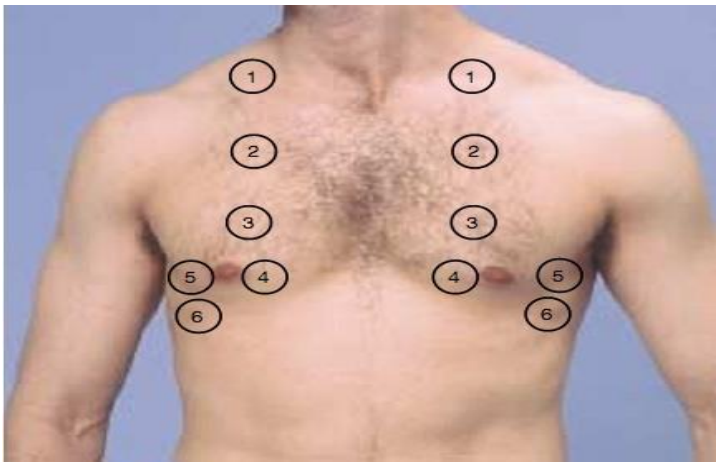
Percussing the anterior chest



Begin percussing the apex in the supra-clavicular areas and then with the inter-space and comparing one side to the other, moving down to the anterior chest. Do not percuss directly over female breast tissue because it produces dull note. Note the borders of cardiac dullness normally found on the anterior chest and do not confuse these with suspected lung pathology. In the right, the upper border of liver dullness is located in the 5th inter-costal space in the right mid-clavicular line. On the left, tympani is evident over the gastric space.

Auscultate the Anterior chest

Auscultate the lung fields over the anterior chest from the apex in the supraclvicular areas down to the sixth rib. Progress from side to side as you move downward, and listen to one full respiration in each location. Do not place your stethoscope directly over the female breast. Displace the breast and listen directly over the chest wall.

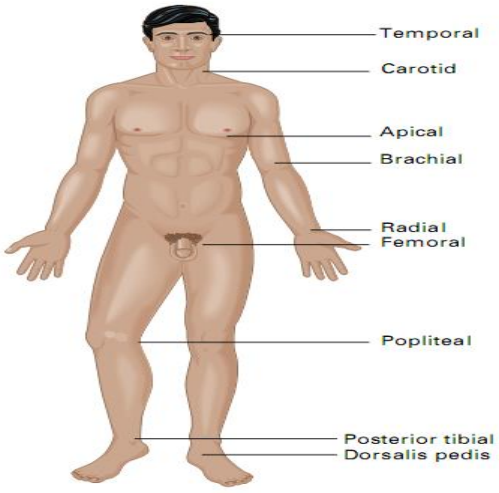


III. Cardiovascular assessment

Inspection

Jugular vein distension

- Elevating the head of the bed to 30-45^{o}, observe for the distension of the jugular vein, which is not usually appearing.



Heaves and lifts

- Look at the apex of the heart at 5th ICS MCL for heaves and lifts and on the abdomen for any visible blood vessels.

Palpation

- Palpate pulse at different body sites like carotid, apical, radial, and femoral and dorsalis pedis.

Palpate the carotid artery

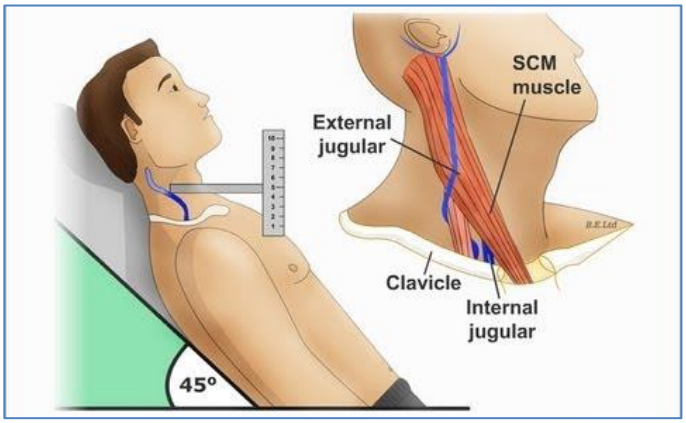
- *The* carotid pulse provides valuable information about cardiac function and is especially useful for detecting stenosis or insufficiency of the aortic valve.
- Take the time to assess the quality of the carotid upstroke, its amplitude and contour, and presence or absence of any overlying *thrills or bruits.*

- *Character and Volume:* best checked on carotid arteries.
- Place fingers behind the patient's neck and compress the carotid on one side
- The amplitude of the pulse.
- The contour of the pulse wave.
- Variations in amplitude from beat
- to beat or with respiration
- During palpation of the carotid artery, you may detect humming vibrations, or thrills, that feel like the throat of a purring cat.
- At the apex of the heart, the pulse could also be palpable.
    - For pulsation & thrill (vibration) in all areas of the pericardium
    - Apical area
    - palpate apical impulse (PMI)

- If pulsation present determine its size, diameter, location & time it pulsates within cardiac cycle.
- Normally no pulsation palpable over the aortic and pulmonic areas but at the PMI

Assess For Jugular Venous Pressure (JVP)

Steps for Assessing the Jugular Venous Pressure (JVP)



A. Make the *patient comfortable*
B. *Raise the head slightly* on a pillow to relax the sternomastoid muscles
C. *Raise the head of the bed* or examining table to about 30°
D. *Turn the patient's head slightly* away from the side you are inspecting
E. Use *tangential lighting* and examine both sides of the neck
F. Identify the *external jugular vein* on each side, then find the internal jugular venous pulsations
G. If necessary, *raise or lower the head of the bed* until you can see the oscillation point or meniscus of the internal jugular venous pulsations in the lower half of the neck
H. *Focus on the right internal jugular vein*. Look for pulsations in the suprasternal notch, between the attachments of the sternomastoid muscle on the sternum and clavicle, or just posterior to the sternomastoid
I. *Identify the highest point of pulsation* in the right internal jugular vein
J. *Extend a long rectangular object* or card *horizontally* from this point and a centimeter ruler vertically from the sternal angle, making an exact right angle
K. *Measure* the *vertical distance* in centimeters above the sternal angle where the horizontal object crosses the ruler
L. This distance, measured in centimeters above the sternal angle or the atrium, is the *JVP*

JVP elevated if measured at greater than:

- 3 cm or possibly 4 cm above the sternal angle, or
- 8 cm or 9 cm in total distance above the right atrium

NB: The sternal angle usually remains about 5 cm above the right atrium

Increased JVP suggests:

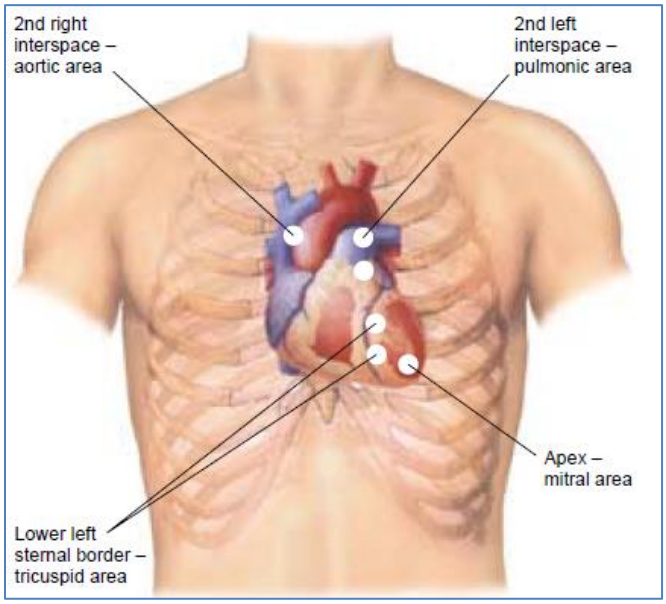
- Right sided heart failure
- Constrictive pericarditis (less common)
- Tricuspid stenosis
- Superior vena cava obstruction
- Obstructive lung disease
    - May appear on expiration only
    - The veins collapse on inspiration
    - This does not indicate congestive heart failure

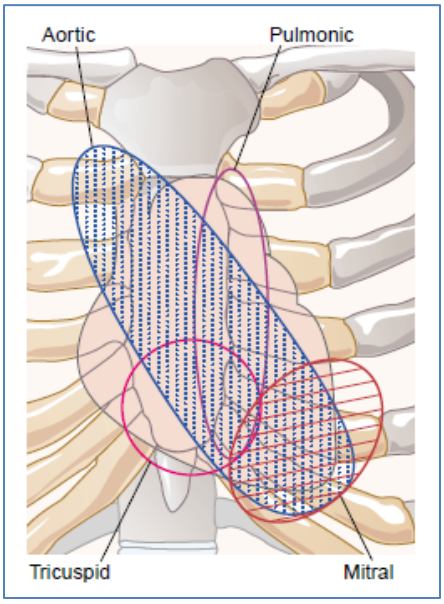
Percussion

- Percussion is used to determine heart size, especially in case of cardiomegaly.

Auscultation

- Auscultate for the heart sound (S1, S2, murmur and gallop) at the following sites





Use of stethoscope

- The ***diaphragm*** is better for picking up the relatively high-pitched sounds of S1 and S2, the murmurs of aortic and mitral regurgitation, and pericardial friction rubs by pressing the diaphragm firmly against the chest.

- The ***bell*** is more sensitive to the low-pitched sounds of S3 and S4 and the murmur of mitral stenosis. Apply the bell lightly, with just enough pressure to produce an air seal with its full rim.

Auscultation sequence

- For auscultation you can start with diaphragm auscultating on the 2nd right sternal border intercostal space, then ask the patient to breath normally and continue to auscultate on the 2nd left sternal border intercostal space, 3rd left sternal border interspace, 4th left sternal border interspace, 5th left sternal border interspace and then at the apex. This sequence is usually helps to hear heart sound 1 and heart sound 2.
- By changing to the bell of the stethoscope start to auscultate at the apex, then to 5th left sternal border interspace and 4th left sternal border interspace. This sequence is for identification of S3, S4 and murmur.

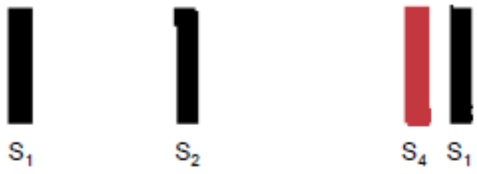
S3

- S3 occurs immediately after S2
- A physiologic third heart sound is heard frequently in children and may persist in young adults to the age of 35 or 40. It is common during the last trimester of pregnancy.

  - It is heard best at the apex in the left lateral decubitus position.
  - The bell of the stethoscope should be used with very light pressure.
- A pathologic S3 or ventricular gallop sounds just like a physiologic S3. An S3 in a person over age 40 (possibly a little older in women) is almost certainly pathologic.
  - Causes include decreased myocardial contractility, myocardial failure, and volume overloading of a ventricle, as in mitral or tricuspid regurgitation.
  - On the left side best heard at typically at the apex in the left lateral position and a right-sided S3 is usually heard along the lower left sternal border or below the xiphoid with the patient supine.

S4

- An S4 (atrial sound or atrial gallop) occurs just before S1.



- An S4 is heard occasionally in an apparently normal person, especially in trained athletes and older age groups.
- More commonly, it is due to increased resistance to ventricular filling following atrial contraction.
  - ✓ Causes of a left-sided S4 include hypertensive heart disease, coronary artery disease, aortic stenosis, and cardiomyopathy.
- A left-sided S4 is heard best at the apex in the left lateral position and the right-sided S4 is heard along the lower left sternal border or below the xiphoid.
  - ✓ Causes of a right-sided S4 include pulmonary hypertension and pulmonic stenosis.

Pattern 5: Sleep and Rest Pattern

This pattern is focused on the person's sleep, rest, and relaxation practices. Dysfunctional sleep patterns, fatigue, and responses to sleep deprivation may be identified.

Subjective data

Ask the patient in any change of sleep in relation to the illness. This may include:

- Change in sleep time: what was the usual sleeping time and change in sleep time, is there waking up early than usual, onset problems/difficulty falling asleep and difficulty remaining asleep.
- Ask also history of use of sleep aids, problems of readiness for work after sleep and history of dreams and nightmares.
- What the patient perceives that hinder and facilitate sleep.

Objective data

- Observe the patient whether he/she seems had adequate sleep (appearance), yawning frequently, irritable and have short attention span. Are there dark circles and puffiness around the eyes?

Pattern 6: Cognitive - Sensory-Perceptual Pattern

This pattern is focused on the ability to comprehend and use information and on the sensory functions. Data pertaining to neurologic functions are collected to aid this process. Sensory experiences such as pain and altered sensory input may be identified and further evaluated.

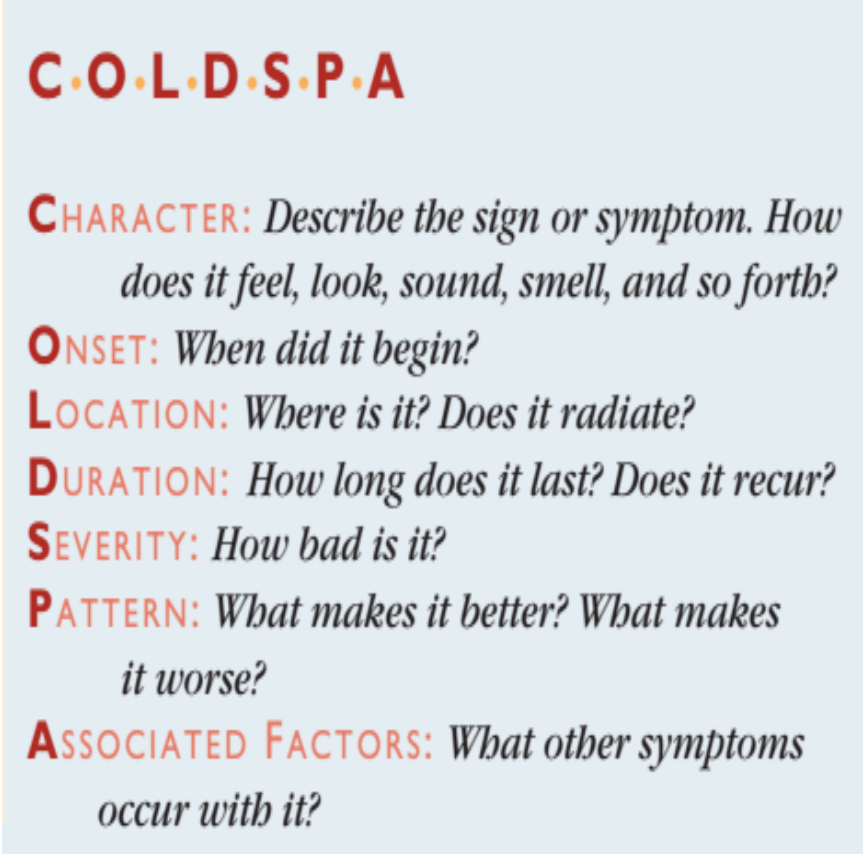
I. Cognitive

Subjective data

- Ask the patient how his/her memory is changed because of the illness (if any) like experiencing loss of memories.
- Ability of speaking, reading and writing and educational status and performance should also be asked as a measure of cognitive function.
    - Hearing problem Yes☐ No☐ explain _____
    - Aid for hearing: Yes☐ No☐
    - Taste problem Yes☐ No☐ explain _____
    - Smelling problem Yes☐ No☐ explain _____
    - Problem in sensation(skin)Yes☐ No☐ explain
    - Pain assessed by PQRST/COLDSPA

Descriptions of pain

- **P**recipitating/aggravating,
- **Q**uality,
- **R**adiation,
- **S**everity/Site
- **T**iming, including: onset, duration, and frequency



Objective data

- Determine level of consciousness using Glasgow Coma Scale.
  - ✓ Orientation to TPP:
  - ✓ Glasgow coma scale :
  - Ability to speak Yes☐ No☐
  - Ability articulate words Yes☐ No☐
  - The Glasgow coma scale for adults and older children is available below

Glasgow coma scale

Response	Score
Eyes open:	
▪ Spontaneously	4
▪ To speech	3
▪ To pain	2
▪ Never	1
Best verbal response:	
▪ Orientated	5
▪ Confused, disoriented	4
▪ Inappropriate words	3
▪ Incomprehensible sounds	2
▪ None	1
Best motor response:	
▪ Obeys commands	6
▪ Localizes pain	5
▪ Withdraws (flexion)	4
▪ Abnormal Flexion posturing	3
▪ Extension posturing	2
▪ None	1
TOTAL	**3-15**

A total score

A. Score 3 or 4: patients have an 85% of chance of dying or remaining vegetative

B. Score <7: State of coma

C. Score <10: Semi-coma

D. Score above 11: patients have only a 5 to 10% likelihood of death or vegetative state and 85 % of chance of moderate disability or good recovery

Mood assessment

- Observe the patient for the status of his mood, is he/she happy/pleasant, euphoric (feels great joy, excitement, or well-being), depressed/sad, irritable (easily annoyed), labile (frequently changing mood) or flat (no interest or excitement)?

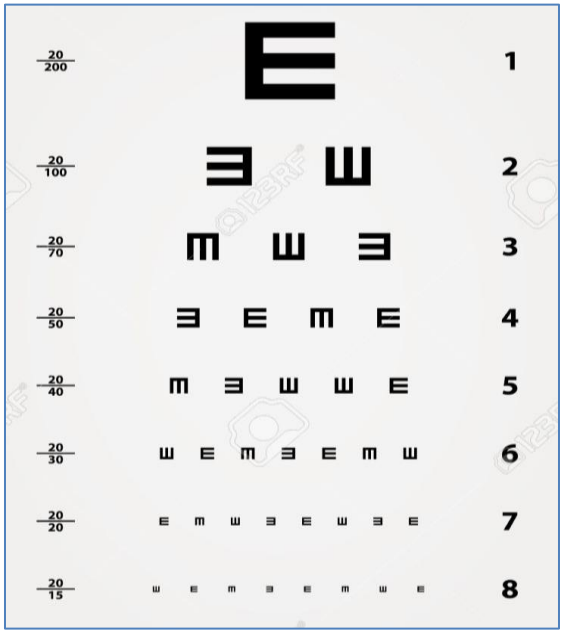
Memory test

- Test the patient for short term and long-term memories. For short-term memory test, you can tell him/her your name, back after 10 or 30 minutes, and ask him/her your name. For long-term memory test by asking the patient something important event in his/her life in the past one year. If the patient can remember either in short term or long term memory test, his/her memory is intact otherwise not intact.

II. Sensory function

Subjective data

- Ask the patient history of visual problems, use of vision aids, hearing problems, use of hearing aids, taste problems and smell problems.



Objective data

Examination of the eye

- Ask the patient to stand at 20ft (6m) away from Snellen's chart. Using the Snell's chart examine visual acuity of the right eye (OD), left eye (OS) and both eyes (OU).
- If the patient cannot read Snell's chart ask him/her to count finger and if cannot count, ask if he/she if he/she can see hand motion. If the patient cannot identify hand motion, flash light to check the ability of the patient to distinguish light from dark site. The higher the lower figure the poor the visual acuity of the eye. For example, 20/100 is to mean what a healthy eye is reading well at 100ft this patient's eye is reading at 20ft.

Visual field assessment

Visual field screening

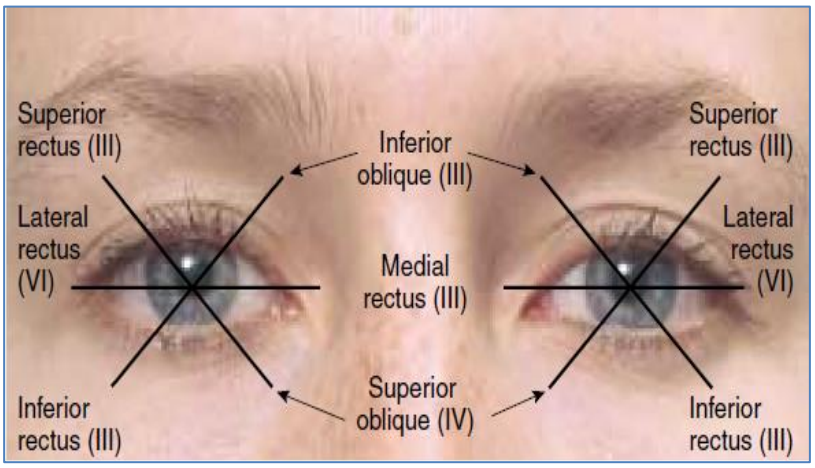
- Ask the patient to look with both eyes into your eyes. While you return the patient's gaze, place your hands about 2 feet apart, lateral to the patient's ears. Instruct the patient to point to your fingers as soon as they are seen. Then slowly move the wiggling fingers of both your hands along the imaginary bowl and toward the line of gaze until the patient identifies them. Repeat this pattern in the upper and lower temporal quadrants.
- Normally, a person sees both sets of fingers at the same time. If so, fields are usually normal.

Further visual field testing

- If you suspect a temporal defect in the left visual field, for example, ask the patient to cover the right eye and, with the left one, to look into your eye directly opposite. Then slowly move your wiggling fingers from the defective area toward the better vision, noting where the patient first responds. Repeat this at several levels to define the border.

Extra ocular muscle examination

- The movement of each eye is controlled by the coordinated action of six muscles, the four rectus and two oblique muscles. You can test the function of each muscle and the nerve that supplies it by asking the patient to move the eye in the direction controlled by that muscle. Ask



the patient to look at these six different directions as shown on the following figure.

- If one of the six muscles is paralyzed, the eye will deviate from its normal position in that direction of gaze and the eyes will no longer appear conjugate, or parallel.

Pupil examination

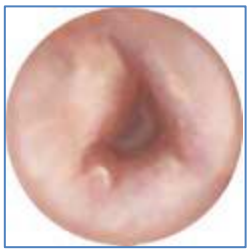
- Using pen light shine on one of the eyes to check for PERRLA (pupil equal, round, and reactive to light and accommodation); normally both pupils should be equal in size, round and reactive to light and accommodation.
- Further examination of the eye can be done with ophthalmoscope.

Examination of the Ear

- ***Auricle***: inspect the auricle for any deformities, lumps, skin lesions and discharge. Palpate for any tenderness.

Ear canal and drum

- Using otoscope inspect the ear canal and drum by straightening the ear canal, by grasping the auricle firmly but gently and pull it upward, backward, and slightly away from the head.



- Inspect the ear canal, noting any discharge, foreign bodies, redness of the skin, or swelling. Cerumen, which can be yellow, flaky or brown in color and sticky or even to dark and hard, which may wholly or partly obscure your view in consistency.
- Swollen, narrowed, moist, pale, tender and reddened canal may be because acute otitis externa.

Inspect the eardrum, noting its color and contour.

- Red bulging drum may be caused by acute purulent otitis media, and amber drum may be of a serous effusion

Auditory acuity

- Test one ear at a time by asking the patient to occlude one ear with a finger or, better still, occlude it yourself.
- Stand at 1 or 2 feet away, exhale fully (so as to minimize the intensity of your voice) and whisper softly toward the unoccluded ear. Choose numbers or other words with two

equally accented syllables, such as "nine-four," or "baseball." If necessary, increase the intensity of your voice can be increased. To make sure the patient does not read your lips, cover your mouth or obstruct the patient's vision.

Air and Bone Conduction

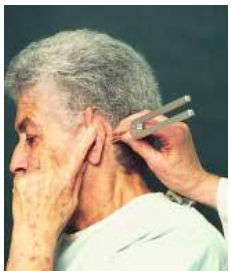
- If hearing is diminished, try to distinguish between conductive and sensorineural hearing loss. Prepare a quiet room and a tuning folk with the frequency in the range of human speech 300 Hz to 3000 Hz (usually 512Hz or 1024Hz).

Test for lateralization (Weber test).

- Place the base of the lightly vibrating tuning fork firmly on top of the patient's head
- Normally the sound is heard in the midline or equally in both ears.
- In unilateral conductive hearing loss, sound is heard in (lateralized to) the impaired ear. May indicate
  - ✓ acute otitis media,
  - ✓ perforation of the eardrum, and
  - ✓ obstruction of the ear canal, as by cerumen
- In unilateral sensorineural hearing loss, sound is heard in the good ear

Compare air conduction (AC) and bone conduction (BC) (Rinne test).

- ❖ Place the base of a lightly vibrating tuning fork on the mastoid bone, behind the ear and level with the canal.
- ❖ When the patient can no longer hear the sound, quickly place the fork close to the ear canal (facing the 'U' of tuning fork forward) and ascertain whether the sound can be heard again
- ❖ Normally the sound is heard longer through air than through bone (AC > BC)
  - Conductive hearing loss: BC = AC or BC > AC
  - Sensorineural hearing loss: AC >BC



III. Pain

Subjective Data

- Does the patient complain any pain/discomfort, if so characterize by PQRST. For severity a 10 point pain assessment scale can be used.

Objective data

- If the patient has an acute pain, PR may be increased and there may be diaphoresis, change in body position, grimacing, guarding, refusal to move body part and rubbing body.
- However, if the patient has a chronic pain he/she may has flat facial expression, dull eye appearance, crying, moaning or yelling.

Pattern 7: Self-Perception and Self-Concept

This pattern is focused on the person's attitudes toward self, including identity, body image, and sense of self-worth. The person's level of self-esteem and response to threats to his or her self-concept may be identified.

Subjective Data

- Try to determine the concern of the patient related to his/her health. Ask the patient to describe oneself and to describe his/her feeling differently because of illness.

Objective Data

- How is the eye contact of the patient? Is he/she well confident to look at people around and you? Is he well groomed or not? How is his mood? Is he well to control his emotion? Is his/her tone of voice appropriate for the situation? Is his/her speech pattern appropriate/coherent?

Pattern 8: Roles and Relationships

This pattern is focused on the person's roles in the country, community, work area or home and relationships with others. Satisfaction with roles, role strain, or dysfunctional relationships may be further evaluated.

Subjective data

- Ask the patient about employment status, weather actively working, retired or unemployed.
- Does he/she have any disability?
- What is his/her primary role at home? At work? In the community?
- What is the effect of illness on his/her role?

- What is his/her living arrangement? Living alone or with whom?
- Does he/she have any source of help?
- Are there problems affecting his/her health at work or home?
- History of possible genetic related diseases, like diabetes, hypertension, cancer, asthma and others

Objective data

- Observe the interaction with family members and significant others. How is the flow of visitors as per the local culture?

Pattern 9: Sexuality and Reproduction

This pattern is focused on the person's satisfaction or dissatisfaction with sexuality patterns and reproductive functions. Concerns with sexuality may he identified. Objectively the reproductive organ system should be undertaken as indicated.

Subjective Data

Female

- Ask her menstruation specific questions like date began, last cycle, length (how long it bleeds), any problems associated with the period?
- Ask her also number of gravida, para, abortions and stillbirth. Is she fertile and pregnant now?
- Does she usually perform breast self-examination (BSE) with certain time interval?

Male-Female

- Ask history of contraception use, undesirable side effects of the contraception method, any problems associated with sexual activities (like pain/discomfort, burning), and effect of illness on sexual activities. Address also history of STDs and any discharge.

Objective Data

Breasts:

- Examine breast for shape, symmetry, nipples condition, any discharge, palpable masses and lymph nodes.

Male genitalia

- As indicated, perform testicular exam feel for any mass, swelling and texture.

- Do penile exam for any masses, growth condition, lesions, foreskin retraction and urethral opening. Pinching the glans penis examine for color and urethral discharge. Inspect and palpate for inguinal masses and lymph nodes.

Female genitalia

- Inspect the labia for color, swelling and symmetry. Open the labia and inspect for color, lesion and urethral discharge. Inspect also the vaginal opening for lesion, discharge, hymen and signs of inflammation.

Pattern 10: Coping and Stress Tolerance

Assessment is focused on the person's perception of stress and on his or her coping strategies. Support systems are evaluated, and symptoms of stress are noted. The effectiveness of a person's coping strategies in terms of stress tolerance may be further evaluated.

Subjective Data

- Ask the patient any big changes/crisis in his/her life in last one or two years and how overcome the crisis (coping mechanisms). Also, ask him/her the most helpful person, common stressors in his life and experience of resent stress.

Objective data

- If the stress is acute, there might be sympathetic stimulation whereby, PR and BP are increased and the patient become diaphoretic.

Pattern 11: Values and Belief

Assessment is focused on the person's values and beliefs (including spiritual beliefs), or on the goals that guide his or her choices or decisions

Subjective Data

- Ask the patient what he/she values most and any change because of the illness. What is also the goal of the patient in his/her life? Identify source of hope/strength for the patient and significant religious persons in contact with the patient.
- What religious practices he/she usually undertake? Any alteration because of the illness?
- What is the perception of the patient regarding his/her relationship with God/Allah?

Objective Data

- Observe the surrounding of the patient for the presence of religious articles, for the practices of religious activities and visits from clergy.

Session Summary

Nursing assessment is the first step of nursing process, which has to be done for all patients on admission to hospital. It involves the systematic collection of subjective and objective data with the aim formulating nursing diagnoses.

The 11 Gordon's functional health patterns is holistic nursing assessment tool that is used by nurses in patient assessment. Each of the pattern incorporated both subjective and objective data.

Session 4.3 Nursing Diagnoses

Session Description

This session is designed to equip trainees with knowledge and skills of constructing nursing diagnoses. The trainees will be able to formulate various nursing diagnoses based on holistic nursing assessment data.

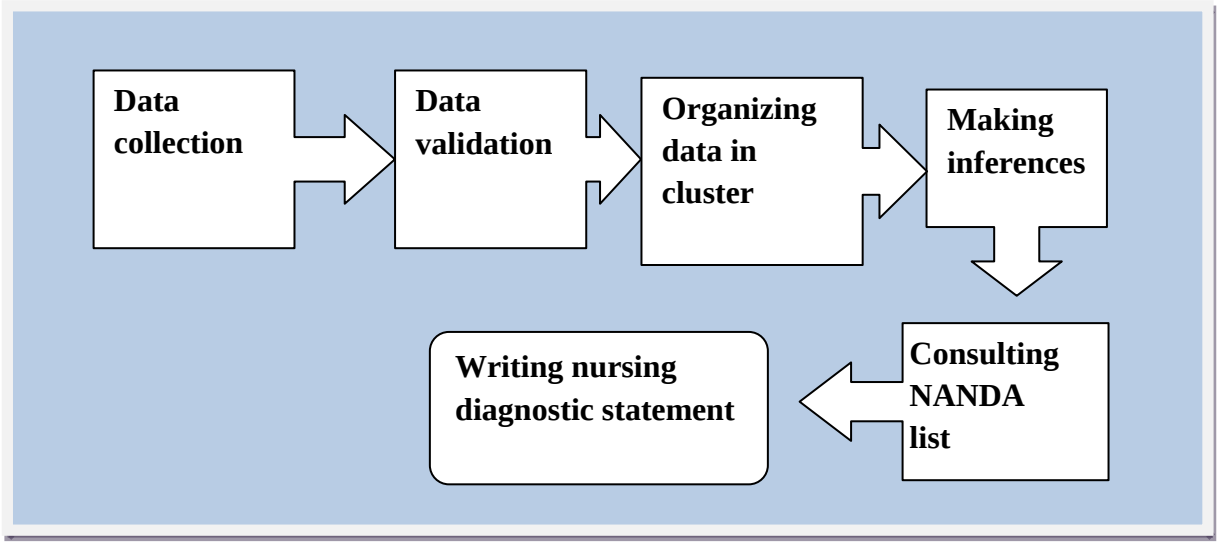
Session Objectives

After completing this session, the trainees will be able to

- Describe nursing diagnoses
- Distinguish nursing diagnoses from medical diagnoses
- Describe the five types of nursing diagnoses
- Explain components of nursing diagnoses by type
- Identify collaborative problems
- Construct various kinds of nursing diagnoses

Introduction

- Transition from **assessment** to **nursing diagnoses**



During assessment, you gather, validate, organize data and finally you record and report abnormal findings. In nursing diagnosis, you further analyze and synthesize (put together) the information and come to some specific clinical judgment; you identify areas of positive functioning, areas where there may be risk of problems and areas problems are existing.

Definition of Nursing Diagnosis

Diagnosis means reaching at a definite conclusion regarding the patient's strengths and human responses through utilization of nurses critical thinking .

> Nursing diagnoses is a clinical judgment about individual, family, or community responses to actual or potential health problems/life processes. (NANDA-North American Nursing Diagnoses Association, 1996, p. 8).

outcomes for which the nurse is accountable.

- For the identified nursing diagnoses, nurses can legally prescribe definitive interventions independently.

Nursing diagnosis versus Medical diagnosis

Exercise 3.1

What are similarities and differences between nursing diagnosis and medical diagnosis?

- **Nursing diagnosis** is the terminology used for a clinical judgment by nurses that identifies the client's actual, risk, wellness, or syndrome responses to a health status.
- **Medical diagnosis** is the terminology used for a clinical judgment by physicians that identifies or determines specific pathologic conditions.

Similarities of nursing diagnoses and medical diagnoses

1. Both are diagnostic process Need professionals cognitive, interpersonal, and psychomotor skills;
2. Involve critically analysis of assessment data;

Table 5. Comparison of nursing diagnoses and medical diagnoses

Nursing diagnosis	Medical diagnosis
• Within the scope of nursing practice	• Within the scope of medical practice
• Identify responses to health and illness	• Focuses on curing pathology
• Can change from day to day	• Stays the same as long as the disease is present

Types of nursing diagnoses

There are five types of nursing diagnoses:

1. Actual nursing diagnosis
2. Risk nursing diagnosis
3. Possible nursing diagnosis
4. Wellness nursing diagnosis
5. Syndrome nursing diagnosis

1. Actual

An actual nursing diagnosis indicates that a problem exists, and is composed of the diagnostic label, related factors, and signs and symptoms.

Example: *Impaired Skin Integrity* related to prolonged pressure on bony prominence as manifested by (AMB) Stage II pressure ulcer over coccyx, 3 cm in diameter.

2. Risk and High-Risk Diagnoses

A risk or / and high risk diagnoses is defined as "a clinical judgment that an individual, family, or community is more vulnerable to develop the problem than others in the same or similar situation. A risk diagnosis is one that is likely to develop if you do not intervene to prevent it.

Example: Risk for Impaired Skin Integrity related to inability to turn self from side to side in bed.

3. Possible Nursing Diagnosis

"*Possible nursing diagnoses* are statements that describe a suspected problem requiring additional data. A possible diagnosis may state a "hunch" or intuition by the nurse that cannot be confirmed or eliminated until more data have been collected. A possible diagnosis is composed of the diagnostic label and related factors.

Example: *Possible Self-Esteem Disturbance* related to recent retirement and relocation.

4. Wellness Diagnoses

A wellness diagnoses is described as "a clinical judgment about an individual, group, or community in transition from a specific level of wellness to a higher level of wellness proceeded by the phrase 'potential for enhanced'." These types of diagnostic statements do not contain related factors, but rather contain the label only.

For example a client who is neither overweight nor underweight tells the nurse that she knows she could improve her diet in some ways. She states that she eats only a small number of vegetables and fruits and thinks that the fat content of her diet is probably high. She expresses a desire to know more about how to improve her diet. The nurse would make a wellness diagnosis as follows

Example. Readiness (Potential) for Enhanced Nutrition.

5. Syndrome Diagnoses

The Syndrome diagnoses "comprise a cluster of predicted actual or high risk nursing diagnoses related to a certain event of situation." (Carpenito-Moyet, 2010, p. 18). This type of diagnostic statements only contain the label (no related to or m/b).

NANDA list has syndrome diagnoses:

Examples. Rape Trauma Syndrome, Disuse Syndrome, Post-Trauma Syndrome, and Impaired Environmental Interpretation Syndrome.

Components of nursing diagnosis

1. *Diagnostic label which contains diagnostic focus and descriptive words*

The diagnostic focus and judgment/modifier are essential components of a nursing diagnosis.

The Diagnostic Focus

The diagnostic focus is the principal element or the fundamental and essential part, the root, of the diagnostic concept. It describes the "human response" that is the core of the diagnosis. The diagnostic focus may consist of one or more nouns. When more than one noun is used (for example, Activity intolerance), each one contributes a unique meaning to the diagnostic focus, as if the two were a single noun; the meaning of the combined term, however, is different from when the nouns are stated separately. Frequently, an adjective (Spiritual) may be used with a noun (Distress) to denote the diagnostic focus Spiritual Distress.

Modifier

A descriptor or modifier limits or specifies the meaning of the diagnostic focus. The diagnostic focus together with the nurse's judgment about it forms the diagnosis. Modifiers may include impaired, altered, decreased, possible, ineffective, and high risk.

Examples

Modifiers	**Diagnostic Focus**
Ineffective	Airway clearance
Risk for	Overweight

Readiness for enhanced	Knowledge
Impaired	Memory
Ineffective	Coping

Each nursing diagnosis has a label with a clear definition. It is important to state that merely having a label or a list of labels is insufficient. It is critical that nurses know the definitions of the diagnoses they most commonly use. In addition, they need to know the "diagnostic indicators" – the data that are used to diagnose and to differentiate one diagnosis from another.

These diagnostic indicators include defining characteristics and related factors or risk factors.

2. *Etiology/* Related factors

Related factors are an integral component of all problem-focused nursing diagnoses. Related factors are etiologies, circumstances, facts, or influences that have some type of patterned relationship with the nursing diagnosis (e.g., cause, contributing factor). **Risk factors** are influences that increase the vulnerability of an individual, family, group, or community to an unhealthy event (e.g., environmental, psychological, genetic).

- The related cause or contributor to the problem can be:
  - Pathophysiological,
  - Treatment related
  - Maturational
- Related factor is joined to the next part by the phrase related to related to "r/t"

3. *Defining characteristics*:

Defining characteristics are observable cues/inferences that cluster as manifestations of a diagnosis (e.g., signs or symptoms). An assessment that identifies the presence of a number of defining characteristics lends support to the accuracy of the nursing diagnosis

- Defining characteristics joined to the first components with the connecting phrase "as evidenced by" (AEB).

Rules for Writing Diagnostic Statements for Actual and Risk Nursing Diagnoses

1. For Actual Diagnoses- Use a three part statement using the PRS format (address the Problem, Related factors (cause), and Signs and Symptoms. Use the words "**related to"** to link the problem and the related factor. Add, "**As evidenced by**" to state the evidence that supports that diagnosis is present.

Components	**Label**	**related to (r/t)**	**Related factors**	**AEB**	**Defining characteristics**
Example	*Activity intolerance*	r/t	*immobility*	AEB	report of fatigue or weakness and exertional dyspnea

2. For High Risk Nursing Diagnoses- Use a two-part statement, using "related to" to link the potential problem with the risk factors present.

Components	**Label**	**related to (r/t)**	**etiology/ related factors**
Example	*Risk for Activity intolerance*	r/t	*immobility*
	High risk for impaired skin integrity	r/t	*confinement to bed*

Avoiding Errors When Writing Diagnostic Statements

- Don't write the diagnostic statement in such a way that it may be legally incriminating.

  For example: ***Incorrect-*** *High risk for injury related to lack of side rails on bed.*

  Correct- *High risk for injury related to disorientation*.

- Don't state the nursing diagnosis using medical diagnostic terminology; focus on the person's response to the medical problems.

  For example: ***Incorrect-*** *Mastectomy related to cancer.*

  Correct- *High Risk for Self-concept Disturbance related to effects of mastectomy*.

- Don't rename a medical problem to make it sound like a nursing diagnosis.

  For Example: ***Incorrect****: Alteration in Haemodynamics related to hypovolemia.*

- Don't state the nursing diagnosis based on a value judgment.

  For example: ***Incorrect-*** *Spiritual Distress related to atheism as evidenced by statements that she has never believed in God.*

- Don't state two problems at the same time.

  For example: ***Incorrect***- *Pain and Fear related to diagnostic procedures***.**

Group Activities

Exercise 3.2: Identifying correctly stated nursing diagnosis

A. Put a "C" in front of each nursing diagnosis that is stated correctly.

1._____High risk for constipation related to confinement to bed.

2._____High risk for impaired skin integrity related to lack of .positioning by nurses.

3._____Pain and anxiety related to surgery.

4._____Hopelessness related to progressive disease process.

5._____Spiritual distress related to atheism

6._____Mastectomy related to cancer

7._____Impaired skin integrity related to heel pressure and rubbing on sheets

8._____Altered haemodynamics related to hemorrhage

9._____Impaired physical mobility related to joint pain as evidenced by reports of pain limiting movement of joints.

10._____Imbalanced nutrition: less than body requirements related to inability to take food by mouth as evidenced by patient's BMI = 16Kg/m^2.

Collaborative problems

Nurses do also make collaborative diagnoses. **Collaborative problems** are defined as physiologic complications monitored by nurses to assess changes in client status. Collaborative problems are managed through the use of interventions prescribed by other health care practitioners and/or nurses. Usually collaborative problems involve alterations in organ and/or system function or structure (e.g., myocardial infarction, duodenal ulcer). Collaborative problems begin with the label *Potential Complication* (PC) followed by the situation—for example, *Potential Complication: Hemorrhage*.

Group Activities

Exercise 3.3: – Differentiating nursing Diagnoses from Collaborative Problems

Instruction: Place "N" in front of nursing diagnoses and place "C" in front of the collaborative problem.

1. _____ Potential complication: hemorrhage related to clotting problems
2. _____ Ineffective airway clearance related to copious secretions as evidenced by crackle sound on auscultation over the left lower lobe of the lung.
3. _____ High risk for injury related to generalized weakness.
4. _____ Fluid volume deficit related to insufficient fluid intake due to sore throat as evidenced by dry oral mucosa and patient verbalization of weakness.
5. _____ Impaired skin integrity related to unrelieved pressure point as evidenced by ulcer on the right heal which is 3cm in length.
6. _____ Potential complication: cardiac arrhythmias related to hyperkalemia
7. _____ Risk for activity intolerance related to prescribed prolonged bed rest.
8. _____Potential complication: Increased intra-cranial pressure related to concussion

Summary

There are five major types of nursing diagnoses. The actual nursing diagnoses and the risk nursing diagnoses are the most widely identified diagnoses by nurses. The actual has three parts incorporating PES formats, whereas the risk nursing diagnoses is two part nursing diagnoses. Nurses do also have identifying collaborative problems.

Session 4.4. Planning: Outcome Identification

Session Description

This session is designed to equip trainees with knowledge and skills of developing plan of care through priority setting, goal setting, and identification of expected outcomes.

Sessions Objectives

By the end of this presentation trainees will be able to:

- Define planning and outcome identification
- Prioritize nursing diagnoses
- Set goal for identified nursing diagnoses
- Write statement of client centered and SMART expected outcomes
- Develop individualized plan of nursing care for a patient

Introduction

Planning is a set of actions that the nurse will implement to resolve existing and potential health problems identified through nursing assessment and formulation of nursing diagnosis. It is one of the critical steps of the nursing process.

It is about "What are we going to do about it?", "What is the best strategy?", and "What do we want to happen?"

Is a record of nursing interventions that will address the identified problems; it's a legal document that identifies the care to be given, and it shows who planned and gave that care, it aids continuity of care, it is a logical and systematic flow of ideas from the initial assessment to the final evaluation (Rush and Fergy, 1996).

Types of planning

- ***Initial planning***: comprehensive plan of care on admission assessment
- ***Ongoing planning***: continuous updating of the client's plan of care.
- ***Discharge planning***: critical anticipation and planning for the client's needs after discharge

Major activities in planning

1. Setting priorities
2. Setting goals

- ✓ Globally written statement describing the intended change in the client's behavior, response, or outcome

3. Outcome identification
4. Determining nursing interventions
5. Recording the plan of care

Establishing Nursing Priorities

After formulating specific nursing diagnoses, the nurse should establish the priorities of the diagnoses by reviewing

- What problems need immediate attention, ranking them in order of importance and urgency of the problems (it is about analysis of the identified nursing diagnoses of what problems need immediate attention)
- What problems have simple solutions
- What problems must be done by nurses or referred

Guidelines for Setting or establishing Nursing Diagnoses Priorities:

- Use the principle of ABC's (airway, breathing, circulation)
- Use Maslow's hierarchy of needs (here physiological needs are of greatest priority and must be met first. Once they are met, the client is more willing and able to seek fulfillment of higher- level needs.)
- Take in to account the concern of the patient
- Usually actual problems take precedence over potential concerns.
- Priorities of the nursing diagnosis by ranking them in order of implication (importance and urgency) can be
  - High (emergency, life-threatening)
  - Intermediate (non- emergency, non- life threatening) or
  - Low (needs that may not be directly related to a specific illness but may affect their future well- being).

Table 6. Prioritizing Nursing Diagnoses with Accompanying Nursing Implications (Importance or Urgency)

Priority	Diagnoses	Nursing implications
High	Ineffective breathing pattern	• Assess breath sounds • Auscultate lungs • Monitor vital signs • Reposition client
Moderate	Risk for impaired skin integrity	• Perform comprehensive skin assessment • Keep skin clean and dry • Provide turning schedule
Low	Ineffective coping	• Assist to identify problem • Encourage keeping daily journal • Teach client strategies for expressing feelings

Breakout

If you have someone with the following problems, which problem would you need to treat immediately?

A. Diarrhea related to gastrointestinal irritation as evidenced by passage of loose stool 3-4 times/day

B. Ineffective breathing pattern related to respiratory muscle fatigue as evidenced by use of accessory muscles to breathe

C. High risk for fluid volume deficit related to persistent loss of loose stool.

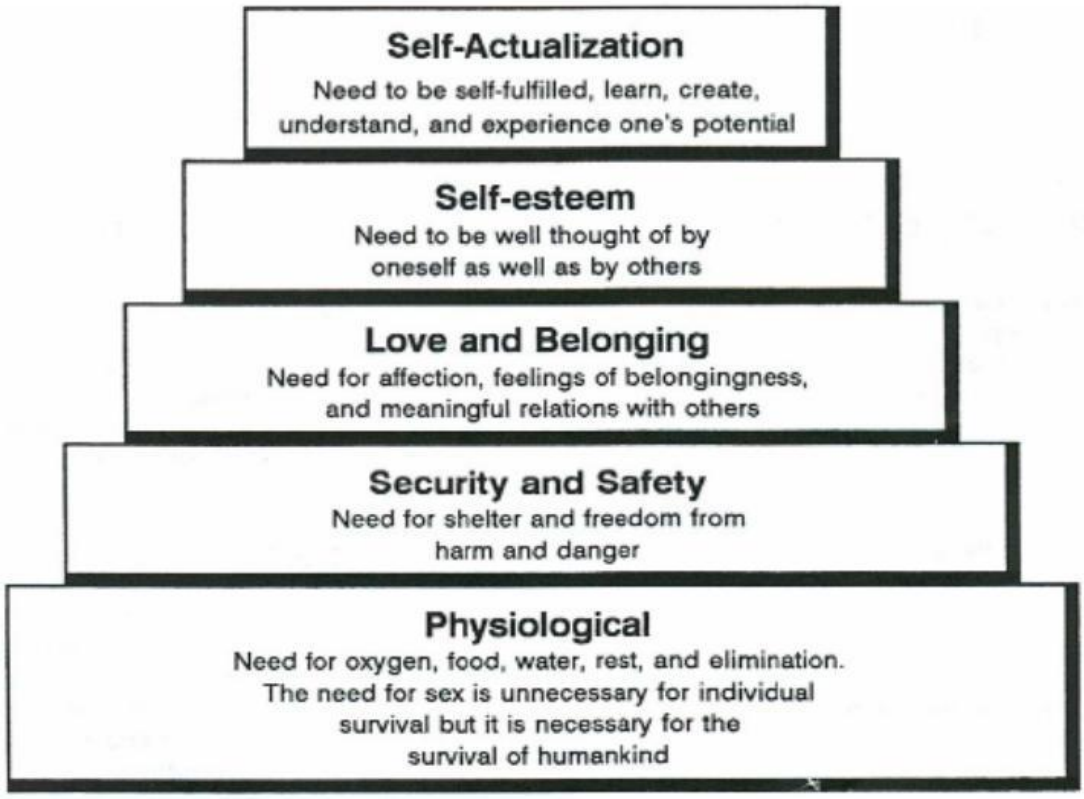


Fig 4.4.1. Maslow's Hierarchy of Human Needs (as one method for setting priority)

Table 7. Ranking Nursing Diagnoses, Using Maslow's Hierarchy of Human needs

Nursing Diagnosis	**Maslow's hierarchy of needs**	**Rank**
Anxiety related to hospitalization	Safety and security	Moderate
Ineffective coping	Self-esteem	Low
Ineffective airway clearance related to excessive secretion	Physiologic	High

Setting Goals

Goal is a broad statement derived using the problem statement in the nursing diagnoses. It should indicate the identified health problem has been resolved or prevented. Goals establish appropriate evaluation criteria to measure the effectiveness of nursing interventions for the resolution of the client's individual nursing diagnoses.

The purpose of writing goals and expected outcomes:

- Provides direction for individualized nursing interventions
- Assist the patient in resolving the diagnosed problems
- Promote client involvement
- Evaluate the effects of nursing care as a part of health care
- Establish evaluation criteria to measure the effectiveness of the nursing care plan (as, goal is an aim, intent, or an end).
- Write client-centered goals instead of nursing goals has been recognized as an effective method of writing goal statements

Examples of goals

- Reducing anxiety before undergoing surgery
- Maintenance of a patent airway
- Relief of pain

Identify Patient Expected Outcomes

Outcome identification describes the specific data that tell the nurse that the broad goal has been achieved and is the basis of evidence that tells patient problems have been prevented, corrected, or controlled.

Writing client-centered goals (what the client is expected to achieve) instead of nursing goals (what the nurse aims to achieve) has been recognized as an effective method of writing goal statements.

Well-identified outcomes help to determine specific interventions and to evaluate effectiveness of care.

Types of expected outcomes

Goals should be established to meet the immediate, as well as long-term prevention and rehabilitation, needs of the client.

1. **Short-term outcome (STO)**:- are those that can be met relatively quickly, often in less than a week, or in a short period. It is usually focused on the etiology.
2. **Long term outcome (LTO):-** are those that are to be achieved over a longer period of time, often weeks or months. requires more time. LTOs usually focused on the problem.

Often you will set several short-term goals in order to reach a long-term goal. Long-term goals may also include goals that are ongoing (i.e., goals that are to be accomplished every day). These types of long-term goals are usually stated by using the words "every day" or "will maintain." Note the examples below:

- " Tigist will dress herself every morning."
- "Ato Daniel will maintain a fluid intake of 2000 mL a day."

Example of STOs and LTOs

Nursing diagnoses: Constipation related to confinement to bed as evidenced by client's verbalization of evacuation of scanty, hard stool less frequently than the usual.

Short-Term Outcome	**Long-Term Outcome**
""Fatuma will demonstrate how to hold her newborn infant by tomorrow (6/7)."	"Fatuma will demonstrate how to dress, feed, and bathe her newborn infant by discharge (15/7)."
"Ato Hailu will turn and reposition himself from side to side every 2 hours.	"Ato Hailu will maintain good skin integrity while he is on bed rest."
"Ato Sium will demonstrate how to change his colostomy bag within 2 days (by 7/7)."	"Ato Sium will demonstrate how to give complete colostomy care according to Hospital standards by discharge (by 7/21)."
"Tekle will walk with crutches with assistance by 3 days after surgery (by 7/28)."	"Tekle will walk unassisted with a crutch by discharge (by 8/10)/"

Components of expected outcomes

- **Subject:** the person expected to achieve the outcome
- **Verb:** actions that the person must take to achieve the outcome
  - ✓ Choosing verbs that measure progress will avoid ambiguity and focuses on the behavior that will measure progress.
  - ✓ **Use measurable verbs in order to be a specific**. *Verbs like -identify, describe, perform, relate, state, list, verbalize, hold, demonstrate, share, express, has an increase in, has a decrease in, has an absence of, exercise, communicate, cough, walk, discuss, etc.*

- ✓ ***Non Measurable Verbs (Do not Use)*** *include -know, understand, appreciate, think, accept, and feel.*

- **Condition:** circumstances under which the person performs the actions
- **Performance criteria:** how well is the person to perform the actions
- **Target time:** by when is the person expected to able to perform the actions,

Example: Ato Hailu will walk with a crutch at least to the end of the hall and back by Friday (May 5, 2017)

Subject: *Ato Hailu* ***Verb:*** *will walk* ***Condition:*** *with a crutch*

Criteria: *at least to the end of the hall and back* ***Specific time- by*** *May 5, 2017*

Guidelines of writing nursing expected outcomes

- Be realistic in establishing goals: when establishing realistic goals, one must know the resources of the health care facilities available to reach expected outcomes in a timely manner.
- Whenever possible, set outcomes mutually with the client and others involved in his/her health care. It ensures agreeable goals to all key players in the plan.
- Be sure that the outcomes describe a client behavior or action that demonstrates the desired improvement, control, or resolution of the identified nursing diagnoses.
    - One expected outcome should address only one behavioral response
- Follow the rules for writing outcome statements.
- Using measurable, observable verbs to describe actions or behaviors that you expect to see

Writing more than one outcome statements

Sometimes there may be more than one outcome criteria to prevent, control, or resolve a problem. In these cases, the outcomes probably relate to the causes, or related factors, of the problem rather than to the problem itself. However, make sure at least one of the outcomes should demonstrate resolution, improvement, or control of the nursing diagnosis.

Example

Nursing Diagnosis: Obesity related to poor eating habits and minimal physical activity as evidenced by BMI of 32 kg/m^2.

Goal: LTG: The client will attain a normal BMI.

Outcome #1: Client will verbalize his feelings about changing eating habits a week after counseling session.

- ✓ This outcome relates to the problem of "poor eating habits, which is a causative factor

Outcome # 2: Client will attend daily exercise classes beginning from May 6, 2017.

- ✓ This outcome relates to the problem of "minimal physical activity," which is a causative factor.

Outcome #3: Client will lose half kilo per week beginning May 20, 2017 until he weighs between 60 and 70 Kg.

- ✓ This outcome demonstrates a direct resolution of the problem of obesity

Steps in identifying Outcomes from Nursing Diagnoses

1. Look at first part of the nursing diagnoses itself or problem statement (the word or words before "related to")

   Example- <u>High risk for impaired skin integrity</u> related to immobility.

   Now restate the first part in a statement that describes improvement, control, or absence of the problem.

   Example- The person will demonstrate no signs of skin irritation or breakdown.

2. In modifiable related factors, identify outcomes that state the related factor (s) is/are resolved, prevented or controlled.

   Example: The patient will use safety and comfort devises (pillow, cotton ring, air ring) over bony prominence areas as of tomorrow.

Exercise

Instruction: Choose the outcomes that are *written correctly* below and state what is wrong with the statements that are written incorrectly.

1. Tesfaye will know the four basic food groups by Tahsas 1, 2009.
2. Wrt. Saba will demonstrate how to use her walker unassisted within 3 days.
3. Ato Lemma will improve his appetite by Meskerm 11, 2010
4. Tullu will list the equipment needed to change sterile dressing by 09/05/2009 EC.
5. David will walk independently in the hall the day after surgery.
6. Wrt. Genet will understand the importance of maintaining a salt-free diet.
7. Wrt. Tadeletch will appreciate the importance of exercise for pt. with diabetes.
8. Ato Sium will feel less pain by Thursday (Jan 10, 2012).

Summary

In the plan of care nurses should prioritize list of nursing diagnoses, set goals and expected outcomes.

Goals are broad statements that states what the client will attain at the end. Whereas, outcomes are action-oriented specific statements that the patient is expected to attain after an implementation of nursing interventions.

Session 4.5. Planning: nursing intervention/instruction

Session description

This session is the continuation part of care plan that focuses on nursing intervention with nursing orders/instructions.

Enabling objectives

By the end of this session, trainees will be able

- Describe nursing intervention
- Describe types of nursing intervention
- Write nursing instructions/orders

Introduction

A nursing intervention is an action planned by a nurse that helps the client to achieve the results specified by the goals and expected outcome. It is important to identify as many nursing interventions as possible so that if one proves to be unsuitable, others are readily available.

The interventions are prioritized according to the order in which they will be implemented. Nursing intervention also facilitates communication between care givers and actively involves the client and family.

Nursing interventions could be carried out through assessing, teaching, counseling, consulting, and determining problem specific interventions.

The three categories of nursing interventions are:

1. **Independent interventions:** interventions that require no supervision or directions from others

   Example: Demonstrating client about insulin self-injection. This intervention do not require any physicians order
2. **Interdependent interventions:** are type of interventions that are implemented in a collaborative manner by the nurse with other health care professionals

   Example: Nursing interventions in operation theatre with other health care team.

3. **Dependent interventions: -** are based on the interaction or written orders by other health care provider.

   Example: Administering a medication, preparing a client for different procedure …

Nursing Instructions/Orders

After setting the goals and planning the appropriate nursing interventions, the nurse writes nursing orders to communicate the exact nursing interventions that are to be implemented for the client. A **nursing order** is a statement written by the nurse that is within the realm of nursing practice to plan and initiate. These statements specify direction and individualize the client's plan of care.

Consider the following when writing nursing instructions:

- What to look for (assessing, or seeing)
- What to do
- What to teach or counsel
- What to record

Elements of nursing order/instruction

- ***Date***: the date on which the order is written. This information is updated to reflect review and revision.
- ***Action Verb***: directs the nurses' action. Example: Explain, demonstrate, auscultate
- ***Detailed description***: precisely clarifies what the nurse's action will be. This phrase explains what, when, where, and how.
- ***Time frame***: Describes when, how often, and how long the nursing order is to be performed.
- ***Signature***: Indicates the nurse who writes the order. This element implies legal and ethical accountability.

Examples of nursing interventions and instructions

Nursing Action	Nursing instructions
Ambulate patient	• Ambulate patient the length of the hall using the walker 3 times a day • Monitor ability to use walker appropriately and record response daily on flow sheet.
Provide for periods of uninterrupted rest	• Do not wake up the patient from midnight to 7 am • Allow the patient to rest from 1 pm to 3 pm (no visitors) • Record the patient's perception of hours slept

SESSION SUMMARY

Nursing intervention is a part of nursing care plan. For ease execution nursing interventions need to be written in nursing instruction or order forms using action verbs, dated and signed.

Session 4.6. Implementation

Session Description

This session is designed to equip trainees with knowledge; skill and the right attitude that will enable them implement nursing care effectively and efficiently according to predetermined plan of care

Sessions Objectives

By the end of this presentation trainees will be able to:

- Define implementation of nursing care
- Put plan of care in to action using various implementation methods
- Record the actual implementation

Introduction

Describes the nursing behavior in which the actions necessary for achieving the goals and expected outcomes of the nursing care are initiated and completed.

It is the fifth step in the nursing process is implementation. Involves the execution of the nursing plan of care derived during the planning phase. It consists of performing nursing activities that have been planned to meet the goals set with the client.

↗ To complete implementation effectively, the nurse must be ***knowledgeable*** about:

1. ***Types of interventions***,
2. Specific ***implementation method*** and
3. ***Implementation process***

   The nurse carries out the nursing care plan by using several implementation methods to achieve the goals of nursing care. The nurse is responsible for knowing when one of these methods is preferred over another.

   The nurse is responsible to know and determine the preferred method

1. ***Assisting*** with ADLs
2. ***Counseling-*** to use problem solving process and manage problems
3. ***Teaching-*** used to present correct principles, procedures, and techniques of health care to clients, to inform clients about their health status and refer clients to social resources
4. ***Preventing Adverse Reactions-*** when providing care and applying correct techniques in administering care and preparing the client for special procedures.

5. ***Compensating for Adverse Reactions-*** Nursing actions that compensate for adverse reactions reduce or counteract the reaction

   Ex. Understanding the known potential side effects of the drug, Assessing the client side effects, or initiation life saving measures

   Implementation process

   i. Reassessing the client
   ii. Delegating interventions
   iii. Direct care
   iv. Supervising the delegated care
   v. Documenting nursing activities

Implementation of nursing interventions include-

- Performing, assisting or directing the performance of objective of daily Living (ADL). These include activities performed in the course of a normal day that include ambulating, eating, dressing, bathing, brushing the teeth, grooming and toileting , .
- Coordinate activities of patient, family, significant others, nursing team members, and other health team members.
- Delegate specific nursing interventions to other members of the nursing team as appropriate.
  - Consider the capabilities and limitations of the members of the nursing team.
  - Supervise the performance of the nursing interventions.
- Counseling and teaching the client or family
- Providing direct care.
- Delegating, supervising and evaluating the work of staff members
- Record and exchange relevant information of the patient's responses to the nursing interventions for the client's continued care precisely and concisely.

To implement nursing interventions clinical decision making (requires knowledge), interpersonal (communication), and psychomotor skills are necessary. Nursing interventions are written in the nursing care or communicated orally and following implementation, the

nurse documents the interventions and the client's response to the treatment on the appropriate record.

SESSION SUMMARY

Implementation is the fifth step in nursing process that puts plan of nursing care in to action. The nurse uses psychomotor, interpersonal and critical thinking skills during implementation of nursing care. Implementation also involves reporting and documentation.

Session 4.7. Nursing evaluation

Session description

This session is designed to equip trainees to evaluate plan of care with the aim of determining whether goal has met, partially met, or not met.

Sessions Objectives

By the end of this presentation participants will be able to:

- Collect necessary data for verification of attainability of the goals
- Rate whether the stated goals were met, or needs of changes
- Compare the relationship between expected outcomes and goals of care
- Assess the function evaluation plays in improving the quality of client care
- Analyze evaluation as a continual process.
- Evaluate the overall interrelated components of nursing process

Introduction

Determines the patient's responses to the nursing interventions and the extent to which the outcomes have been achieved. or the measurement of how well the patient achieved the outcomes specified in the plan of care.

Is the regular review of the effect of nursing interventions and the treatment regimen on the patient's health status and expected health outcomes, or a systematic measures the client's response to nursing actions and the client's progress toward achieving the goals and expected outcomes (consideration of reviewing ADOPI "Did it work? Why didn't it work?", "Did we end up where we wanted to?", and "Are we done or is there more? What's the problem?")

The purpose of the nursing care evaluation is:

- Assist the client in minimizing or resolving actual health problems
- Preventing the occurrence of potential problems, and
- Promoting the maintenance of a healthy state
- Measure how well the patient has achieved desired outcomes
- Identify factors contributing to the patient`s success or failure
- Modify the plan of care, if indicated.

Evaluation is done primarily to determine whether a client is progressing—that is, experiencing an improvement in health status. It is not an end to the nursing process, but rather an ongoing mechanism that assures quality interventions.

Evaluation of the goals of care determines whether this purpose was accomplished. There are different degrees of goals attainment. If the client's response matches or exceeds the expected outcome, the goal is met. If the client's behavior begins to show change but does not yet met criteria set, the goal is partially met. If there is no progress, the goal is not met.

Steps used to objectively evaluate the degree of success in achieving a goal:-

1. Examine the goal statement and identify the client behavior or response
2. Assess the client for the presence of that behavior or response
3. Compare the established expected outcome with the behavior or response
4. Judge the degree of agreement between expected outcome and the behavior or response
    a. **Goal is Met-** if the client's response matches or exceeds the outcome criteria.
    b. **Goal is partially Met-** If the client's behavior begins to show changes, but does not yet meet specified criteria.
    c. **Goal is Not Met -** If there is no progress
5. Ask questions if there is no agreement.

N.B. When goals have been partially met or when goals have not been met, two conclusions may be drawn:

- The care plan may need to be revised, since the problem is only partially resolved OR
- The care plan does not need revision, because the client merely needs more time to achieve the previously established goals. So the nurse must reassess why the goals are not being partially achieved.

During evaluation, the following questions should be considered:

- Have the goals of the nursing care plan been achieved, If not, why not
- Were the goals realistic
- Was the patient committed to the goals
- Was there enough time to achieve the goals
- Did other problems arise that impeded progress
- Were interventions consistently performed as prescribed
- Have any new problems developed that have not been addressed

Example

Nursing Diagnosis: - Knowledge deficit regarding insulin therapy related to inexperience

Goals: client will self- administer insulin by 12/18

Outcome criteria

- Client prepares insulin dosage in syringe by 12/17
- Client demonstrates self – injection by 12/18

Evaluation finding (Client response)

- Client prepared accurate dosage in syringe on 12/17
- Client administered morning insulin dosage; self – injection was correctly performed on 12/18

Judgment: Goal achieved, no need to revise this part of care plan

SESSION SUMMARY

Evaluation is the final step of nursing process whereby the implemented nursing care is measured against the pre-determined goal and expected outcomes. Based on which judgment can be made as goal is met, partially mate or unmet.

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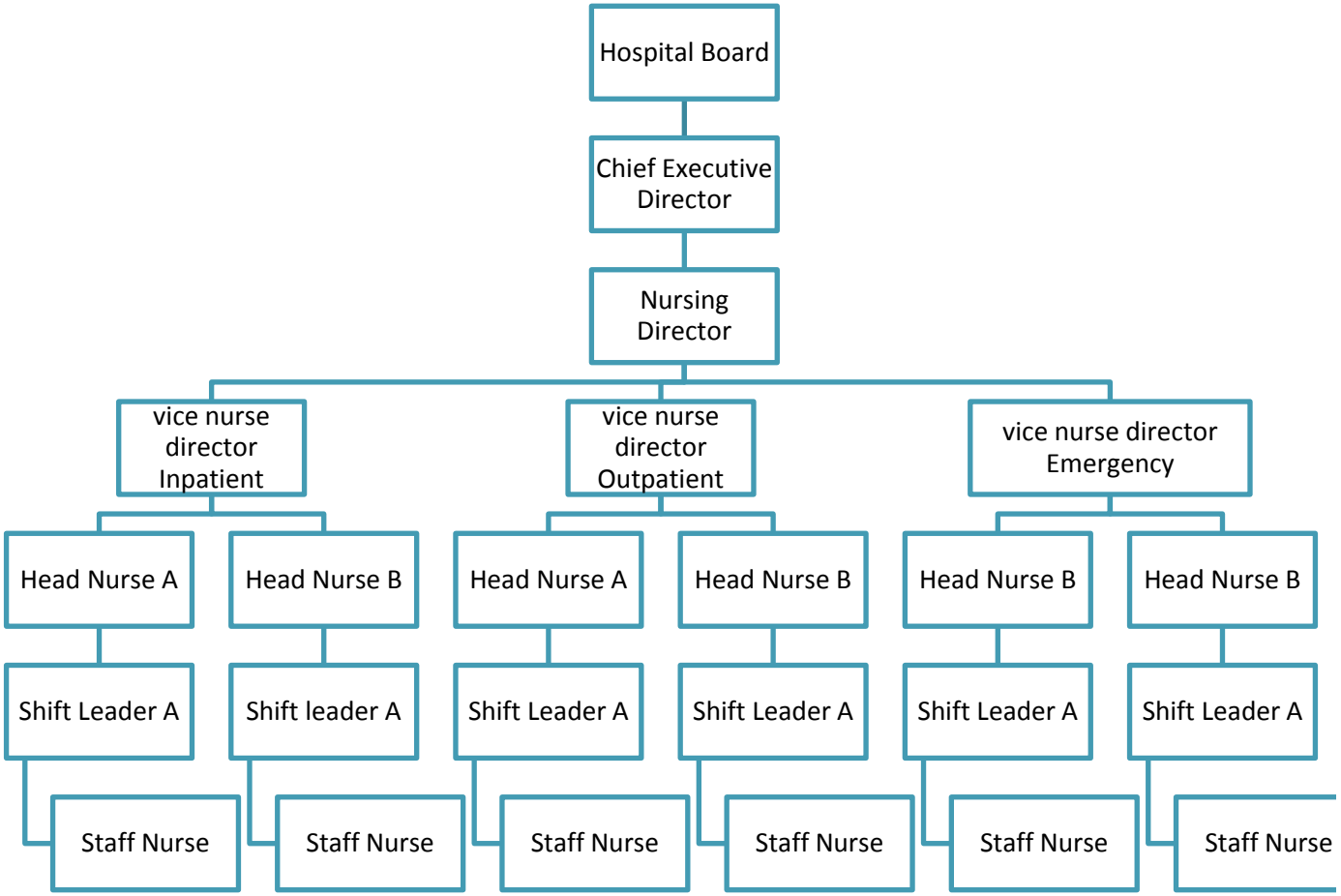
Annexes

Annex 1. Example of nursing service managerial structure



Annex 2: Nurse Director Job description

Job Title: - Nurse Director

Department: -

Report to: - Chief Executive Director

Employment type: - Regular

Education level: - Degree/Master/PHD

Summary of service: the matron is responsible for setting the direction for the delivery of high quality, cost efficient nursing care, which includes the nursing overseeing the nurse service's fiscal management and patient care units. As the leader of a nursing service, the matron, also known as the nurse director, is the link between nursing and hospital administration, physician leadership and the human resource department. The nurse director participates in senior level decision-making and the strategic planning of the hospital in order to ensure that hospital initiatives are implemented across the patient care units.

Essential job responsibilities

Leadership

- Establishes a model of nursing practice, guided by comprehensive knowledge of current nursing theory and practice, and ensures its successful implementation to improve nursing services.
- Provides visible leadership in a continuous manner to improve learning, performance and quality, while also promoting a clear sense of direction in accordance with the mission and objectives of the hospital.
- Is responsible for creating a work environment within the nursing service that inspires high morale, encourages teamwork, stimulates innovation, provides quality care, and increases staff retention.
- Attends hospital meetings and effectively communicates patient care issues to the senior management level of the hospital.
- Demonstrates knowledge and skills in strategic planning and uses these skills to advance the quality of nursing services and to integrate the hospital's goals and objectives into the nursing service goals.

Quality and process implement

- Demonstrates knowledge and skill in quality improvement and uses these concepts to administer best practices across the nursing service.
- Reviews and develops systems which optimize department efficiency and improve patient care.
- Collaborates effectively with other departments within the hospital to develop systems that solve issues or problems which are identified by the management team or are raised by the nursing staff.
- Establishes standards of care and nursing policies to ensure that nursing protocols and procedures are appropriate and evidence-based.
- Ensures that all regulatory standards are met across the nursing service.
- Approve all food, laundry and cleaning quality of service.

Staff management and development

- Ensures that policies and procedures are in place to hire, orient, develop, reward and discipline staff.
- Ensures that nursing directors and nurse managers are aware of the policies and that they are implemented fairly.
- Develops the nursing management staff to ensure that they have the skills to function at a level necessary for the efficient operation of the hospital.
- Act as a role model.
- Assists in the development of teaching and training materials for all nursing care staff.

Fiscal management

- Demonstrates knowledge and skill in developing and operating capital budgets.
- Monitors budgetary performance to ensure that all patient care units are within budget.
- Develops and implements manpower planning strategies, including creating guidelines for the use of agency nurses and other external assistance as needed.

Supervise to: nurse supervisor

Benefit package'

1. Monthly salary; Based on the government policy

2. Other payments;
3. To facilitate the work done by matron:
4. Position allowance:

Name of Nurse_____ Signature _____date _____

Annex 3. Head nurse job description

Job Title: - Head nurse

Department:-

Report/accountable to: - Nurse Director

Employment type: - Regular

Educational level: - Degree/Master

Summary of jobs: - head nurses direct the performance of nursing functions on their unit, consistent with the philosophy, goals, objectives, and standards of care in the nursing Service. They structure their activities to anticipate and respond to events, in order to ensure that the patients on their unit receive optimum care. Each manager is responsible for a defined area and must collaborate with others to achieve the best care for their patients. In order to achieve the hospital's goals, nurse managers are a direct link between the hospital's strategic objectives and the staff on their unit.

Essential job responsibilities

Leadership

- Provides direction and leadership to nursing staff, ensuring quality and patient-focused care.
- Establishes systems/processes that ensure effective unit operations.
- Demonstrates a positive, supportive attitude toward patients, families and staff.
- Attends all departmental and committee meetings and activities to share the unit's perspective.
- Acts as a liaison between staff, the matron and the hospital.

Fiscal management

- Manages the unit's budget by staffing within budgeted employee levels while maintaining staff to patient ratios. Creates staff work schedules based on the budget.
- Responsible to the cost effective utilization of supplies and equipment.

- Maintains ward statistics pertaining to the unit's admissions, discharges, mortality and staffing.
- Ensure all food, laundry and cleaning quality and availabilities of service.

Unit objectives

- Responsible for ensuring that the unit is clean and orderly.
- Establishes systems to ensure effective utilization and availabilities of equipment and supplies.
- Ensures adequate staffing on all shifts, verifying that all patients have an assigned nurse.
- Ensures that nurses and students are assigned appropriate patients.
- Manages the flow of patients by coordinating admissions, and transfers in a time manner.
- Makes rounds on the unit to assess the adequacy of staff assignments and the availability of adequate equipment and supplies.
- Maintains an inventory of supplies and equipment for the unit.
- Ensures adequate stock levels, and makes timely requisitions or repairs.

Human resource management

- Holds all staff accountable for achieving high levels of performance.
- Ensures that duties and responsibilities of staff nurses and students are carried out efficiently.
- Monitors the productivity of staff through performance appraisals.
- Regularly meets with staff receives education, so that they remain current in the latest treatments and technology.
- Supports nursing students to ensure that students get the desired learning experience.
- Organizes orientation and training programs for new staff.
- Make sure that all members of the team have annual leave program and used based on the program.
- Make sure that all the nurses, students and other staff in the ward wear their uniforms and have a badge that bears their name and profession.

Standard compliance

- Understands and communicates all relevant regulatory standards to staff, ensuring that the standards are met or exceeded.
- Ensures that all staff complies with standards of performance, including those related to infection controls and staff and patient safety practise in the hospital.
- Initiates the development of standard operating procedures for all new procedures and nursing interventions.

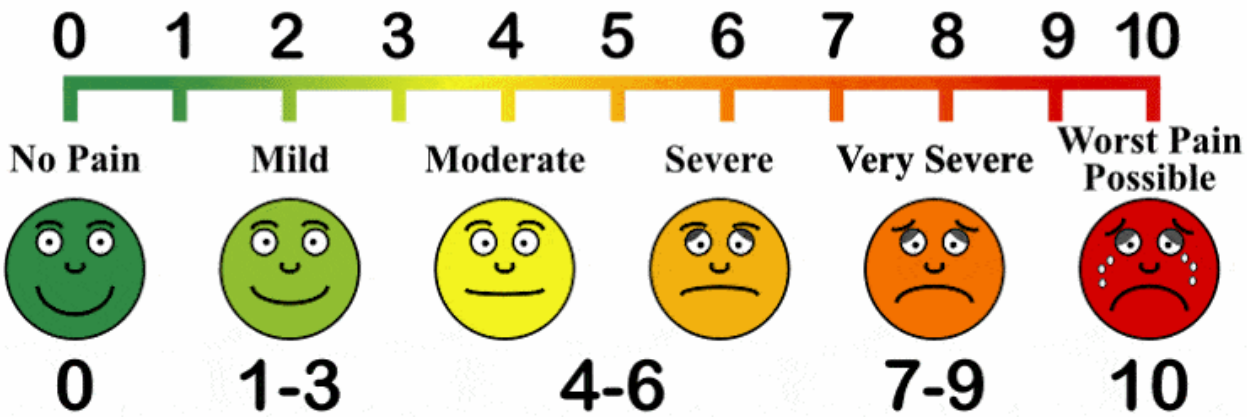
Benefit packages

1. Monthly salary: Based on government scale
2. Other payments:
3. To facilitate the work done by head nurse:
4. Position allowance:
5. Annual leave: Based on program

Name of Nurse_____ Signature _____Date_____

Annexes 4: Pain Assessment Scale

Pain assessment scale for adults chart



Pain assessment scale for pediatrics chart: FLACC Pain Rating Scale for infants to 7 years age

Category	Scoring 0	1	2
Face	No particular expression or smile	Occasional grimace or frown withdrawn, disinterested	Frequent-constant quiver chin, clenched jaw
Legs	Normal position, relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back & forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep) occasional complaint	Moans or whimpers; sobs; frequent complaint	Crying steadily, screams,
Consolabilty	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Annex 5: LOC for pediatrics

Blantyre coma scale for young children who are preverbal	
	Score
Eye movements: • Directed (followed mother/caretakers face) • Not directed	 1 0
Verbal response: • Appropriate for age (cry) • Moan or inappropriate for age (cry) • Gasp/none	 2 1 0
Best motor response: • Localizes painful stimulus (rub your knuckles firmly on the patients sternum) • Withdraws limb from pain (press firmly on patients thumbnail bed with the side of a horizontal pencil) • None specific or absent response	 2 1 0
Total	**1-5**

Annex 6: Nursing process format

Nursing/Midwifery Comprehensive Client Assessment Format

Please Complete or Affix Label	_____HOSPITAL
Full Name:_____ Age:_____ Sex:____ MRN: Address:- City: Sub city: Kebele: House no. - Tel. No.:_____ Source of information:_____ Source of referral: _____	Ward: _____ Bed No.: _____ Medical diagnosis:_____ Date of admission: _____ Time of admission: _____

Personal Details

Marital Status:	Nationality: Ethnic group:
	Language:
Single ☐ Widowed ☐	Religion:
Married ☐ Living common law ☐	Occupation(previous and current):
Divorced ☐	
Patient's support	
1. Name:	2. Name:
Relationship:	Relationship:
Address: Tel No.: City: Sub city: Kebele: House no.	Address: Tel No.: City: Sub city: Kebele: House no.

1. Health perception and Management pattern

Subjective data

Client's statement about reason of admission: _____

_____

_____

Significant others' statement about reason of admission:

_____

Substance use

Type	Unit /measurement	Frequency	Effect if not taken	Remark
Alcohol				

Khat				
Tobacco				
Others				

Health maintenance practice:_____

_____

Past medical history

Measures taken for the problem

Understanding of Medication(what, how and why) Patient is taking before admission (incl. "over the count"					
Drug name	Dose	Freq.	Drug name	Dose	Freq.

Known allergies for **medication: ____food:____Others: ____ Specify: _____

Last immunization (type and date): _____

2. Nutrition and Metabolism pattern	
Subjective data	**Objective data**
Pattern of food intake Breakfast:☐Lunch: ☐ Dinner: ☐Snacks: ☐ Others_____ Special diet _____ Appetite: Normal ☐Increased ☐Decreased ☐ Average Fluid intake per day in ml: _____ Difficulty in chewing: Yes☐ No☐ Sore tongue: Yes ☐No☐ Difficulty in swallowing: Yes☐ No☐	**Wt**: _____**Ht**:_____**BMI**: _____**MUAC** ___ **Skin** • Color**:** jaundice ☐Pallor ☐Erythema ☐ Central cyanosis☐Petechiae☐ Other _____ • Lesion: Macule ☐Papule ☐ Vesicle ☐Nodule☐Postule☐Wheal ☐ Ulcer ☐Creast☐ scale ☐Other_____ • Texture: Smooth and Soft ☐Rough ☐Thick ☐ • Temperature: Warm☐Extremely warm ☐ ▪ Extremely cool ☐ other____ • Moisture: Dry ☐ Wet☐ Oily☐ • Turgor/skin pinch: Immediately ☐Slowly☐ Very Slow ☐ • Any visible Wound Yes ☐ No ☐ If yes type of wound _____

Nausea: Yes☐ No ☐Vomiting: Yes ☐No☐ Abdominal pain: Yes☐ No☐ Antacid: Yes☐ No☐ Wt. gain: Yes☐ No☐ Wt. losing: Yes☐ No☐ History of weight gain:Yes☐ No☐ Cold intolerance: Yes☐ No☐ Hot intolerance: Yes☐ No☐	Location:_____ length in cm:___width in cm: ___ Discharge Yes☐ No☐ If yes colour: _____ Odour: _____ • Bilateral pitting edema Yes☐ No☐ • Oral cavity • Mucosa: Intact Yes☐ No☐Pink Yes☐ No☐ • Moist Yes ☐ No☐ Dry Yes ☐ No☐ • Lesion Yes☐ No☐Others _____ • Teeth: malformation Yes☐ No☐Denture Yes☐ No☐ • Dental caries Yes☐ No☐ Other _____ • Tongue: Pink☐Pale ☐ Dry☐ Moist ☐ Lesions ☐ Intact☐

3. Elimination pattern	
Subjective	**Objective**
Bowel habits Frequency: _____Color _____ Pain: Yes ☐No☐ Consistency_____ Laxative: Yes☐ No☐ Enema: Yes☐ No☐ Hx of Bowel surgery • Colostomy Yes☐ No☐ • Illeostomy Yes☐ No☐ **Bladder habit** Frequency _____Amt____ml Color: ____ Pain:Yes☐ No☐ Hematuria:Yes☐ No☐ Incotinenance: Yes☐ No☐ Nocturia: Yes☐ No☐ Retention: Yes☐ No☐ Urinary Catheter: Yes☐ No☐Type_____	**Abdomen** Contour/shape: Rounded ☐ Flat☐Distended ☐Scaphoid Abdominal detention Umbilicus: Protrusion☐Inflamed☐ Drainage ☐ Vein: Engorged and Prominent Vein : Yes☐ No☐ Bowel sound:<5/m☐5-30/m☐>31/m☐ Abdominal Tenderness: Yes☐ No☐ Characterize_____

4. Activity and exercise pattern	
Subjective	**Objective**

Daily Activities (any difficulties with :)

Hygiene: Yes☐ No☐ cooking: Yes☐ No☐

House work: Yes☐ No☐ shopping: Yes☐ No☐

Eating Yes☐ No☐ toileting Yes☐ No☐

Dyspnea: Yes☐ No☐ During Minor activity☐

During vigorous activity ☐

Chest pain:Yes☐ No☐

Stiffness: Yes☐ No☐

Weakness: Yes☐ No☐

Aching:Yes☐ No☐

Effect of illness on activity of daily living:_____

_____

_____

_____

____

Objective data

Score	Level of dependence
0	Fully independent in personal care
1	Requires minimal intervention
2	Requires moderate intervention
3	Requires intensive intervention
4	Requires intensive intervention(fully dependent)

Musculoskeletal:

Grooming _____

Gait: Steady/Balanced ☐ Unsteady/Unbalanced ☐

Posture:_____

Extremity swelling:Yes☐ No☐Symmetrical: Yes☐ No☐

Range of motion : Normal for all joint☐

Decreased ☐

Crepitus: Yes☐ No☐Tone: Strong☐ Weak☐

Respiratory

Thorax Shape: Normal ☐funnel ☐Barrel ☐pigeon☐

Symmetry: equal ☐unequal☐

Intercostals space: even and relaxed ☐Bulging ☐Retracting☐

Tenderness: Yes☐ No☐

Breathing

- Pattern: regular ☐irregular☐
- Difficulty:Yes☐ No☐
- Respiratory rate_____
- Depth: Normal ☐Deep ☐shallow☐
- Adventitious sound_____

Cardiovascular

Jugular vein distension Yes☐ No☐

Heart sound: S_1:Yes☐No☐S_2:Yes☐ No☐

Murmurs_____

Blood pressure : Rt arm :_____ Lt arm :_____

Pulse

Rate : ___

Rhythm : regular ☐ irregular ☐

Bilaterally equal Yes☐ No☐

Temperature(in ^{0}C): Axilary___

Oral_____Rectal___

5. Rest and sleep pattern

Subjective	Objective
Sleep time_____ Adequacy: Yes☐ No☐ Difficulty falling sleep: Yes☐ No☐	Yawning: Yes☐ No☐ Short attention span: : Yes☐ No☐

Sleep aid: Yes☐ No☐ Sleep medications: Yes☐ No☐ Change in sleeping pattern: Yes☐ No☐ Difficulty remaining sleep**:** Yes☐ No☐ What facilitate sleep_____ What hinders sleep _____	Irritability **:** Yes☐ No☐

6. Sexuality and reproductive pattern	
Subjective	**Objective**
Female Menstruation Date began: _____Lastcycle_____Length_____ Gravida: ____ Para____ Abortion___ still birth_____ Current Pregnancy:Yes☐ No☐ LNMP:_____EDD--------GA--------- Fertility: Fertile☐infertile☐ Male/Female Contraception: Yes☐ No☐ Undesirable side effects of contraceptives :_____ Problem with Sexual activities:_____ _____ Effect of illness on Sexual activities:_____ _____ STD/STI: _____ Pain during intercourse: Yes☐ No☐ Burning during intercourse: Yes☐ No☐ Discomfort during intercourse: Yes☐ No☐	Breast: Shape_____Symmetry_____ Nipple: erected☐ flat☐Inverted☐Discharge:Yes☐ No☐ Masses: Present ☐ No mass ☐ Lymph node: Enlarged: Yes☐ No☐Tenderness: Yes☐ No☐ Testicular exam Masses:Yes☐ No☐Swelling:Yes☐ No☐ Penile exam Mass: Yes☐ No☐ Growth: Yes☐ No☐ Lesion:_____ Discharge: Yes☐ No☐ Female Genetalia Swelling:Yes☐ No☐ Symmetry: symmetrical ☐asymmetrical ☐ Discharge: Yes☐ No☐ Characterize _____ Vaginal opening: Lesion _____Discharge_____Inflammation: Yes☐ No☐

7. Cognitive and perceptual	
Subjective	**Objective**
Educational status:_____ Able to read _____Write _____ Primary language:_____ Visual problemYes☐ No☐ explain _____	• Ability to speak Yes☐ No☐ • Ability articulate words Yes☐ No☐ • Level of consciousness : **Glasgow coma scale** : _____ • Orientation to TPP:_____

Aids for vision: Yes☐ No☐ Hearing problemYes☐ No☐ explain _____ Aid for hearing:Yes☐ No☐ Taste problem Yes☐ No☐ explain _____ Smelling problemYes☐ No☐ explain _____ Problem in sensation(skin)Yes☐ No☐ explain _____ Pain(any):Yes☐ No☐ Characterize if yes _____ Ability to recall: Remote: Yes☐ No☐Recent: Yes☐ No☐ Ability to make decisions: Yes☐ No☐ Expression of feelings**:** _____	• Hearing : Tympanic Membrane: Intact☐ Ruptured☐ whisper test: respond ☐unable to respond☐ • Visual acuity: OD_____OS:_____OU:_____ • PERRLA: intact Bilaterally ☐Non intact☐ • Skin : Sensations: Superficial: +Ve☐ –V ☐ ○ Deep Pressure: +Ve☐ –V ☐ ○ 2 Point discrimination: +Ve☐ –V ☐

8. Self-Perception and Self-concept pattern

Subjective	Objective
What do you feel differently about yourself? _____ Perception of abilities:_____ Things frequently make you angry ,fearful or anxious :_____ _____	Appearance(dressing and Hygiene):_____ _____ Mood(expression): Nervous ____ relaxed ____ _____ Speech: Pace of conversation: Appropriate☐ inappropriate☐ Tone of voice: Appropriate to the situations☐ Inappropriate to situations☐

9. Role and relationship

Discharge Arrangements and Other Social Details

Subjective	Objective
Role in family:_____ Responsibility: _____ Work role:_____ Social role:_____ Level of satisfaction:_____	**Communication between family members:**___ _____ _____ **Family visits:** Yes☐ No☐ ☐ Yes No ☐ Comments: _____ ☐ Yes No ☐ Comments: _____

Effect of illness on roles:_____ Lives alone? Employee? Self-employee? Ability to pay: ☐ Yes☐No Comments:_____	☐ Yes No ☐ Comments: _____

10. Coping and stress tolerance pattern

Subjective	
Any big change that can Cause Stressor:_____ _____ Coping methods: _____ _____ Support system: _____	

11. Value and belief

Subjective	
• Cultural practice :Yes ☐ No☐ • Religious practice Yes ☐ No ☐ • Familial traditions (yes ☐ no ☐) • Would you like your religious leader to be contacted? Yes ☐ No ☐	

Additional information: Clinical Data

S.№	Date	Investigations/procedures	Specimen	Result	Reference value

Summary of subjective and objective data	
Summary subjective data	**Summary objective data**

Signature and initial of admitting nurse: _____ **Date:**_____

Date :_____

Nursing Problem Index List

Please Complete or Affix Label

Name:_____ Father Name: _____

Address: City:_____ Sub city: _____

Kebele:_____ House No: _____

MRN:_____ Age:_____ Tel. No.:_____

Hospital_____

Ward:_____

Bed No.: _____

Date Identified & Time	Problem No	Problem/Nursing Diagnosis	Signature & Designation	Date Resolved & Time	Signature & Designation

Nursing Care Plan

Please Complete or Affix Label

Hospital_____

Name:_____ Father Name: _____

Ward:_____

Address: City:_____ Sub city: _____

Kebele:_____ House No: _____

MRN:_____ Age:_____ Tel. No.:_____

Bed No.: _____

Date and Time	Prioritized Problem No	Goals	Expected outcomes	Instructions	Signature & Initial

Implementation			
Full name_____ Age __ Sex____ MRN:_____ Tel. No.: _____ Ward: _____ Bed No.:_____			
Date Identified and Time	**Problem No**	**Implementations**	**Signature and Designation**

Progress Note (SOAP)

Progress Report No: _____ Shift: Morning ☐ Afternoon ☐ Night ☐
Date: _____ Time: _____ Signature: _____

Evaluation Judgment: _____
Subjective Data: _____

_ _____

Objective Data: _____

_ _____

Analysis/Assessment: _____ _____

_____

Plan:____ _____

_ _____

Progress Report No: _____ Shift: Morning ☐ Afternoon ☐ Night ☐
Date: _____ Time: _____ Signature: _____

Evaluation Judgment: _____
Subjective Data: _____

_ _____

Objective Data: _____

_ _____

Analysis/Assessment: _____ _____

_____

Plan:____ _____

_ _____

Progress Report No: _____ Shift: Morning ☐ Afternoon ☐ Night ☐
Date: _____ Time: _____ Signature: _____

Evaluation Judgment: _____
Subjective Data: _____

_ _____

Objective Data: _____

_ _____

Analysis/Assessment: _____ _____

_____

Plan:____ _____

Annex 7. Trainee assessment check list. Blood pressure

S.N	TASKS The trainee	SCORE	
		Yes	No
1	Prepared setting for measurement that was quiet and free of interruptions.		
2	Asked patient about eating, drinking caffeine, smoking or exercising 30 minutes before measurement. Measurement was delayed if there were any "Yes" answers.		
3	Seated patient with feet flat on floor, back supported for a period of rest.		
4	Positioned patient's bared arm on a hard surface, with midpoint of upper arm at level of heart.		
5	Used appropriate cuff size, determined by measuring patient's arm using 80/40 rule.		
6	Located brachial artery by palpation.		
7	Centered bladder of the cuff over brachial artery.		
8	Wrapped cuff smoothly and snugly around patient's arm, with the lower edge one inch above bend in elbow.		
9	Placed aneroid dial at eye level and easily visible.		
10	Checked cuff tubing for obstruction.		
11	Placed first and second fingers firmly over patient's radial pulse.		
12	Inflated cuff to approximately 70 mm Hg.		
13	Inflated cuff at 10 mm Hg increments until the patient's pulse disappears.		
14	Deflated cuff completely.		
15	Waited 15 seconds before continuing with technique.		
16	Placed earpieces in ears so they were angled forward.		
17	Placed stethoscope head in bell position.		
18	Placed bell side of stethoscope over brachial artery.		
19	Inflated cuff quickly to a level 20–30 mm Hg over palpate estimate.		
20	Deflated cuff at a steady rate of 2–3 mm Hg/second.		
21	Obtained systolic (Phase 1) and diastolic (Phase 5, or 4 if no Phase 5) blood pressure.		

21	Deflated cuff at least an additional 10 mm Hg after Phase 4, then quickly deflated completely.		
22	Recorded systolic and diastolic blood pressure.		
23	Recorded cuff size, arm used and patient's position (if not seated).		
24	Waited one to two minutes before recheck.		
25	Waited one to two minutes before recheck.		
26	Recorded both measurements.		
27	Performed measurement on same arm as previous measurement.		
28	Explained measurements to patient and discussed recommended follow-up.		

Annex 8. Competency Checklist for Radial Pulse

S.N	**Did the trainee**	**Yes**	**No**
1	Gather Equipment/Supplies: Gather Equipment/Supplies: □□Watch with second hand □□Gloves		
2	Perform hand hygiene and don gloves.		
3	Select the appropriate peripheral site based on assessment data and move the patient's clothing to expose only the site chosen.		
4	Place your first, second, and third fingers over the artery. Lightly compress the artery so pulsations can be felt and counted		
5	Using a watch with a second hand, count the number of pulsations felt for 30 seconds. Multiply this number by 2 to calculate the rate for 1 minute.		
6	If the rate, rhythm, or amplitude of the pulse is abnormal in any way, palpate and count the pulse for 1 minute.		
7	Note the rhythm and amplitude of the pulse.		
8	When measurement is completed cover the patient and help him or her to a position of comfort		

Annex 9. Competency Checklist for body temperature

	Did the trainee	**Yes**	**No**
1	Select appropriate site and thermometer type. "Zeroes" or shakes down glass thermometer as needed.		
2	Insert thermometer in sheath or uses thermometer designated only for the patient.		
3	**Insert in chosen route/site.** a. ***Oral*****:** Place thermometer tip under the tongue in the posterior sublingual pocket (right or left of frenulum). Asks patient to keep lips closed. b**.** ***Rectal*****:** Lubricate thermometer; uses rectal thermometer; inserts 1 to 1.5 inches (2.5–3.7 cm) in an adult; 0.9 inches (2.5 cm) for a child, and 0.5 inch (1.5 cm) for infant. c. ***Axillary*****:** Dries axilla; Place thermometer tip in the middle of the axilla; lowers patient's arm. d. ***Tympanic membrane***: Position the patient's head to one side and straighten the ear canal. 1) For an adult, pulls the pinna up and back. 2) For a child, pull the pinna down and back		
4	Leave glass thermometer recommended time (oral 3–5 min, rectal 2 min, axillary 6–8 min).		
5	Hold rectal thermometer securely in places; does not leave patient unattended		
6	Leave electronic thermometer until it beeps.		
7	Read temperature. Holds glass thermometer at eye level to read.		
8	Shake down (as needed) and cleans or stores thermometer.		

ANNEX-10 Competency Checklist for assessment of respiration

S.N	Trainee did	Yes	No
1	Place your hand over client's wrist and observe one complete respiratory cycle.		
2	Start to count with first inspiration while looking at second hand sweep of watch. • Infants and children: count a full minute. • Adults: count for 30 seconds and multiply by 2. If an irregular rate or rhythm is present, count for a full minute.		
3	Observe depth of respirations by degree of chest wall movement and rhythm of cycle (regular or interrupted).		
4	Replace client's gown.		
5	Record rate and character of respirations.		

ANNEX 11. NANDA-APPROVED NURSING DIAGNOSES 2015-2017

Indicates new diagnosis for 2015-2017—25 total

Indicates revised diagnosis for 2015-2017- 14 total

(Retired Diagnoses at bottom of list—7 total)

1. Activity Intolerance
2. Activity Intolerance, Risk for
3. Activity Planning, Ineffective
4. Activity Planning, Risk for Ineffective
5. Adaptive Capacity, Decreased Intracranial
6. Airway Clearance, Ineffective
7. Allergy Response, Risk for
8. Anxiety
9. Aspiration, Risk for
10. Attachment, Risk for Impaired
11. Autonomic Dysreflexia
12. Autonomic Dysreflexia, Risk for
13. Behavior, Disorganized Infant
14. Behavior, Readiness for Enhanced Organized Infant
15. Behavior, Risk for Disorganized Infant
16. Bleeding, Risk for
17. Blood Glucose Level, Risk for Unstable
18. Body Image, Disturbed
19. Body Temperature, Risk for Imbalanced
20. Breastfeeding, Readiness for enhanced
21. Breastfeeding, Ineffective
22. Breastfeeding, Interrupted
23. Breast Milk, Insufficient
24. Breathing Pattern, Ineffective
25. Cardiac Output, Decreased
26. Cardiac Output, Risk for Decreased

27. Cardiovascular Function, Risk for Impaired
28. Childbearing Process, Ineffective
29. Childbearing Process, Readiness for Enhanced
30. Childbearing Process, Risk for Ineffective
31. Comfort, Impaired
32. Comfort, Readiness for Enhanced
33. Communication, Readiness for Enhanced
34. Confusion, Acute
35. Confusion, Chronic
36. Confusion, Risk for Acute
37. Constipation
38. Constipation, Perceived
39. Constipation, Risk for
40. Constipation, Chronic Functional
41. Constipation, Risk for Chronic Functional
42. Contamination
43. Contamination, Risk for
44. Coping, Compromised Family
45. Coping, Defensive
46. Coping, Disabled Family
47. Coping, Ineffective
48. Coping, Ineffective Community
49. Coping, Readiness for Enhanced
50. Coping, Readiness for Enhanced Community
51. Coping, Readiness for Enhanced Family
52. Death Anxiety
53. Decision-Making, Readiness for Enhanced
54. Decisional Conflict
55. Denial, Ineffective
56. Dentition, Impaired

57. Development, Risk for Delayed
58. Diarrhea
59. Disuse Syndrome, Risk for
60. Diversional Activity, Deficient
61. Dry Eye, Risk for
62. Electrolyte Imbalance, Risk for
63. Elimination, Impaired Urinary
64. Elimination, Readiness for Enhanced Urinary
65. Emancipated Decision Making, Impaired
66. Emancipated Decision Making, Readiness for Enhanced
67. Emancipated Decision Making, Risk for Impaired
68. Emotional Control, Labile
69. Falls, Risk for
70. Family Processes, Dysfunctional
71. Family Processes, Interrupted
72. Family Processes, Readiness for Enhanced
73. Fatigue
74. Fear
75. Feeding Pattern, Ineffective Infant
76. Fluid Balance, Readiness for Enhanced
77. Fluid Volume, Deficient
78. Fluid Volume, Excess
79. Fluid Volume, Risk for Deficient
80. Fluid Volume, Risk for Imbalanced
81. Frail Elderly Syndrome
82. Frail Elderly Syndrome, Risk for
83. Gas Exchange, Impaired
84. Gastrointestinal Motility, Dysfunctional
85. Gastrointestinal Motility, Risk for Dysfunctional
86. Gastrointestinal Perfusion, Risk for Ineffective

133. Mobility, Impaired Wheelchair
134. Mood Regulation, Impaired
135. Moral Distress
136. Nausea
137. Noncompliance
138. Nutrition, Imbalanced: Less than Body Requirements
139. Nutrition, Readiness for Enhanced
140. Obesity
141. Oral Mucous Membrane, Impaired
142. Oral Mucous Membrane, Risk for Impaired
143. Other-Directed Violence, Risk for
144. Overweight
145. Overweight, Risk for
146. Pain, Acute
147. Pain, Chronic
148. Pain, Labor
149. Pain Syndrome, Chronic
150. Parenting, Impaired
151. Parenting, Readiness for Enhanced
152. Parenting, Risk for Impaired
153. Peripheral Neurovascular Dysfunction, Risk for
154. Personal Identity, Disturbed
155. Personal Identity, Risk for Disturbed
156. Poisoning, Risk for
157. Post-Trauma Syndrome
158. Post-Trauma Syndrome, Risk for
159. Power, Readiness for Enhanced
160. Powerlessness
161. Powerlessness, Risk for
162. Pressure Ulcer, Risk for

163. Protection, Ineffective
164. Rape-Trauma Syndrome
165. Reaction to Iodinated Contrast Media, Risk for
166. Relationship, Ineffective
167. Relationship, Risk for Ineffective
168. Relationship, Readiness for Enhanced
169. Religiosity, Impaired
170. Religiosity, Readiness for Enhanced
171. Religiosity, Risk for Impaired
172. Relocation Stress Syndrome
173. Relocation Stress Syndrome, Risk for
174. Renal Perfusion, Risk for Ineffective
175. Resilience, Impaired
176. Resilience, Readiness for Enhanced
177. Resilience, Risk for Impaired
178. Role Conflict, Parental
179. Role Performance, Ineffective
180. Role Strain, Caregiver
181. Role Strain, Risk for Caregiver
182. Self-Care, Readiness for Enhanced
183. Self-Care Deficit, Bathing
184. Self-Care Deficit, Dressing
185. Self-Care Deficit, Feeding
186. Self-Care Deficit, Toileting
187. Self-Concept, Readiness for Enhanced
188. Self-Directed Violence, Risk For
189. Self-Esteem, Chronic Low
190. Self-Esteem, Risk for Chronic Low
191. Self-Esteem, Situational Low
192. Self-Esteem, Risk for Situational Low

193. Self-Mutilation
194. Self-Mutilation, Risk for
195. Self-Neglect
196. Sexual Dysfunction
197. Sexuality Pattern, Ineffective
198. Shock, Risk for
199. Sitting, Impaired
200. Skin Integrity, Impaired
201. Skin Integrity, Risk for Impaired
202. Sleep, Readiness for Enhanced
203. Sleep Deprivation
204. Sleep Pattern, Disturbed
205. Social Interaction, Impaired
206. Social Isolation
207. Sorrow, Chronic
208. Spiritual Distress
209. Spiritual Distress, Risk for
210. Spiritual Well-Being, Readiness for Enhanced
211. Spontaneous Ventilation, Impaired
212. Standing, Impaired
213. Stress Overload
214. Sudden Infant Death Syndrome, Risk for
215. Suffocation, Risk for
216. Suicide, Risk for
217. Surgical Recovery, Delayed
218. Surgical Recovery, Risk for Delayed
219. Swallowing, Impaired
220. Thermoregulation, Ineffective
221. Tissue Integrity, Impaired
222. Tissue Integrity, Risk for Impaired

223. Tissue Perfusion, Ineffective Peripheral

224. Tissue Perfusion, Risk for Ineffective Peripheral

225. Tissue Perfusion, Risk for Decreased Cardiac

226. Tissue Perfusion, Risk for Ineffective Cerebral

227. Transfer Ability, Impaired

228. Trauma, Risk for

229. Vascular Trauma, Risk for

230. Unilateral Neglect

231. Urinary Retention

232. Ventilatory Weaning Response, Dysfunctional

233. Verbal Communication, Impaired

234. Walking, Impaired

235. Wandering

RETIRED DIAGNOSES

Energy Field, Disturbed

Failure to Thrive, Adult

Immunization Status, Readiness for Enhanced

Nutrition, Imbalanced: More than Body Requirements

Nutrition, Risk for Imbalanced: More than Body Requirements

Environmental Interpretation Syndrome, Impaired

Growth and Development, Delayed

ANNEX 12. SAMPLE NURSING PROCESS

ON A PATIENT WITH FIBULAR FRACTURE SECONDARY TO CAR ACCIDENT

1. PT IDENTIFICATION

Name: **Mengistu**	Father Name: **Zenebe**
Address:- City: **Debrebirhan**	Sub city: Kebele: **Bakelo** House no. -
MRN: 004567	Age: **43yrs** Tel.No.:
Ward: **Surgical ward**	Bed No**.: 7**
Medical Dx : Fibular # secondary to car accident	Nationality: **Ethiopian**
Ethnic group: **Amhara** Language: Amharic	Religion: **orthodox** Occupation: **farmer**
Marital Status**: Married**	

2. SUMMARY OF SUBJECTIVE AND OBJECTIVE DATA

SUBJECTIVE DATA		**OBJECTIVE DATA**
The client verbalized pain in response to movement of the Rt leg, consumption of food low in fiber(white bread, egg, milk products, pasta and white rice) evacuation of scanty amount of hard stool every other day (usual bowel habit was once in a day) and inability to bath and go to toilet by himself.		• V/S=To=36.5Oc,BP=100/70mmHg,PR=82bpm RR=20/min • Bowel sound=2/min(hypoactive) • Limited ROM in the Rt leg • Visible wound of 5cm in width and 12cm in length on the right leg. • Visible devitalized tissues around the wound • Observed that he was un able to wash and dry his body, unable to go, sit on and rise from toilet

3. NURSING DIAGNOSES

S. N	PROBDLEM (NURSING DIAGNOSES)
1	ACUTE PAIN related to physical injury to the bone and soft tissue as evidenced by patient's verbalization of pain on the right leg.
2	CONSTIPATION related to consumption of diet low in fiber, low fluid intake and confinement to bed as evidenced by patient's verbalization of evacuation of scanty hard stool less frequent than the usual(qod)
3	BATHING SELF CARE DEFICIT related to immobility and weight bearing limitation as evidenced by in ability to gather supply for bath ,wash and dry his body .
4	TOILETING SELF CARE DEFICIT related to immobility and weight bearing limitation as evidenced by in ability to go to toilet, sit on or rise from toilet .
5	IMPAIRED SKIN INTEGRITY related to physical injury to the soft tissue as manifested by visible wound of 5cm in width and 12cmin length on the right leg
6	RISK FOR INFECTION related to loss of skin barrier and disruption of bone unity
S. N	PROBLEM (NURSING DIAGNOSES)
1	ACUTE PAIN related to physical injury to the bone and soft tissue as evidenced by patient's verbalization of pain on the right leg.
2	CONSTIPATION related to consumption of diet low in fiber, low fluid intake and confinement to bed as evidenced by patient's verbalization of evacuation of scanty hard stool less frequent than the usual(qod)
3	BATHING SELF CARE DEFICIT related to immobility and weight bearing limitation as evidenced by in ability to gather supply for bath, wash and dry his body.

4. NURSING CARE PLAN

S.N	GOAL	EXPECTED OUTCOMES	INTERVENTIONS/INSTRACTIONS
1	The client will be relieved from pain	1.1 Ato Mengesha will verbalize relief from pain 1hr after administering analgesic as after consulting physician	1.1 Administer parenteral analgesics after consulting the physician
2	The client will achieve normal bowel elimination	2.1 Ato Mengesha will report temporary relief from constipation 30 min after administering oil enema 2.2 The client will describe different food items and amount of fluid consumed every day to combat constipation an hour after counseling session 2.3 Ato Mengesha will consume food rich in fiber and more than 2liters of oral fluid per day beginning from December 20,2011. 2.3 Ato Mengesha will verbalize return of usual bowel evacuation (QD) from December 23, 2011 onwards.	2.1 Administer oil enema with 300ml of olive oil every day until normal bowl elimination returns. 2.2 Counsel the client about consuming diet with high fibers(vegetables, fruits and beans) , high fluid intake on a daily basis. 2.3 Monitor bowel elimination pattern daily by asking the patient about frequency of bowel habit, consistency of the stool and auscultation of bowl sound.
3	The client will demonstrate performance of ADL (self care)	3.1 The client will perform toileting and bathing everyday with assistance 3.2 The client will ambulate after a month without	3.1 Offer bed pan to the patient as soon as his/her urge to defecation comes 3.2, 4.3 encourage and assist the client with isometric exercise of the lower extremities 3 times a day.

		assistance . 3.3 The client will perform toileting and bathing being unassisted after a month	3.3 Ambulate patient the length of the hall using the walker 3 times a day 3.4 Monitor ability to use walker appropriately and record response daily on flow sheet.
4	The client's skin will restore normal integrity	The client will attain normal skin texture ,color and intactness a month later	4.1 advise the client about consumption of diet rich in protein, vitamin C
5	Infection will be prevented	5.1 The client's wound will remain free from signs of infection(foul smelling, pus from the site ,Temperature below 37.5 oc) throughout his hospital stay	5.1.1 Clean the wound using aseptic technique with antiseptic solutions QD. 5.1.2 administer topical and parenteral antibiotics as prescribed 5.1.3 remove devitalized tissue with scalpel