FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA
MINISTRY OF HEALTH

Nursing Care Practice Standards

A Reference Manual for Nurses and Healthcare Managers in Ethiopia

Version 2.0

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Version 2.0

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CPD Continuing Professional Development
EHRIG Ethiopian Hospital Reform Implementation Guidelines
EHMI Ethiopian Hospital Management Initiative
ENA Ethiopian Nurses Association
FMHACA Food, Medicine, Healthcare Administration Control Authority
FMOE Federal Ministry of Education
FMOH Federal Ministry of Health
GBs Governing Boards
HIV/AIDS Human immunodeficiency virus (HIV) is a lentivirus (a member of the retrovirus family) that causes acquired immunodeficiency syndrome (AIDS), a condition in humans in which the immune system begins to fail, leading to life-threatening opportunistic infections.
HIV/AIDS Human immunodeficiency virus (HIV) /acquired immunodeficiency syndrome (AIDS)
NNTWG National Nursing Technical Working Group
Student nurse a person undergoing education or training in basic nursing.
TB Tuberculosis
TOT Training of Trainers

Acknowledgement

This reference manual is an update on the first version published in May 2010 and has been developed for practicing nurses and managers, nursing students, as well as, lecturers/instructors/tutors/teachers of nursing educational institutions. For the latter group, it can be adapted to the needs of the nursing students to ensure they are equipped with the required level of knowledge and competency to implement the nursing process when caring for patients in health care facilities both during clinical placements and following registration/licensing as nursing graduates.

working with;l second edition of Ethiopian Hospital Reform Implementation Guidelines (EHRIG) for **Nursing Care Practice Standards' Reference Manual** is the product of a collaborative effort between the Medical Services Directorate (MSD) of the Federal Ministry of Ministry (FMOH), I-CAP Ethiopia ,Clinton Health Access Initiative (CHAI) Ethiopia Hospital Management Initiative (EHMI), I-TECH Ethiopia, , Ethiopian Nurses Association(ENA), Addis Ababa University (AAU) School of Nursing. Furthermore, our sincere thanks go to all partners in Ethiopia for their useful suggestions that have enriched this manual.

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SECTION 1 OVERVIEW

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[1]. 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 the following common attributes:

- caring for, supporting and comforting clients;
- continuously assessing and monitoring health needs and responses to
- interventions;
- advocacy and education of clients and communities;
- identifying care gaps and developing appropriate responses;
- delivering and coordinating health services across the care spectrum[2]

Nursing practice covers assessment, diagnosis, planning, implementation and evaluation in:

a) The promotion and maintenance of health,
b) The management of illness, injury or infirmity, and
c) The restoration of optimal function, or palliative care.

Nursing care practice also includes education and research in relation to the above activities. Good professional nursing care ensures that patients:

• receive high quality, safe and effective care delivered by competent nurses,
• are treated as a person – with respect, honesty and dignity,
• are safe and comfortable – confident in the care environment, and
• are informed and have a say in the care they receive.

This nursing care practice reference manual also contains the published national hospital reform implementation guidelines (EHRIG) with nursing practice standards, which all hospitals should fully implement to ensure patients receive evidence based nursing care services.

The content of the manual have been pre-tested and piloted in Amhara, Oromia and Tigray with specific emphasis on the basic principles of evidence based nursing services' provision using the nursing process. The manual, which is in five main parts, contains both sub overview section and implementation guidance in each of the sections. The appendices and source documents also provide additional information, implementation tools and sample nursing documentation forms.

Goal and Objectives

The overall goal of this reference manual is to provide all information needed for trainers/facilitators to conduct the nursing care practice course in a logical manner, as well as, a guide for practicing nurses. The objectives of the reference manual are:

1. To serve as the "text" for the participants and the "reference source" for the facilitator without the need for special handouts or supplementary material.
2. To provide information to both trainers and participants/ practitioners that is consistent with the course goals and objectives; i.e. its an integral part of all classroom exercises-such as giving an illustrated lecture or providing problem-solving information.

Roles and Responsibilities of stakeholders

The training of trainers and nurses at facility level and subsequent implementation of the NHRIG for nursing care practice will require concerted efforts by all stakeholders at various levels of the health sector in Ethiopia, including federal, regional, Woreda and health facility levels.

Federal Level

- Provide guidance, leadership and ensure necessary resource mobilization and allocation.
- Develop an overall nursing strategy for planning, resource mobilization and allocation, implementation, and monitoring and evaluation of the nursing contribution to health and healthcare.
- Provide capacity building programs to implementing regional health bureaus and federal health facilities.
- Create partnership networks with and coordinate key partners and stakeholders in strengthening the nursing contribution.
- Provide sample systems and processes (as well as tools and detail guidance) and support to aid implementation of the NHRIG.
- Ensure the provision of evidence based nursing care through effective application of the NHRIG.
- Monitor and evaluate the overall implementation of NHRIG at national level

Regional Level

- Provide capacity building programs to implementing health facilities.
- Provide guidance, leadership and ensure resource mobilization and allocation
- Adapt national relevant strategies/policies to regional context.
- Create regional partnership networks with and coordinate key partners and stakeholders in strengthening the nursing contribution.

- Ensure implementation resources (as well as TOT and practitioners) are in place to promote evidence based nursing care provision using the nursing process.
- Actively support health facilities, monitor and evaluate the implementation of NHRIG at facility level.
- Document and disseminate best practices in nursing care and lessons learned from NHRIG implementation.

Hospital/Health Facility Level

- Identify partners and support the implementation of NHRIG for nursing care.
- Provide capacity building programmes to implementing case team nurses.
- Mobilize community, regional and health facility resources to support capacity building programmes and subsequent implementation of NHRIG for nursing care.
- Participate in regional/national capacity building programmes, monitoring and evaluation and reporting on the nursing contribution to health and health care.

SECTION 2. MODULE 1: STANDARDISING NURSING CARE PRACTICE IN ETHIOPIA

2.1 An Overview of the nursing function

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.

2.2 Operational standards of Nursing Care Practice

The operational standards below have been extracted from the *National Hospital Reform Implementation Guidelines* document, which all hospitals should fully implement to ensure proper nursing care.

1. The Hospital has established management structures and job descriptions that detail the roles and responsibilities of each nursing professional, including reporting relationships.

2. The hospital has a nursing workforce plan that addresses nurse staffing requirements and sets minimum nurse to patient ratios in each service area.

3. The hospital has written policies describing the responsibilities of nurses for the nursing process including the admission assessment, planning, implementation and evaluation of nursing care.

4. All admitted patients have a nursing care plan that describes holistic nursing interventions to address their needs. The plan is regularly reviewed and updated as required.

5. The Hospital has established guidelines for verbal and written communication about patient care that involves nurses, including verbal orders.

6. The Hospital has standardised procedures for the safe and proper administration of medications by nurses or designated clinical staff.

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.

7. Nurses adhere to and provide information on infection prevention practices to patients, clients, family members and other caregivers, as appropriate.

8. Hospitals have appropriate arrangements to ensure nurses access clinical supervision and support and participate in regular clinical audit and reviews of clinical services.

9. Nurses may not receive gifts, favours or hospitality of any kind from patients, caregivers, or visitors at any time including prior to or after the provision of care.

10. 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.

11. Nurses should work with others to protect and promote the health and wellbeing of those under their care.
12. Nurses must abide by published code of professional practice relevant to their professional role.

13. Nurses should take part in the ongoing continuing professional development (CPD) required by their professional body and maintain a CPD portfolio.

14. Nurses should be open and honest, act with integrity and uphold the reputation of their profession.

15. 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.

16. 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.

17. Nurses should seek verbal or written informed consent from their patients or their relatives/next of kin (for incompetent patients) before any procedure.

18. 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.

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

20. All nurses should be in full uniform as designated by hospital guidelines

2.3 Implementation Guidance

2.3.1 Job descriptions

Nurses play many roles within a hospital. They may work as part of inpatient, outpatient or emergency case teams; they may lead specialist clinics and may provide health education to patients and the community both within the hospital and at outreach sites. Given the different roles of nursing staff within a hospital it is essential that each hospital develops clear job descriptions for the various nursing posts which will guide nurses in their day to day work and form the basis for performance evaluation/appraisal of the nurse in his/her duties (see Section 3.8 of *Chapter 11 Human Resource Management*).

A job description should contain the following components:

1. **Job Title:**
The title of the position
2. **Reporting to:**
The position of the immediate supervisor to whom the post holder will report
3. **Department/Case Team:**
The department within which the position is located
4. **Employment type:**
Full-time, part-time, contract, consultancy, temporary position, or otherwise
5. **Job Summary:**
Provides a 2-3 sentence description of the job
6. **Essential Duties and Responsibilities:**
A detailed explanation of the position's task
7. **Supervisory responsibilities:**
Statement that outlines which staff will be supervised by the post holder, and the specific tasks associated with supervision (e.g. conduct PBE etc)

8. Educational Qualifications

The minimum educational requirement for the position

9. Certificates, Licenses, Registrations:

All minimum required credentials and equivalents should be outlined here.

10. Experience:

The minimum work experience required for the position

11. Other required skills

Any other required skills /competence. For example language skills, IT skills, mathematical or statistical skills; reasoning skills (such as ability to define problems, collect data, establish facts, and draw valid conclusions) planning and organization skills etc

12. Physical Demands:

If the position requires heavy lifting, high level of physical activity, or exposure to natural elements such as outdoors in weather conditions, it should be noted here.

13. Description of job site and work environment:

This contains specific information about the work environment, including a description of surrounding areas, building layout, and other information relevant to the work atmosphere including environmental hazards.

14. Occupational Exposure:

If the employee will be exposed to a known risk for an extended period of time, it should be noted on the job description.

15. Salary and Benefits:

The specific salary or salary range. This information may or may not be included in the job description. Instead, a hospital may use a job-grade system, which rates each job and assigns a job grade number that correlates to a wage range.

16. Employee Name and Signature Date:

A job description should be created for every position in the hospital. Template job descriptions may be available from the FMOH or Regional Health Bureaus (RHBs).

However, each hospital should adapt these job descriptions to reflect the hospital's needs and to define the responsibilities of the position. Job descriptions should be developed collaboratively with the Human Resources Department and head of the department/case team in which the position is located.

The job description should be explained to each new employee when he/she commences employment and he/she should sign the job description to indicate their understanding of and agreement with the duties and responsibilities therein. Two copies of the job description should be prepared. The first copy should be kept by the post holder and the second copy should be filed in his/her personnel file.

The job description should be kept under review and amended if the need arises, for example if duties or supervisory responsibilities are added to or removed from the post. At the time of Performance Based Evaluation (PBE), the employee and supervisor should consider whether the job description is still an accurate description of the post and should amend if necessary. If an employee is promoted or transferred to another

position then a new job description should be signed for the new position. The date on the new job description will indicate the date at which the employee changed position.

Sample for Laboratory Technologist Job Description :

Job Title: Laboratory Technologist
Department: Laboratory
Reporting to: Laboratory Head
Employment type: Full time, regular employee (following completion of probation period)
Education required: BSC Laboratory Technology
Job Summary: Conduct laboratory tests, prepare and report results, prepare laboratory reagents, conduct quality assurance activities to ensure accuracy of laboratory results.
Key responsibilities:
1. Collects samples (blood, urine, excrement, sputum and other samples)
2. Conducts required tests, records results and informs requesting department of the results
3. Manages laboratory chemicals (ensuring proper usage, non-expiry of their usage period, timely re-stocking).
4. Makes timely requests for lab materials and chemicals, and shall keep same with care and economization.
5. Ensures that the containers for handling and collecting samples are clean, properly sterilized and free from contamination.
6. Shall inform his/her immediate supervisor of any defect in materials in a timely manner.
7. Shall make exchange of experience with the relevant experts/professionals as regards to work performance.
8. Ensures proper placement of lab materials at suitable places.
9. Participates in trainings and skill development related to laboratory work
10. Ensures proper storage and use of equipment and supplies
Supervisory responsibilities: Nil
Evaluation criteria: Performance Based Evaluation will be conducted prior to the end of the probation period and annually thereafter. Evaluation will be conducted to assess your performance in relation to the duties described in this job description.

Name _____

Signature_____

Position_____

Date Month Year_____

2.3.2 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 care givers
- work with colleagues in the 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 referrals, including provisions for continuity of care, as appropriate
- collaborate with other disciplines in teaching, consultation, management, and research activities as opportunities arise

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.

2.3.3 Clinical Supervision and Delegation

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 consumer protection and safety of care in complex clinical situations". In all work settings nurses should receive adequate support and supervision to ensure that they have the opportunity to gain professional knowledge and expand their skills (see appendix A: sample guidelines for hospital nurses in Ethiopia).

Delegation

Nurses may delegate nursing procedures to junior nurses/health assistants and/or to student nurses. Before delegating the nurse must ensure that anyone they delegate to is able to carry out the instructions, and the nurse must provide adequate supervision to ensure that the outcome of any delegated task meets required standards. The delegation of nursing care must be appropriate, safe and in the best interests of the person in the care of a nurse. Prior to agreeing to delegation, the nurse has the responsibility to understand this advice.

Failure to follow the provision of this advice may bring the nurse's fitness to practise into question. However, the decision to delegate would be judged against what could be reasonably expected from someone with their knowledge, skills and abilities when placed in those particular circumstances. The United Kingdom Nursing and Midwifery Council's Code: standards for conduct, performance and ethics for nurses and midwives, states nurses must:

• establish that anyone they delegate to is able to carry out your instructions
• confirm that the outcome of any delegated task meets the required standards
• make sure that everyone they are responsible for is supervised and supported

This advice provides a set of principles for nurses and midwives when delegating to others (this may also include delegation to carers and relatives but in general terms the employer would not have vicarious responsibility for non-employees). The principles in this advice should be adhered to with clear lines of accountability and responsibility identified and agreed.

The nurse, when delegating, is authorizing that person to perform aspects of care normally within the nurse scope of practice.

Principles of delegation:

- The delegation of nursing care must always take place in the best interests of the person the nurse or midwife is caring for and the decision to delegate must always be based on an assessment of their individual needs.
- Nurse Midwives should not delegate their statutory midwifery duties e.g. attending women in childbirth. Where a nurse midwife has authority to delegate tasks to another, they will retain responsibility and accountability for that delegation.
- A nurse may only delegate an aspect of care to a person whom they deem competent to perform the task and they should assure themselves that the person to whom they have delegated fully understands the nature of the delegated task and what is required of them.
- Where another, such as a Case Team Director/Leader, has the authority to delegate an aspect of care, the Case Team Director/Leader becomes accountable for that delegation. The nurse will however continue to carry responsibility to intervene if she feels that the proposed delegation is inappropriate or unsafe.
- The decision whether or not to delegate an aspect of care and to transfer and/or to rescind delegation is the sole responsibility of the nurse and is based on their professional judgment.
- The nurse has the right to refuse to delegate if they believe that it would be unsafe to do so or if they are unable to provide or ensure adequate supervision.

- Those delegating care, and those employees undertaking delegated duties, should do so in accordance with robust local employment practice, to protect the public and support safe practice.
- The decision to delegate is either made by the nurse or senior person in authority and it is the decision maker who is accountable for it.
- Healthcare can sometimes be unpredictable. It is important that the person, to whom an aspect of care is being delegated, understands their limitations and when not to proceed should the circumstances within which the task has been delegated change.

Accountability

A nurse who delegates aspects of care to others remains accountable for the appropriateness of that delegation and for providing the appropriate level of supervision in order to ensure competence to carry out the delegated task. The nurse remains accountable for the delivery of the care plan and for ensuring that the overall objectives for that patient are achieved.

Responsibility

An aspect of care may be delegated to a person who the nurse judges as having the competence to undertake it. If the person to whom the task is delegated is in employment it is the employer's responsibility to ensure that they have sufficient education and training to competently undertake the aspects of care which a nurse or midwife is expected to delegate to them. If, in any particular case, the nurse or the person to whom the nurse might delegate an aspect of care does not think that the latter is competent to undertake the task, then they should not delegate it. Having delegated an aspect of care the person to whom it is delegated will be responsible to their line manager for the performance of the task. The nurse delegating an aspect of care has a continuing responsibility to judge the appropriateness of the delegation by:

• Reassessing the condition of the person in the care of the nurse at appropriate intervals and determining that it remains stable and predictable;

• Observing the competence of the caregiver(s) and determining that they remain competent to safely perform the delegated task of care safely and effectively and;
• Evaluating whether or not to continue delegation of the task.

Documentation
The assessment, planning and evaluation of the persons care must be documented. The nurse has a responsibility also to ensure that any aspect of care delegated has been documented appropriately. 'Registrants are required to use their professional judgement to decide what is relevant and what should be recorded' before delegation occurs, the nurse or midwife must have considered the following:

1 The condition of the person in their care
2 The competence of the recipient(s) of the delegation; there should be records to support and evidence this
3 How frequently the person in their care should be reassessed in relation to the continued delegation of the aspect of care
4 The ongoing support arrangements that will be provided to those undertaking delegated duties.
Documentation should clearly outline any decision-making processes and must be person specific. The most appropriate place to record this information should be decided based on the working environment i.e. patient records/care plans. At each delegation, the names of those being delegated to must be clearly stated. Nurses are accountable for ensuring continued assessment of the competence of those they are delegating to.

2.3.4 Nursing Workforce Plan

Shortages of appropriate nursing staff or inappropriate distribution of available staff adversely affects the quality of patient care. Inappropriate workforce planning has been shown to increase staff dissatisfaction and nurse turnover, increase patient mortality, increase hospital-acquired infections, and increase the risk of needle-stick injuries[18].

The hospital should establish a nursing workforce plan that:

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

Determining the minimum nurse staffing level is a complex process. Factors to be considered include:

- the severity of the clinical condition of patients,
- the intensity of nursing 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, and

- the availability of and responsibilities of patient care givers.

There should be a minimum of a registered professional nurse in-charge of each ward/unit who has a diploma or bachelor degree education and relevant knowledge, skills and experience to manage a ward/unit and the nursing staff therein. The nurse-in charge, together with hospital management should determine the minimum nurse to patient ratio for the unit. The ratio should be kept under review and amended as necessary.

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

2.3.5 Provision of Resources

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

2.3.6 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.

2.3.7 Standard IPC Precautions

Standard precautions are a set of recommendations to minimize the spread of infections in a health care setting. Healthcare workers should apply the principles of standard precautions with each encounter with a patient and consider every person, patient or staff, as potentially infectious or susceptible to infection.

Most HCAIs can be prevented through readily available and relatively inexpensive strategies. The elements of standard precautions include implementation of recommended practices regarding:

- Hand hygiene,
- Personal protective equipment,
- Safe work practices (such as safe injection practice, safe practice in the operating room),
- Safe house keeping,
- Disposal of health care waste management, and
- Processing of instruments and linens.

Hand Hygiene

Hand hygiene is one of the most important measures for infection prevention. Studies have shown that effective and consistent hand hygiene practice among hospital staff can significantly reduce the occurrence of HCAIs. Hand hygiene generally refers to hand washing, hand antisepsis (with alcohol based hand rub) and surgical hand scrub. Hand hygiene should be practiced by all healthcare providers before and after contact with a patient/client regardless of their health status. Steps of hand hygiene (hand washing and hand antisepsis) should be posted close to every sink and steps of surgical hand scrub near scrubbers' sink (See appendix A for a sample hand washing poster). To achieve the greatest compliance in hand hygiene ***all staff*** should be trained in proper hand hygiene techniques as part of infection prevention training program and hand hygiene facilities (such as functioning sinks, soap and water) should be in place in all patient care areas. The hospital should provide a consistent supply of clean water for all patient care areas. This can be achieved by short term provision of water using containers with improvised sinks (buckets with faucets fixed to it) and /or temporary storage tankers or long term provision of water from a reliable supply designed for the hospital.

The hospital should also provide plain soap, in the form of bar or liquid, antiseptic soap, and/or alcohol and glycerine (for preparation waterless antiseptic hand rub) for all patient care areas on a regular basis. If bar soap is used, provision of small bars and draining soap racks is recommended to prevent accumulation of contaminated liquid which harbours microorganisms. When the soap dispensers are reused they should be thoroughly cleaned before refilling; adding soap to a partially empty soap dispenser is not recommended as it

leads to bacterial contamination of the soap. The major and minor operation rooms should be provided with plain soap, antiseptic soap, 2-4% chlorohexidine and 7.5-10% povidone iodine, alcohol, non-contaminated glycerine, and nail cleaners/soft brushes for surgical hand scrubs.

In procedure areas, it is advisable to install faucets with foot controls or faucets that can be closed by elbow to minimize contamination after hand washing. Disposable paper towels should be placed close to the faucets for easy access after washing hands. If it is not possible to supply disposable towels, every health care provider should have a pair of personal towels for everyday use to dry hands after washing. These personal towels should be washed and dried every day. Using common towels should be avoided as this is associated with cross contamination.

In addition to staff training, the hospital should ensure that hand hygiene is included in the health education program given to patients and caregivers.

Personal Protective Equipment

Personal protective equipment (PPE) can be defined as "specialized clothing or equipment worn by an employee for protection against infectious materials."[1] PPE protects the healthcare worker by creating a barrier between the person and any potentially infectious substance. Personal protective equipment includes: gloves, gowns, aprons, masks/respirators, protective eyewear (face shield, goggles), caps, protective shoes.

Hospitals should make certain that there is a sufficient supply of all personal protective equipment for all hospital staff. Regular supply should be provided when there is increased demand or need for replacement of worn out items. The hospital should monitor staff use of all personal protective equipment to ensure consistent utilization.

The table below outlines the different types of personal protective equipment that are commonly used in a hospital setting.

Personal Protective Equipment: Types

Personal Protective Equipment	Type
Gloves	Heavy duty gloves
	Surgical gloves
	Examination gloves (latex or nitrile)
	Other types (ex. those worn by cleaning and laundry staff)
Protective Eyewear	Eye shield
	Goggle
	Visors
Masks	Dust mask
	Surgical
	Respirators

[1] CDC, *Guidance for the selection and use of personal protective equipment in healthcare settings.*

	Other type of face mask
Aprons	Plastic apron
	Other types
Protective shoes	Boots
	Nurse shoes
	Other protective shoes
Caps	
Face shield	

Each personal protective has a different use and application. Table 2 presents a summary of the types of PPE, when each should be worn and by whom.

Personal Protective Equipment: Uses

Type of PPE	Who should wear PPE?	What is Protected?	When PPE should be worn
Gloves Surgical (normal and elbow length) Examination Nitrile Latex Heavy duty	Medical, nursing staff (including students) Porters Runners/transitors Cleaning, laundry staff	Hands	When there is direct contact with exposed wounds, blood, body fluids, or any type of lesion. When drawing blood or handling medical instruments involved with invasive procedures (catheters, IV insertion, probes, etc.). During surgical procedures When handling waste items or others contaminated surface When cleaning patient areas.
Protective eyewear	Medical, nursing staff (including students) Porters Runners/transitors Cleaning, laundry staff as needed	Eyes	When splattering of blood or body fluids to the face is possible, When handling biohazardous, soiled linens, When performing waste collection for hazardous or non-hazardous waste.
Masks Surgical mask	Medical, nursing staff (including students) Porters Runners/transitors Cleaning, laundry staff as needed	Mouth, nose	To protect mucous membranes of mouth and nose when splattering of blood, body fluids, secretions or excretions is possible
Particulate respirators	Medical, nursing staff, cleaning staff entering isolation rooms	Mouth and nose	When entering the room of airborne infectious agents such as TB
Face shields	Medical, nursing staff (including students)	Face, mouth, nose and eyes	To protect mucous membranes of eyes when splattering of blood, body fluids, secretions or excretions is likely

Plastic aprons Gowns	Medical, nursing staff (including students) Porters Runners/transitors Cleaning, kitchen and laundry staff as needed	Skin, clothing	To protect skin and clothing when splattering of blood, body fluids, secretions or excretions is likely
Protective shoes	Medical, nursing staff (including students) Porters Runners/transitors Cleaning, kitchen and laundry staff as needed	Shoes	To protect feet when there is the likelihood of the splattering of blood, body fluids, secretions or excretions To protect from sharps injury
Caps	Medical, nursing staff (including students) Porters Runners/transitors Cleaning, kitchen and laundry staff as needed	Hair	To protect hair when there is the likelihood of the splattering of blood, body fluids, secretions or excretions To reduce spread of microorganisms from healthcare personnel to patient or food

SECTION 3: MODULE 2 - NURSING PROCESS PART 1

3.1 An Overview of the Nursing Process

The overall objective of this module is, on its successful completion, you will be able to effectively formulate and carry out the nursing process using the five steps process and in particular, you will be able to:

- Identify the five steps of assessment
- List at least four benefits of using the nursing process
- Discuss how the nursing process complements the medical process

3.1.1. Defining the Nursing Process

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

The nursing process is an organized and systematic process of giving goal oriented and humanistic nursing care that is both effective and efficient[3]. It is organized and systematic in that it consists of five sequential and interrelated steps- Assessment, Diagnosis, Planning, Implementation, and Evaluation- during which you perform deliberate activities designed to maximize long-term results[4 & 5]. Nursing Process is based on the assumption that professional nursing practice is interpersonal in nature. It is also assumed that 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.

The nursing process is the underlying scheme that provides order and direction to nursing care. It is the essence of professional nursing practice. It is the "tool" and methodology of the nursing profession and, as such, helps nurses in arriving at decisions and in predicting and evaluating consequences.

The nursing process was developed as a specific method for applying a scientific approach or a problem solving approach to nursing practice[6 & 7]. 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[8].

The nursing process also provides a means for evaluating the quality of nursing care given by nurses and assures their accountability and responsibility to the 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 behavioural sciences, and from the humanities, in order to provide a rationale for decision making, judgments, interpersonal relationships, and actions[9]. These concepts and theories provide the framework for nursing care.

The nursing process complements the medical process by focusing on how the person is responding to the medical problems, treatment plan, and changes in activities of daily living. By doing this, nurses ensure that interventions are tailored to the individual, not just the disease, increasing the likelihood that the interventions are tailored to the individual, not just the disease.

3.1.2. Benefits of the Nursing Process

- 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 thinking;
- Tailors interventions for the individual (not just the disease);
- Helps nurses to gain satisfaction of getting results.

3.1.3. Comparison of Nursing Process and Medical Process

Nursing Process	Medical Process
Deals with two types of health problems (1) Human response problems (2) Problems with structure and function of organs or systems requiring physicians' orders	Deals mostly with problems with structure and function of organs or systems
Uses the five step approach and provides strict rules for how each step is followed	Uses the five step approach but has less precise rules for how planning, implementation and evaluation are done- eg. Goals are not clearly recorded during planning
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.

3.1.4. Practice Session

- List the steps of the nursing Process

- List five advantages of using the nursing process- see 3.1.2 above.
- Explain how the nursing process complements the medical process – see 3.1.3 above.

3.2. Nursing Assessment

At the end of this step of the nursing process, you will be able to:

- Identify the four phases of Assessment
- List the resources used for data collection
- Describe how data is collected
- Discriminate between subjective and objective data
- Describe a method of organizing data that facilitates identifying information that should be reported to the physician.

Assessment is the first phase in the nursing process and includes

- Collection of data (Gathering information about the patient or client),
- Validating data (making sure your information is accurate),
- Organizing data (clustering facts into groups of information that help you identify patterns of health or illness),
- Reporting and Recording Data (Reporting and recording abnormalities to expedite treatment; recording assessment findings to communicate current status.

3.2.1. 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 Resources do you need to gather the data?

- Patient/client (primary source)
- Verbal and written consultations
- Family, significant others
- Records of diagnostic studies
- Nursing Records
- Relevant literature

How data is gathered?

1. Before you see the patient**-** Through reading records to familiarize yourself or asking the patient's

name, age, and sex.

2. When you see the patient- Interviewing, examine, and observation as you perform the nursing assessment.
3. After you see the patient- Review the resources and determine what other resources may offer additional information.

Types of Nursing Assessment

Comprehensive data collection includes two types of nursing assessments:

- Data Base Assessment- Performed on initial contact with the patient to gather information about all aspects of health status. This information also called baseline data, tells how the patient is today, before intervention begins.
- Focus Assessment- Performed to gather detailed information about the status of a specific condition.

Ways of Designing Assessment Tools

- The nursing model- e.g. the Functional health pattern; Change from medical model (disease oriented) to nursing model (holistic, human response oriented- Bio-psychosocial human being).

- The needs and problems commonly encountered on a specific unit- tool on maternity unit may differ from a tool used on adult health.

Identifying Subjective and Objective Data

Separating these two types of data aids critical thinking because each complements and clarifies the other. For example: skin color, vital signs and laboratory studies.

Subjective Data	Objective Data
Relates to what the patient states about their state of health, feelings or perceptions Examples: • I feel sick • I have stomach ache	Is what the examiner observes and measures Examples: • Pulse rate is 100, strong and regular • Distended abdomen

3.2.2. 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 suspect a problem. Example:

Subjective Data *Patient states, "I just started taking penicillin for a tooth abscess*

Objective Data *Fine rash over the trunk*

The above data give you cues that may lead you to infer (suspect) that the person is having an allergic reaction to penicillin. How you interpret or perceive a cue is called an inference. In this case you have made an inference about the rash and has interpreted as probably having a penicillin allergy. 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 moving my bowels"	Letti may be constipated
Haile is silent and withdrawn and has a bad face	Haile may be depressed
Tenagen B/P is 60/50	Tenagne is in Shock
Almaz sates, "I can't stand this pain anymore."	Almaz is experiencing unbearable pain

3.2.3. Validating Data

The purpose of validating, or verifying data is to make sure your information is factual and complete**.** You have to be sure that you have correctly identified all the cues, your inferences, or interpretations are correct. If you are not sure about the validity of your 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.

Guidelines 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").

3.2.4. Practice Session

Case history A- Part I- Subjective and objective Data

Ato Misganaw is 51 years old. He was admitted 2 days ago with chest pain. His physician has ordered the following studies: ECG, Chest X-ray, and complete blood studies including blood sugar. These studies were just posted on the chart. When you spoke to him, he said, "I feel much better today, no more pain. It is a relief to get rid of that discomfort." You think he appears a little tired or weary; he seems to be talking slowly and exhale noisily more often than you think is normal. He denies being weary. His vital signs are: T. 37 degree C. P. 74 (regular). R: 20 B/P 140/90 mmHg

1, List the subjective data noted in the case history given above.
2. List the objective data noted in the case history given above.

Case History B

Wro Hanna is a 33-year-old mother of two young children. She is admitted with the medical diagnosis of diabetes. Today you enter her room, and she states, "The doctor says I have diabetes. I can't see how I could have diabetes. No one in my family has diabetes. I feel fine. I don't see how I can make myself change the way I eat. Dieting drives me crazy. That's why I weighed 97 kg when you weighed me." On further questioning, she states, "I have been feeling unusually tired lately. You know, I have had to urinate a lot lately. Do you think there is anything wrong?" You check her chart and note that her fasting blood sugar was elevated at 144. Her vital signs are: T: 36.5

P.88 (regular) R: 24 and B/P: 144/88 mmHg

1. List the subjective data noted in the case history given above.
2. List the objective data noted in the case history given above.

Part II- Cues and Inferences

1. a. List the cues in Case History A (Ato Misgnaw)
   b. List the inferences you might make about the cues you have identified
2. a. List the cues in case History B. (Wro Hanna)

b. List the inferences you might make about the cues you have identified

Part III- Validating Data

1. A. From the cues and inferences that you identified in case history A (Ato Misganaw) indicate in the three separate columns those that you feel are certainly valid, probably valid, and only possibly valid.

Certainly valid **probably valid** **possibly valid**

B. For the data you list in the possibly valid and probably valid columns identify some methods of clarifying if they are indeed true. (e.g. other questions you ask).

2. A. From the cues and inferences that you identified in case history B (Wro Hanna) indicate the three separate columns those that you feel are certainly valid, probably valid, and only possibly valid.

Certainly valid **probably valid** **possibly valid**

B. For the data you list in the possibly valid and probably valid columns identify some methods of clarifying if they are indeed true. (e.g. other questions you ask).

3.2.5. Organizing (Clustering) Data

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

3.2.6. Reporting and Recording

The final activity of assessment is reporting and recording. Report abnormal data to expedite treatment and record assessment findings so that they will be communicated to others. Report anything you suspect might be abnormal to your instructor, preceptor or supervisor.

3.3 Nursing Diagnosis

Objectives:

- State the responsibilities of the nurse for nursing diagnoses, medical diagnoses and collaborative problems
- Write diagnostic statements for actual, high risk and possible nursing diagnoses and collaborative problems

During assessment, you gather, validate, organize data and finally you report abnormal data and record in the database. In Nursing Diagnosis, you further analyze and synthesize (put together) the information and come to some specific conclusions; you identify areas of positive functioning, areas where there may be risk of problems and areas that are problems.

3.3.1. Definition

Nursing diagnosis is a clinical judgment about an individual, family or community response to actual or potential health problems (Marriner-Thomey and Alligood, 2006). It provides the basis for selection of nursing intervention to achieve outcome for which the nurse is accountable. Nursing diagnoses are those problems for which nurses can legally prescribe definitive interventions independently.

3.3.2. Recognizing Collaborative Problems/Potential Complications

Involves recognizing when your patient's data indicate increasing problems with structure or function of organs or systems that requires nurse prescribed and physician prescribed interventions. Nurses share accountability for treating these problems with the physician.

The focus of nursing accountability for collaborative problems is three- folds.

- Detecting and reporting early signs and symptoms of potential complications requiring physician prescribed interventions
- Implementing Physician prescribed interventions; and
- Initiating interventions within the nursing domain to manage the problem. These could be detected with some knowledge of medical surgical or obstetrics and gynecology nursing.
  Ex. Potential complications: paralytic ileus related to back surgery.

  -Arrhythmia, stroke, congestive heart failure related to MI.

  Example- A chest tube and its potential complications (compromised respiratory function, bleeding, and malfunction of the chest tube). The definite intervention for chest tubes include nurse-prescribed interventions (monitoring respiratory function, promoting drainage by assisting the patient to turn and move, and preventing dependent loops in the tubing) and physician prescribed

interventions (inserting the tube, deciding how much suction to use, and deciding when to remove the tube).

Rule: If you need to write a diagnostic statement for collaborative problem, focus on the potential complications of the problem. Use "PC" for potential complications, followed by a colon and list the complications that might occur. For clarity, link the potential complications and the collaborative problem by using "related to." Ex. Pneumothorax related to fractured ribs.

Nursing Diagnosis	Collaborative Problems/Medical diagnosis
• Focuses on identifying and treating actual or potential unhealthy responses to diseases or life changes.	• Focuses on identifying problems with structure or function of organs or systems.
• Related signs and symptoms respond to nurse-prescribed interventions.	• Related signs and symptoms don't respond to nurse-prescribed interventions alone.
• Definitive diagnosis is validated by independent nursing assessment.	• Definitive diagnosis is validated by medical diagnostic studies.
• Nurses are responsible for: 1) early detection and diagnosis of the problems; 2) initiating an independent treatment plan to prevent, correct, or manage the problem;	• Nurses are responsible for: 1) early detection of signs and symptoms that may indicate the need for medical treatment; 2) notifying the physician of the signs and symptoms; 3) initiating actions within the nursing domain to prevent, correct, or manage the problem; 4) collaborating with the physician to initiate a comprehensive treatment plan to prevent, correct, or manage the problem.
• Identifies health problems from the patient's perspective;	• Identifies health problems from the perspective of medical science.

3.3.3. Rules for Writing Diagnostic Statements for 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.

*Example: Impaired communication **related to** language barrier **as evidenced by** inability to speak or understand English.*

2. For High Risk Nursing Diagnoses- Use a two-part statement, using "related to" to link the potential problem with the risk factors present.

*Example: High risk for impaired skin integrity **related to** obesity, excessive diaphoresis and confinement to bed.*

3. For Possible Diagnoses- list the suspected problem and the suspected cause, if known.

*Example: Possible altered sexuality patterns **related to** possible fear of transmitting the herpes Virus.*

Making Sure Nursing Diagnostic Statements will direct Nursing Interventions-

When you study the statement, it should answer the question, "What can I do about this problem?" The second part of the statement (related factors) directs interventions. If not possible, the problem directs the intervention.

Examples:

- **Right:** High Risk for Ineffective Airway Clearance related to **copious thick secretions.**
- **Wrong:** High Risk for Ineffective Airway clearance related to **Pneumonia.**

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 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***.**

3.3.4. Practice Session

Part I- The data presented in each clinical situation below matches one of the following diagnoses:

Powerlessness; Altered Nutrition: Less than body requirement: Ineffective Airway Clearance.

Study each case, choose the matching diagnosis, and write a three-part format diagnostic statement using the PRS (problem, related factor and s/s) format.

1. Ato Hailu demonstrated the following cues (signs and symptoms):

Subjective Data: *Asks for help clearing secretions; states he can clear airway with help from suction.*
Objective Data: *Copious secretions from tracheostomy tube.*

2. Sium demonstrates the following cues (Signs and Symptoms):

SD- *Reports that he's had no appetite for 2 weeks because of depression.*
OD- *Five-kilo weight loss since last visit; 7 kilos under recommended weight*

3. Senait demonstrates the following cues (Signs and Symptoms) **:**

SD- *Reports she's depressed and has no control over daily activities*
OD- *She is quadriplegic and has a rigorous schedule of daily physical therapy*

Part II- the data presented in each clinical situation below matches one of the following diagnoses

High risk for Ineffective Airway Clearance; Possible Ineffective Individual Coping; High Risk for Fluid Volume Deficit; Possible Sexual Dysfunction.

Study each situation, choose the matching diagnosis, and write a two-part statement, stating the problem and its cause:

1. Ato Nega has been confined to bed with casts on both his legs. He seems angry and has stated that he does not want to talk to anyone. You're aware that he's had a fight with his girlfriend.
2. Wro. Hanna has a temperature of 38.3 degree C. She sleeps a lot and has a poor appetite. She drinks about 2 L. a day if you offer frequent fluids and encourage her to drink.
3. Ato Dawit has just had his gallbladder removed today under general anesthesia. His nursing assessment form shows that he has smoked a pack of cigarettes a day for the past 20 years. He has a productive cough.

4. You see Wro. Letti in clinic 3 months after a hysterectomy and states that she feels well physically, but that emotionally she just doesn't feel like herself yet. She states that she gets angry easily, cries a lot, and that she's concerned the hysterectomy is affecting her emotionally and physically.

Part III- 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 injury related to lack of side rails on bed.
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._____Altered skin integrity (1" blister on heel) 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._____Altered nutrition: less than body requirements related to being NPO as evidenced by inability to take food by mouth.

B. For each diagnosis you identified as being incorrect, explain the reason if it's incorrect.

Part IV- differentiating between nursing Diagnoses and Collaborative Problems

a. Place "N" in front of the phases that described characteristics of nursing diagnoses. Place "C" in front of the phases that describe a collaborative problem or medical diagnoses.
   1. _____ Deals mostly with problems with structure or function of organs, or systems.
   2. _____ Includes health problems as identified from patient's perspectives.
   3. _____ Definitive diagnosis is validated by medical diagnostic studies.
   4. _____ Deals mostly with actual or potential problems with human responses to disease or life changes.
   5. _____ Related signs and symptoms don't respond to nurse prescribed intervention alone.
   6. _____ Related signs and symptoms respond to nurse prescribed interventions.
b. For each of the following problems write "N" in front of those that are nursing diagnoses and "C" in front of those that are collaborative problems or medical diagnoses.
   1. _____ Potential complication: hemorrhage related to clotting problems
   2. _____ Ineffective airway clearance related to copious secretions
   3. _____ High risk for injury related to generalized weakness.
   4. _____ Intravenous therapy

5. _____ Fluid volume deficit related to insufficient fluid intake due to sore throat.
6. _____ Impaired skin integrity (right heal) related to unrelieved pressure point.
7. _____ Potential complication: cardiac arrhythmias related to potassium
8. _____ Diabetes
9. _____ Diversional activity deficit related to prescribed bed rest
10. _____Potential complication: Increased intra-cranial pressure related to concussion.

3.4 Planning

Objectives

- Describe the four phases of planning
- State the main purposes of the plan of care
- Identify a systematic method of setting priorities
- Explain why specific measurable outcomes are essential to planning
- Develop a comprehensive Plan of Care

Planning involves the following activities:

- Setting priorities
- Establishing expected outcomes
- Determining nursing interventions
- Recording the plan of care

The plan of care serves the following purposes:

- Facilitating communication between care givers
- Directing care and documentation
- Providing a record that can later be used for evaluation and research

3.4.1. Setting Priorities

The first step to getting organized is setting priorities. To set priorities, look at the identified problems and ask some key questions:

1. What problems need immediate attention (ex. Life threatening problems, pain, discomfort)?
2. What problems have simple solutions?
3. What problems must be referred?
4. What problems must be recorded on the plan of care?

Fundamental Principles of Setting Priorities (Maslow, 1943, Smeltzer 2003 and Cherry, 2011)

Priority 1 - Life threatening problems and those interfering with physiological needs. *Examples: Problems with respiration, circulation, nutrition, hydration, elimination, temperature regulation, physical comfort.*
Priority 2 - Problems interfering with safety and security. *Examples: Environmental hazards and fear.*
Priority 3 - Problems interfering with love and belonging. *Examples: Isolation or loss of a loved one.*
Priority 4 - Problems interfering with self esteem. *Examples: Inability to wash hair, perform normal activities*.
Priority 5 - Problems interfering with the ability to achieve personal goals.

Suggested Steps for Setting Priorities

Step 1- Ask, "What problems need immediate attention and what could happen if I wait until later to attend to them?" Rationale: Identifying what could happen if you wait until later to resolve a problem helps determine what must be done. Initiating a call for help expedites treatment for severe problems while you continue to act independently.

Step 2 - Identify problems with simple solutions and initiate actions to solve them. Rationale: Sometimes there are easy solutions for problems that have a big impact on the patient's physiological or psychological status. Often the really important things that need doing take very little time.

Step 3 - On the worksheet, develop an initial problem list, identifying the problems and their causes, if known. Rationale: this ensures none of the problems are overlooked and helps you get an idea of the big picture of the problems.

Step 4 - Study your problem list and decide what problems require nurse prescribed interventions (nursing diagnoses) and what problems require nurse prescribed and physician prescribed interventions (collaborative problems). Check whether you have physician's orders or facility guidelines to manage the collaborative problems; notify the physician if you don't. Rationale: Notifying the physician expedites treatment of collaborative problems while you're planning treatment for nursing diagnoses.

Step 5 - Determine a set of priority problems (i.e., the most important ones that must be addressed on the recorded plan). Go down the list asking yourself, "What will happen if I don't record this problem on the plan of care?" Rationale: the patient's record must communicate the nurse's awareness of, and responsiveness to, all patient care priorities.

Step 6 - Follow school or facility policies for recording the problem list and determine how each problem will be managed (e.g. Physician's orders, following protocol, nurse- developed individualized plan). Rationale: policies may vary from one facility to another; you must identify where to record a problem and how to manage it according to facility facilities.

3.4.1 Practice Session

A nurse is formulating a plan of care for a client receiving enteral feedings. Which nursing diagnosis is of highest priority for this client?

a. altered nutrition, less than body requirements
b. high risk for aspiration
c. high risk for fluid volume deficit
d. diarrhea

Try to answer this question before turning to the next page for the correct answer.

Answer: B and the rationale is as follows:
Any condition in which gastrointestinal motility is slowed; oroesophageal reflux is possible which places a Client at risk of aspiration. Options 1 and 4 may be appropriate nursing diagnoses but are not of highest priority. Option 3 is not likely to occur in this client (Ann-Hogan, 2007).

3.4.1a. Short Term and Long Term Goals

Planning goal directed care sometimes includes setting both long term and short term goals.

Short-term goals (STG) are those that can be met relatively quickly, often in less than a week, whereas, long-term goals (LTG) are those that are to be achieved over a longer period of time, often weeks or months.

Often you'll 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."

Examples of Long-Term and short-Term Goals

Short-Term Goal	Long-Term Goal
""Hanna will demonstrate how to hold her newborn infant by tomorrow (6/9)."	"Hanna will demonstrate how to dress, Feed, and bathe her newborn infant by Discharge (6/13)."
"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 bedrest."
"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)/"

3.4.1b. Client Centered Goals (Outcomes)

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. This is

because client centered goals focus on the desired result of the plan of care, which is that the client benefit from nursing care.

Rule
The subject of a client centered goal (or outcome) must be either the client or a part of the client. *For example. "Hailu will ambulate three times a day in the room." "The skin will remain intact, free from signs or irritation".*

Below are some additional examples of client-centered goals:

- *" Wrt. Tenagne will lose 2Kg in 3 weeks (by 7/30)."*
- *" Wro. Saba will walk unassisted with crutches by 2/6."*
- *" Ato Daniel will demonstrate sterile injection technique by 9/18."*

3.4.2a. Goals versus Outcomes

The terms goals, outcomes and objectives are often used interchangeably because they are all statements of what is expected to be accomplished by a certain time. Most nurses view goals and objectives as more general descriptions and outcomes as more specific. Others use broad goals or objectives together with specific outcomes so that the goal statement clearly describes what will be observed in the patient when the goal is achieved.

For example, you may have a broad goal or objective of "will demonstrate effective airway clearance," and be required to list exactly what you expect to observe or hear that will tell you the person is able to clear her airway.

In the above situation, your goal statement (or outcome statement) would look like this:

- *The person will demonstrate effective airway clearance as evidenced by ability to clear lungs by coughing every 2 hours.*
- *Will demonstrate knowledge of medication regimen as evidenced by ability of list drug names, actions, doses, and side effects.*

The first part of the statement is the broad goal, and the second part of the statement (after the "as evidenced by") is the outcome, which describes the specific data that tell you the broad goal has been achieved.

3.4.2b. Writing Outcome Measures

Identifying outcomes that clearly describe the evidence that tells you the problems have been prevented, corrected, or controlled is the key to determining specific interventions and evaluating care.

Example- Will demonstrate effective breathing pattern as evidenced by clear lungs and practicing deep breathing and coughing every 2 hours.

3.4.2c.Writing more than one outcome statement

Sometimes you may decide to write more than one outcome for 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 demonstrates resolution, improvement, or control of the nursing diagnosis.

Example:
Nursing Diagnosis: Altered Nutrition: More than Body Requirements related to poor eating habits and minimal physical activity.
Outcome #1: Client will verbalize his feelings about changing eating habits. (This goal relates to the problem of "poor eating habits which is a causative factor.)
Outcome # 2: Client will attend daily exercise classes. (This goal relates to the problem of "minimal physical activity," which is a causative factor.)
Outcome #3: Client will lose 2 Kg per week beginning 10/25 until she weighs between 60 and 70 Kg.
(This goal demonstrates a direct resolution of the problem of Altered Nutrition: More than body requirements).

3.4.2d. Steps in identifying Outcomes from Nursing Diagnoses

1. Look at first clause 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*.
2. Now restate the first clause in a statement that describes improvement, control, or absence of the problem- *Example- The person will demonstrate no signs of skin irritation or breakdown*.

3.4.2e. Clients Outcomes (Goals) Derived from Nursing Diagnoses

Nursing Diagnosis	Corresponding Client Outcome (Goal)
Altered Nutrition: Less than Body requirements	The client will demonstrate normal nutritional state as evidenced by weight of 60 – 70 Kg and record of eating balanced meals with few snacks every day.
Ineffective Individual Coping Constipation	The client will demonstrate and relate effective coping as evidenced by self report of coping better and ability to demonstrate good problem solving. The client will demonstrate normal bowel function as evidenced by having a normal Stool every 1-2 days by statements of feeling as though bowels are moving well.

Making Outcomes Clear and Specific- Outcomes that are clear and specific address:

- What is to be done?
- Who is to do it?
- When they are to do it?
- How they are to do it?
- Where they are to do it?
- and how well they are to do it?

Each outcome must have the components listed below:

- **Subject:** Who is the person expected to achieve the goal?
- **Verb:** What actions must the person take to achieve the goal?
- **Condition:** Under what circumstances is the person to perform the actions?
- **Criteria:** How well is the person to perform the actions?
- **Specific Time:** When the person expected to perform the actions?

Example: Ato Hailu will walk with a crutch at least to the end of the hall and back by Friday.

Subject: *Ato Hailu* ***Verb:*** *will walk* ***Condition:*** *with a crutch*
Criteria: *at least to the end of the hall and back* ***Specific time- by*** *Friday*

Choosing verbs that measure progress will avoid ambiguity and focuses on the behaviour that will measure progress.

Example - will understand how to use sterile technique- vague- State something like, "as verbalizes" or "demonstrates", which are measurable.

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.*

Below are some guidelines for determining client centered outcomes

- Be realistic in establishing goals.
- Whenever possible, set goals mutually with the client and others involved in his health care. It ensures agreeable goals to all key players in the plan.
- When indicated, establish both short and long term goals (the short term goals can be used for steps toward meeting the long term goals).
- Be sure that the outcomes describe a client behaviour or action that demonstrates the desired improvement, control or resolution of the identified nursing diagnoses.
- Follow the rules for writing outcome statements.
- Using measurable, observable verbs to describe actions or behaviours that you expect to see.

3.4.3. Nursing Care Planning Process

3.4.3a. Determining Nursing Interventions

Nursing Interventions are activities performed by the nurse to:

- Monitor health status
- Prevent, resolve, or control a problem
- Assist with activities of daily living (bathing and so forth)
- Promote optimum health and independence.

Nursing Interventions could be carried out through assessing, Teaching, Counselling, consulting, and determining problem specific interventions.

3.4.3a. Practice sessions

For each nursing diagnosis and outcome listed below. List some possible nursing interventions that would help the client to reach the goal.

1. **Nursing Diagnosis:** High Risk for impaired skin integrity related to prescribed bed-rest and loss of sensation in lower extremities.
Outcome: Will maintain healthy looking skin while on bed-rest as evidenced by absence of redness or breakdown. List appropriate nursing interventions.

2. **Nursing Diagnosis:** Constipation related to insufficient exercise and inadequate fluid and roughage intake as evidenced by no BM in 4 days.
Outcome: Will have daily soft bowel movement as evidenced by patient report. List appropriate nursing interventions.

3. **Nursing Diagnosis:** High risk for infection related to new incision and diabetes.
Outcome: Incision will show no signs of infection (redness, swelling, drainage). Incision will be protected from microbial invasion as evidenced by clean, dry dressing at all times.
List appropriate nursing interventions.

3.4.3b. Determining nursing instructions to be carried out

Once you have determined the interventions you will use, you need to write out the nursing instructions so that all nurses have clear instructions in implementing the 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

Example: High risk for ineffective Airway Clearance related to history of smoking and incisional pain. Nursing instructions/activities to be carried in caring for such a patient are:

- Nurse the patient in an upright position
- Check the respiration rate /osculate lungs every 4 hours.
- Assist the person to perform coughing and breathing exercises with pillow and hand over incision area every 4 hours.
- Reinforce the importance of coughing and deep breathing.
- Record lung sounds and sputum production once a shift/per shift.

3.4.3c. Making Nursing Instructions/actions Specific

Nursing actions must be specific and clear, including the following:
Date: The date the order was written
Verb: action to be performed
Subject: Who is to do it
Descriptive Phrase: How, when, where, how often, how long, how much
Signature: Whoever wrote the order should sign it.

Example: 4/29/2010 Assist Hailu to sit on the side of the bed for 10 minutes tid. Tekle G. RN
Nursing actions with corresponding nursing 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.
Maintain Caloric intake of 3000 Calories/day	•Assess appetite and determine desired high calorie foods • Consult dietician to plan meals and snacks • Stress the importance of completing all meals • Offer between meal milk. •Have the patient keep a daily record of food eaten.

Provide for periods of uninterrupted rest	•Do not wake up the patient from midnight to 7 am • Allow low to rest from 1 pm to 3 pm (no visitors) •Record the patient's perception of hours slept

3.4.3c. Practice Session – Writing Nursing Orders

For each nursing intervention listed below, write specific nursing instructions for the nursing team:

1. Maintain a programme of turning the patient from side to side.
2. Maintain fluids intake to 3000 ml/day.
3. Encourage patient to express her feelings.
4. Promote daily bowel elimination.

3.4.4. Documenting the Plan of Care

Purpose:

- Facilitate communication between care givers
- Direct care and documentation
- Provide a written record that can later be used for evaluation

To achieve these purposes, each plan usually includes the following:

- A brief client profile (name, age, height, weight, reason for seeking care, and any other pertinent information).
- Important client problems and nursing diagnosis
- Expected outcomes
- Instructions for nursing interventions
- A space for evaluative (i.e., progress notes)

N.B. Forms for, and methods of, documenting care plans are usually tailored to meet the needs of the nurses and clients in each unique setting.

Sample Documentation of Care Plan

Assessment Data	Nursing Dx/ Collaborative Problems	Goals	Nursing orders/ Implementation	Evaluation/outcome
10/15	Ineffective	Restoration of	Promote appropriate	Voice rose only at 24 hr.

Anger and demanding, Complained " no one has been in to check"	Coping	appropriate Communication. Verbalization of Feelings; Participation in therapeutic regimen	communications; Establish relationship built on trust; Remain calm; encourage patient to express feelings.	Verbalized frustration, fear, anger and loss of control; Apologized for shouting behaviour.
Wt. loss 5 kg in 10 Days, eats only 10% meal due to feeling of fullness immediately after beginning of meal	Altered nutrition less than body requirements related to sensation of fullness with meals	Client will maintain weight during hospitalization. Client will eat 100% of meal by 10/20.	Wt. daily at 7 am on scale; Small, frequent, high calorie feeding ; Assist client to high fowler's position for each meal.	Weight remains at 70 Kg. Client consumes all food on meal tray

3.5 Implementation- (Putting the Plan into Action)

Objectives:

- Distinguish independent, interdependent or collaborative and dependent nursing interventions
- Discuss differences between protocols and standing Nursing instructions.
- List and discuss the five steps of the nursing implementation process.
- Select appropriate implementation methods for a client.

The purpose of implementation is to carry out the nursing care plan developed in the previous component of nursing process. Implementation includes:

- Performing, assisting, or directing the performance of activities of daily living,
- Counseling and teaching the client or family,
- Giving direct care to achieve client centered goals,
- Supervising and evaluating the work of staff members, and
- Recording and exchanging information relevant to the client's care.

To complete implementation effectively, the nurse must be knowledgeable about:

- Types of interventions
- The implementation process and
- Specific implementation methods

3.5.1. Types of Nursing Interventions

When implementing the plan of care, the nurse functions independently, dependently and collaboratively.

Independent interventions or nursing actions involve carrying out nurse prescribed orders written on the nursing care plan or actions initiated without the direction of another health care professional. Nurses are legally accountable for the assessments they make and for their nursing responses.

Dependent interventions or nursing actions involve carrying out physician orders. Nurses are accountable for the dependent orders they implement and are thus responsible for the clarification of any questionable order.

Collaborative or Interdependent interventions are those performed jointly by nurses and other members of the health care team.

3.5.2. Protocols and Standing Orders

A protocol (Guidelines, policies, procedures) is a written plan specifying the procedures to be followed during an assessment or when providing treatment for a specific condition or nursing care problems.

Example- Protocol for admissions and discharges

A standing order dictates a clinical situation and prescribes standardized interventions. Standing orders are approved and signed by the physician in charge of care before their implementation. They are commonly found in critical care settings, in which clients' needs can change rapidly and require immediate attention. Thus standing orders and protocols give the nurse the legal protection to intervene appropriately in the client's best interest.

3.5.3. Nursing Implementation Skills

- Intellectual Skill
- Interpersonal Skills
- Technical Skills

3.5.4. Implementation Methods

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 and for having the necessary theoretical knowledge and skills to implement each.

1. **Assisting with activities of Daily Living (ADLs) –** such as eating, dressing, bathing, brushing the teeth, or grooming(Ref).
2. **Counseling-** is an implementation methods that helps the client to use problem solving process to recognize and manage stress and that facilitates interpersonal relationships between the client and family, significant others, or health care team members. Counseling encourages individuals to examine available alternatives and to choose useful and appropriate choices. When clients examine alternatives, they develop a sense of control and are able to better manage stress.
3. **Teaching-** is an activity closely aligned to counseling. Both involve using communication skills to effect a change in the client. Teaching is an implementation method 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-** To achieve the therapeutic goals of the client, the nurse initiates interventions to prevent adverse reactions by using precautionary and preventive measures when providing care and applying correct techniques in administering care and preparing the client for special procedures. **An adverse reaction** is a harmful or unintended effect of a medication,

diagnostic test or therapeutic treatment. Ex. What will the nurse do in case of patient with penicillin allergy?

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.

3.6 Evaluation

Objectives

- Explain the relationship between expected outcomes and goals of care
- Describe how evaluative measures are used to determine a client's progress;
- Explain the function evaluation plays in improving the quality of client care

3.6.1. Goals as the Basis for Evaluation

The purpose of nursing care is to assist the client in resolving actual health problems, preventing the occurrence of potential problems, and maintaining a healthy state. Evaluation of goals determines whether these purposes are accomplished. When a plan of care is established, the nurse identifies the goals, specific client behaviours or responses that will reveal resolution of a nursing diagnosis.

To objectively evaluate the degree of success in achieving a goal, the nurse should use the following steps:

1. Examine the goal statement to identify the exact desired client behaviour or response;
2. Assess the client for the presence of that behaviour or response;
3. Compare the established outcome criteria with the behaviour or response;
4. Judge the degree of agreement between outcome criteria and the behaviour or response.

Goal is Met- if the client's response matches or exceeds the outcome criteria.
Goal is partially Met- If the client's behaviour begins to show changes, but does not yet meet specified criteria.
Goal is Not Met - If there is no progress.

3.6.2. Expected Outcomes

Expected outcomes are statements of progressive; step by step responses or behaviours that measure movement toward goal achievement. A client must meet outcomes in-order to remove or modify the etiology of a nursing diagnosis.

3.6.3. Evaluative Measures and Sources

Evaluative measures are the assessment skills and techniques used to collect data for evaluation.

Example- Questioning a patient about his/her health related problems, measuring temperature, ***inspecting*** *skin turgor/texture, are evaluative measures*.

The client is a primary source of data; however the nurse also uses the family and other care givers for information.

3.6.4. Care Plan Revision

After the nurse evaluates the goals, adjustments are made to the care plan. If a goal was successfully met, that portion of the care plan is discontinued. Unmet and partially met goals require the nurse to reactivate the nursing process sequence. After reassessment, modification or addition of nursing diagnosis, goals, expected outcomes, and interventions is made as needed.

3.6.5. Practice Session

Outcome Achievement- For each number below, compare the outcome criteria with the listed observable patient data. Circle "A" if the goal has been achieved. Circle "P" if the goal has only been partially met. Circle "N" if the goal has not been met.

1. **Outcome**: Will demonstrate self injection of insulin using aseptic technique.
   Observable Data: injected self using good technique, but contaminated needle without noticing it.
   Answer: A P N

2. **Outcome**: Will demonstrate safe crutch walking, including climbing and descending stairs.
   Observable Data: Demonstrates ability to use crutches for walking, climbing, and descending With-out problems.
   Answer: A P N

3. **Outcome**: Will relate the effect of increased exercise upon insulin demand.
   Observable Data: States that insulin demand is not affected by increased exercise.
   Answer: A P N

4. **Outcome**: Will maintain skin free from signs of irritation
   Observable Data: Skin is intact, with some reddened areas noted on both elbows.
   Answer: A P N

5. **Outcome**- will list the signs and symptoms of infection.
   Observable Data- lists pain, swelling, and drainage
   Answer: A P N

3.7 Methods of Documentation

3.7.1. 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

3.7.2. 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*

SECTION 5 MODULE 3 - NURSING PROCESS PART II

Objectives

1. Take Subjective and Objective data to establish nursing diagnosis of patients' problems
2. Use standardized techniques to collect subjective and objective data
3. Perform physical assessment
4. Synthesize Nursing diagnosis using health assessment

4.1 Unit I- History Taking

The purpose of history taking is to collect subjective data, what the person says about himself or herself and objective data from the physical examination and laboratory studies to form the database. The database is used to make a judgment or a diagnosis about the health status of the individuals. History taking is done through interview technique.

Components of Nursing Health history include: -

- Biographic Data
- Chief complaints
- History of present illness
- Past health history
- Family history of illness
- Life style and social data
- Review of systems

4.1.1. Biographical Data

Name, age, Sex, Place of birth, Address, Marital status, Occupation and Religion.

4.1.2. Chief Complaints

This is a brief spontaneous statement in the person's own words that describes the reason for the visit. It states one or two signs or symptoms and their duration. It is enclosed in quotation marks to indicate the person's exact words.

Example- " Chest pain" for 2 hours.

Chief complaints are not a diagnostic statement and avoid translating it in the terms of medical diagnosis. Ask for symptoms rather than diagnostic statement from the patient. State the most important reason for seeking care.

4.1.3. History of Present illness

This is a chronological record from the time of the onset of the symptom, its manifestations, and any treatments. The principal symptoms should include: -

1. **Location-** Be specific- Ask the person to point to it.
   Example- "pain behind the eyes,"
   "Jaw Pain" and "Occipital pain". Is the pain localized or radiating? Is the pain superficial or deep?
2. **Character or quality--** This calls for specific descriptive terms such as *burning, sharp, dull, aching, gnawing, throbbing, and shooting.*
3. **Quantity or severity-**

Example- " profuse bleeding", " sharp/stabbing pain".

4. **Timing (onset, duration, frequency) -** When did the symptom first appear? Give specific date and time. How long did the symptom last (duration)? Was it steady or did it come and go during that time (constant or intermittent).
5. **Aggravating and relieving factors-** What makes the pain worse? Is it aggravated by food, medication, time of the day, season. What relieves it, e.g. rest medication, or ice pack?

4.1.4. Past Health History

Childhood illnesses- Record the occurrences of measles, mumps, pertusis and strep. Throat.

Accidents or injuries- Record auto accidents, fractures, penetrating wounds, head injury.

Serious or chronic illnesses- Indicate for example, the presence of diabetes, hypertension, heart disease and seizure disorder.

Hospitalizations- Record the cause, place, result.

Operations- Record the type of surgery, date, place and outcome.

Immunizations- Record all childhood immunizations (measles, mumps, polio, DPT).

4.1.5. Family History of Illness

The purpose of the family history illness is to obtain data about immediate and blood relatives. The objectives are to determine whether the client is at risk for illnesses of a genetic or familial nature.

4.1.6. Life Style and Social Data

Life style history shows habits and preferences, including preferred foods, drinks and hobbies. A complete social history reveals who the support systems are for the client, including spouse, children, other family members, or close friends. Social history includes information about ways that the client and family typically cope with stress.

4.1.7. Review of systems (ROS)

Is a systematic method for collecting data on all body systems. During the ROS the nurse asks the client about the normal functioning of each system and any noted changes. Such changes are usually subjective data because they are described as perceived by the client.

Purpose-

1. To evaluate the past and present health status of each body system.
2. To double-check in case any significant data were omitted in the present illness section.

The Order of examination- From head to toe. When recording information, avoid writing "negative or normal" after the system heading. Record the ***presence or absence*** of all symptoms; otherwise the reader does not know which factors you asked. Avoid recording some physical findings, Or objective data here, e.g. "skin warm and dry." The history should be limited to client responses, or subjective data-factors that the person says were or were not present.

General overall Health status

-Ask about the person's general state of health, including present weight (gain or loss, period of time), fatigue, weakness or malaise, fever, chills, and sweats or night sweats.

Skin- record any history of skin disease, color change, pruritus and rash or lesion.

Head- record any history of unusually frequent or severe head-ache, any head injury, dizziness.

Ear- ask about ear-aches, infections, discharge and vertigo.

Nose and sinuses- any discharge, severe colds, sinus pain, nosebleeds.

Mouth and Throat- ask about mouth pain, frequent sore throat, toothache, difficulty in swallowing, hoarseness or voice change.

Neck- ask about pain, limitation of motion, lumps or swelling.

Breast- ask about pain, lump, nipple discharge, rash, history of breast disease and any surgery on breasts.

Axilla- ask about tenderness, lump, or swelling, and rash.

Respiratory system- Ask about history of lung diseases (bronchitis, pneumonia, tuberculosis), chest pain with breathing, wheezing, shortness of breath, cough, haemoptysis.

Cardiovascular- ask about pericardial or retrosternal pain, (palpitation, cyanosis, dyspnoea on exertion) orthopnoea, nocturia, edema, hypertension, and anemia.

Peripheral vascular- ask about coldness, numbness and tingling, swelling of legs, discoloration of hands or feet, varicose veins or ulcers.

Gastro-intestinal- ask about appetite, food intolerance, dysphagia, heartburn, indigestion, abdominal pain, nausea and vomiting, history of abdominal disease, flatulence, constipation or diarrhea, and rectal bleeding.

Urinary system- ask about frequency, urgency, nocturia, dysuria, polyuria, or oliguria, incontinence, history of urinary disease and pain in the flank, groin, or suprapubic region.

Male genital system- ask about any penile or testicular pain, sores or lesion, penile discharge, lumps or hernia.

Musculo-skeletal system- note any history of arthritis, pain, stiffness, swelling, deformity, limitation of motion? Muscle- any pain, cramps, weakness, gait problems. In the back- pain, stiffness, limitation of motion or history of back-pain.

Neurologic system- any history of seizure, stroke, fainting. Any paralysis or coordination problems. Numbness, tingling.

Endocrine system- Record any history of diabetes or symptoms (polyuria, polydipsia, polyphagia), history of thyroid disease, nervousness, tremors.

4.2 Unit II - Techniques of Physical Examination

The health history describes in previous class provides subjective data for health assessment. This chapter presents objective data through the physical examination that helps you to develop technical skill and knowledge. The skills used for the physical examination includes:

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

The skills are performed one at a time and in the aforementioned order.

4.2.1. 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).

4.2.2. Palpation

Palpation follows and often confirms points you noted during inspection. Palpation applies your sense of touch 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, pulsatility 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 of the hand 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.

4.2.3. 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 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.

The five normal percussion notes include: -

1. **Resonant**- Over normal lung tissue.
2. **Hyperresonant-** Normal over child's lung. In the adult, over lungs with abnormal amount of air, as in emphysema.
3. **Tympany-** Over air-filled, example- the stomach and the intestine.
4. **Dull-** Relatively dense organ like the liver or spleen.
5. **Flat-** When no air is present like over thigh muscles, bone or over tumor.

4.2.4. Auscultation

Auscultation is listening to sounds produced by the body, such as heart and blood vessels and 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 against the person's skin, firm enough to leave a slight ring afterward. ***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.

Equipments

Items needed for screening physical examination includes: -

- ✓ Sphygmomanometer
- ✓ Stethoscope
- ✓ Thermometer
- ✓ Flashlight
- ✓ Tuning fork
- ✓ Tongue depressor
- ✓ Lubricant
- Flexible tape measure
- Reflex hammer
- Sharp object (sterile needle)
- Cotton balls
- Bivalve vaginal speculum
- Clean gloves

4.3. Unit III – Examination /Observation

Observe the general state of your patient's health.

4.3.1. General

Take note of the posture (straight or stopped), motor activity and gait, ability to dress and groom self and personal hygiene (hair, oral, hygiene, nails).Also note any odours of body or breath, patient's facial expression, and note the manner and reaction to the persons and things in the environment. Listen to the speech and observe for anxiety, depression, uncooperativeness, anger, suspiciousness. Weigh the patient, take height and check vision using Snellen eye chart for visual acuity.

4.3.2. Examination of the skin

1. Inspect the skin for colour, general pigmentation (areas of hypo-pigmentation or hyper-pigmentation-redness, pallor, cyanosis and yellowish of skin) around the fingernails, lips and mucous membranes of mouth, conjunctivae for anaemia.
2. Palpate the skin for temperature, moisture, oedema, mobility and turgor (speed with which it returns into place- sign of dehydration.
3. Note for any skin lesion
4. Inspect and palpate the nails for shape, consistency an color.

4.3.3. Vital Signs

Assess and record:

- Radial pulse- assess for its rate, rhythm (regularity), force (weak, absent, full) and elasticity (springy, straight).
- Respirations- normally it is relaxed, regular, automatic and silent
- Blood pressure - Temperature

4.3.4. Head and Face

1. Inspect and palpate the scalp for any deformities, lumps and tenderness
2. Inspect the face for facial expression, symmetry (cranial nerve 7) and palpate the frontal sinuses, maxillary sinuses for any tenderness

Eyes

1. Ask the person to hold the head steady and to follow the movement of your finger or pen with the eyes
2. Inspect the conjunctivae, and corneas for smoothness and clarity
3. Test pupil for its size and response to light (normally round, regular and of equal size).

Ears

1. Inspect the external ear for its color, lumps, lesions and any discharge
2. Check the movement of auricle for tenderness
3. Using and otoscope, inspect the external ear for cerumen, discharge, foreign bodies and lesions

Nose

Inspect the external nose for symmetry, lesions, or deformity. Inspect the patency of each nostril.

Mouth and Throat

Using a penlight and spatula, inspect the mouth on buccal mucosa, teeth, and gums, tongue, palate and uvula. Note mobility of uvula as the person phonates “ahhh” and test gag reflex (cranial nerve 9,10). Ask the person to stick out the tongue (cranial nerves 12).

Neck

1. Inspect the neck for symmetry, lumps and pulsations
2. Palpate the cervical lymph nodes (tonsillar, maxillary)
3. Palpate the carotid pulse, one side at a time and palpate the trachea in midline
4. Step behind the person, and palpate thyroid gland

4.4. Unit IV- Examination of the Respiratory System

Subjective Data: - Cough, shortness of breath, chest pain with breathing, past history of respiratory infections, cigarette smoking.

4.4.1. Method of Examination

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. The antero-posterior diameter is less than the transverse diameter.
Antero-posterior = transverse diameter or "barrel chest "in chronic obstructive pulmonary disease.

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Breath Sounds

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.

The Anterior Chest

Inspect the anterior chest for the shape, symmetry, facial expression, level of consciousness and quality of respiration.

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

4.4.2. 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.

4.4.3. 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.

4.4.4. 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.

4.5. Unit V- Cardiovascular system

4.5.1. Normal Heart Sounds

The first heart sound (S1) occurs with the closure of the AV valves and signaling the beginning of the systole.

You can hear S1 over all the pericardium, but usually it is loudest at the apex.

The second heart sound (S2) occurs with closure of the semi-lunar valves and signals the end of the systole.

Third heart sound (S3) occurs when the ventricles are resistant to fill and creates vibration.

Fourth heart sound (S4) occurs at the end of diastole at pre-systole, when the ventricle is resistant to fill and creates vibration.
For subjective data, ask the patient for chest pain, dyspnea, orthopnea, cough, fatigue, cyanosis or pallor, edema and nocturia.

4.5.2 Methods of Examination the neck blood vessels

Palpate each carotid artery medial to the sterno-mastoid area. Take care to palpate gently and only one carotid artery at a time. Feel the pulse.
Abnormal - diminished pulse feels small and weak.

For persons older than the middle age or who show symptoms or signs of the cardio-vascular disease, auscultate each carotid artery for the presence of a ***Bruit.*** This is a blowing swishing sound indicating blood flow; normally there is none. Ask the person to hold his or her breath while you listen so that tracheal breath sounds do not mask or mimic a carotid artery bruit.

Inspect the anterior chest
Pulsations- Check the apical pulse, especially for children or those with thinner chest walls. It occurs with ventricular hypertrophy due to increased load.

4.5.3. Methods of Examination the heart (cardiac) sounds

In palpating the apical pulse, use one finger pad and ask the person to "exhale and then hold it" as this aids the examiner in locating the pulsation. You may need to role the person midway to the left in order to find it.. Not palpable with obese or persons with thick chest walls. **Location**- The apical pulse is found in one inter-space, the fourth or fifth, and be at or medial to the mid-clavicular line. It is **abnormal in the case of** cardiac enlargement (increased size, force and duration).

Palpating across the pericardium- Using the palm of your fingers, gently palpate the apex over the left sternal border, and the base, searching for any other pulsations. Normally there is none. Use the carotid artery pulsation as a guide or auscultate as you palpate.

Abnormal - *a thrill* is a palpable vibration that feels like the throat of a purring cat.
Auscultatory areas where you will listen for different cardiac areas:

Chest area	Type of cardiac sound
Second right interspace	Aortic valve
Second left interspace	Pulmonary valve
Left lower sternal border	Tricuspid valve
Fifth interspace at around left midclavicular line	Mitral valve

Concentrate and listen selectively to one sound at a time. Consider that at least two, and perhaps three or four, sounds may be happening in less than one second. Begin with the diaphragm end-piece, and use the following routine:

(1) Note the rate and rhythm;
(2) Identify S1 and S2;
(3) Assess S1 and S2 separately and;
(4) Listen for extra heart sounds, and (5) listen for murmurs.

Note the Rate and Rhythm- the rate ranges normally from 60-100 beats/minute. The rhythm should be regular. Note any

- **Abnormal-** ***Premature beat-*** every third or fourth beat that sounds early.
- Irregularly irregular- no pattern to the sounds; beats come rapidly and at random intervals

To identify S1 and S2- you will hear a pair of sounds close together (lub-dup) and S1 is the first of the pair. Other guidelines to distinguish S1 from S2 are:

- S1 is louder than S2 at the apex; S2 is louder than S1 at the base.
- S1 coincides with the carotid artery pulse. Feel the carotid gently as you auscultate at the apex; the sound you hear as you feel each pulse is S1.

Listen to S1 and S2 separately for normal beat. First heart sound (S1) is caused by the closure of the AV valves which signals the beginning of the systole. It is loudest at the apex. The second heart Sound (S2) is associated with closure of the semilunar valves and it is loudest at the base. **Focus on systole, than on diastole, and listen for any extra heart sounds.**

For extra sounds of S3 and S4, listen around the diaphragm area, and then switch to the dumbbell shaped area, covering all auscultatory areas.

Listen for murmurs- A murmur is a blowing, swooshing sound that occurs with turbulent blood flow in the heart or great vessels. Present may indicate Mitral Stenosis or Aortic stenosis.

4.6. Unit VI- Abdominal Examinations

1. **Subjective Data-** appetite, dysphagia, food intolerance, abdominal pain, nausea/vomiting, bowel habits, rectal conditions, and past abdominal history.
2. **Objective Data- equipment needed**- Stethoscope, small centimetre ruler, and skin marking pen.

4.6.1 Method of Examination

1. **Inspection-** inspects the contour, symmetry, umbilicus, skin, pulsation of movement, and hair distribution. **Contour-** Stand on the right side and look down on the abdomen. See the profile from the rib margin to the pubic bone. The contour describes the nutritional state, and normally ranges from flat to round. **Abnormal-** bulges, masses, hernia.

2. **Auscultation-** auscultate bowel sounds and vascular sounds. Auscultate abdomen next, because percussion and palpation can increase peristalsis. Use the diaphragm-end piece because bowel sounds are relatively high pitched. Hold the stethoscope lightly against the skin; pushing too hard may stimulate more bowel sounds. Begin in the RLQ at the ileocecal valve, because bowel sounds are always present here normally.

3. **Percussion-** Percuss general tympany, liver span, and splenic dullness. Percuss to assess the relative density of abdominal contents to locate organs, and to screen for abnormal fluid or masses

Bowel Sounds- Originate from the movement of air and fluid through the small intestine. Below are some examples of abnormal bowel sounds:

- Hyperactive sounds are loud, high pitched, rushing.
- Hypoactive or absent- sounds tend to occur following abdominal surgery or with inflammation of the peritoneum.
- Vascular Sounds- check for the presence of any vascular sounds or bruit. Using firmer pressure, check over the aorta, renal arteries, iliac and femoral arteries, especially with hypertensive cases.

. 4.6.2. Percussing the liver

To map out the boundaries of certain organs like the liver, measure its height in the right mid-clavicular line (mid-way between the acromioclavicular and sternoclavicular joint). Begin in the area of lung resonance, and

percuss down the interspaces until the sound changes to a dull quality. Mark the spot and its usually in the fifth intercostal space. Then find the abdominal tympany and percuss up in the midclavicular line. Mark where the sound changes from tympany to a dull sound, normally at the right costal margin. Measure the distance between the two marks and the normal adult liver ranges from 6-12cm. The height of the liver correlates with the height of the person (tall longer liver; male- larger liver span than female of the same height). **Enlarged liver is known as- hepatomegally**.

4.6.3. 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.

4.6.4. Assessing the Kidney

You assess the kidney for tenderness in the costo-vertebral angle area. To do so, you'll need to place one hand over the 12th rib at the costo-vertebral angle on the back. Thump that hand with ulnar edge of your other fist. The person should not feel any pain. Sharp pain occurs with cases of inflammation of the kidney..

4.6.5. Procedure for palpating internal organs

To palpate the liver edge, spleen and kidneys to judge the size, location, and consistency of these organs and screen for an abnormal mass tenderness, you need to ensure there is complete muscle relaxation by:

a. Bending the person's knees.
b. Keeping your palpating hand low and parallel to the abdomen.
c. Teaching the person to breathe slowly (in through the nose and out through the mouth).

Begin with light palpation and with the first four fingers close together, depress the skin about 1cm. Make a gentle rotary motion, sliding the fingers and skin together. Then lift the fingers and move clockwise to the

next location around the abdomen. The objective here is not to search for organs but to form an overall impression of the skin surface and superficial musculature. In deep palpation push down about 5-8cm and repeat the same process as above.

4.6.6. Iliopsoas Muscle and Obturator Tests

Perform this test when acute abdominal pain or appendicitis is suspected. With the person supine, lift the right leg straight up, flexing at the hip; then push down over the lower part of the right thigh as the person tries to hold the leg up. When the test is negative, the person feels no change/pain. Pain in the right lower quadrant indicates appendicitis.

You conduct the Obturator Test when appendicitis is also suspected. Again with the person supine, lift the right leg, flexing at the hip and 90 degrees at the knee. Hold the ankle, and rotate the leg internally and externally. Again , normally, there is no pain.

4.7 Unit VII- Neurological system

4.7.1. Subjective and objective data relating to the neurological system

Subjective Data:- head ache, head injury, dizziness, seizure, tremors, weakness or incoordination, numbness or tingling, difficulty swallowing, difficulty speaking, significant past history.

Objective Data: - You need equipment to assess the person and these include penlight, tongue depressor, blade, sterile needle, cotton ball, tuning fork, percussion hammer, familiar aromatic substance.
Use the following sequences for complete neurologic examination:

1. Mental status
2. Cranial nerves
3. Motor system
4. Sensory system
5. Reflexes.

Position the person in sitting up with the head at your eye level.

4.7.2. Cranial nerves tests

Cranial Nerve I – olfactory Nerve Test

The sense of smell in those who report loss of smell. First assess patency by occluding one nostril at a time and asking the person to sniff. Then, with the person's eyes closed, occlude one nostril and present an aromatic substance like coffee, orange, soap, or alcohol.

Cranial Nerve II- Optic Nerve – Test visual acuity.

Snellen eye chart- The Snellen alphabetical chart has lines of letters arranged in decreasing size.
Place the snellen chart in a well lit spot at eye level. Position the person on a mark exactly 20 feet from the chart. Hand the person an opaque card with which to shield one eye at a time during the test. Ask the person to read through the chart to the smallest line of letters possible. Encourage the person to try the next smallest line also.

Record the result using the numeric fraction at the end of the last successful line read. Normal visual acuity is 20/20. Numerator indicates the distance the person is standing from the chart, while the denominator gives the distance at which a normal eye could have read that particular line. Thus "20/20". Numerator indicates the distance the person is standing from the chart, while the denominator gives the distance at which a normal eye could have read that particular line. Thus "20/20" means," you can read at 20 feet what the normal eye could have read at 20 feet.

Cranial Nerves III – IV-VI Oculomotor, Trochlear, and abducens nerves

Check pupils for size, regularity, equality and light reaction.

Cranial Nerve V -Trigeminal Nerve

Motor function – Assess the muscles of mastication by palpating the temporal and masseter muscles as the person clinches the teeth. Muscles should feel strong on both sides. Try to separate the jaws by pushing down the chin; normally you cannot.

Sensory function – with the person's eyes closed, test light touch sensation by touching a cotton wisp to these designated areas on persons face: forehead, cheeks, and chin. Ask the person to say "now" whenever the touch is felt. This tests all three divisions of the nerve – ophthalmic, maxillary, and mandibular.

Corneal Reflex – with the person looking forward, bring a wisp of cotton, in from the side and lightly touch the cornea. Normally the person will blink bilaterally.

Cranial Nerves VII- Facial Nerve

Motor Function-Note mobility and facial symmetry as the person responds to smile, frown, close eyes tightly. Lift eyebrows, show teeth and puff cheeks. Then press the person's puffed cheeks in and note that the air should escape equally from both sides.

Sensory Function - do not test routinely. When indicated, test sense of taste by applying to the tongue a cotton applicator covered with a small amount of solution of sugar, salt, or lemon juice. Ask the person to identity the taste.

Cranial Nerve VIII- Acoustic (vestibulocochlear) nerve

Voice test – placing one finger on the tragus of each ear, and shielding your lips, exhale and whisper slowly calling the words, "Monday", "fourteen". Normally the person repeats each word correctly after you say it.

Cranial Nerves IX and X- Glossopharyngeal and vagus nerves

Motor function – depress the tongue with a tongue depressor, and note pharyngeal movement as the person says “ahhh”, the uvulae and soft palate should rise in the midline.

Cranial Nerve XI _ Spinal Accessory Nerve

Examine the sternomastoid and trapezius muscles for equal size. Check equal strength by asking the person to rotate the head forcibly against resistance applied to the side of the chin. Then ask the person to shrug the shoulders against resistance. These movements should feel equally strong on both sides.

Cranial Nerve XII _ Hypoglossal Nerve

Inspect the tongue. There should be no wasting or tremors.

4.7.3. Reflexes

1. Biceps Reflex – Support the person’s forearm on yours; this position relaxes, as well as partially flexes, the person’s arm. Place your thumb on the biceps tendon and strike a blow on your thumb. You can feel as well as see the normal response, which is flexion of the forearm.

2. Brachioradialis reflex- Hold the person’s thumbs to suspend the forearms in relaxation. Strike the forearm directly, about 2-3 cm. above the radial styloid process. The normal response is flexion and supination of the forearm.

3. Quadriceps Reflex (Knee jerk)- Let the lower legs dangle freely to flex the knee and stretch the tendons. Strike the tendon directly just below the patella. Extension of the lower leg is the expected response. For the person in the supine position, use your own arm as a lever to support the weight of one leg against the other leg.

4. Achilles Reflex – (Ankle Jerk) position the person with the knee flexed and the hip externally rotated. Hold the foot in dorsiflextion, and strike the Achilles tendon directly. Feel the normal response at the foot flexes against your hand.

4.8. Unit VIII- Breasts and Lymphatic System

4.8.1. Breast examination

General Appearance – note symmetry of size and shape. A sudden increase in the size of one breast signifies inflammation or new growth.

Skin – the skin normally is smooth and of even color. Note any localized areas of redness, bulging, or dimpling.

Nipple- the nipples should be symmetrically placed on the same plane for both breasts. Distinguish a recently retracted nipple. Note any dry scaling, any fissure or ulceration, and bleeding or other discharge.

The Axillae- Inspect and palpate the axillae. Reach your fingers high into the axillae. Move them firmly down in your directions: down the chest wall in a line from the middle of the axillae, the anterior border of the axilla, the posterior border and along the inner aspect of the upper arm. Usually nodes are not palpable, although you may feel a small, soft, non-tender node in the central group. Nodes enlarge with any local infection of the breast, arm, or hand, and with breast metastases.

Breast Palpation – put the woman in a supine position. Tuck a small pad under the side to be palpated and raise her arm over her head. Use the pads of your first three fingers and make a gentle rotary motion on the breast. Start at the nipple and palpate in concentric circles, increasing out to the periphery. Move clockwise taking care to examine every square inch of the breast. Normal breast tissue feels firm, smooth, and elastic. After pregnancy, the tissue feels softer and looser. Premenstrual engorgement is normal owing to increasing progesterone. This consists of a slight enlargement, tenderness to palpation, and a generalized nodularity. Heat, redness, and swelling in nonlactating and nonpostpartum breasts indicate inflammation.

After palpating over the four breast quadrants, palpate the nipple. Note any induration or subareolar mass. Use your thumb and forefinger to apply gentle pressure or a stripping action to the nipple. If any discharge, appears, note its colour and consistency.

Breast self examination

Finish your own assessment first; then teach the self-examination. Help each woman establish a regular schedule of self-care. The best time to conduct breast self-examination is right after the menstrual period, or the fourth through to the seventh day of the menstrual cycle, when the breasts are the smallest and least congested. While teaching, focus on the positive aspects of breast self-examination. Avoid citing frightening mortality statistics about breast cancer. This may generate excessive fear and denial that actually obstructs a woman's self cares action. Describe the correct technique and rationale, and the expected findings to note as the woman inspects her own breasts. Teach the woman to examine in front of a mirror. At home, she can start palpation in the shower where soap and water assist palpation. Then palpation should be performed while lying supine. Encourage the woman to palpate her own breasts while you are there to monitor her own technique use the return demonstration to assess her technique and understanding the procedure.

4.9. Unit IX- MUSCULO-SKELETAL SYSTEM

The skeletal muscles are attached to bone by a tendon. Skeletal muscles produce the following movements:

1. Flexion- bending a limb at a joint.
2. Extension- straightening a limb at a joint.
3. Abduction- moving a limb away from the midline of the body.
4. Adduction- moving a limb toward the midline of the body.
5. Pronation- turning the forearm so that the palm is down.
6. Supination- turning the forearm so that the palm is up.
7. Circumduction- moving the arm in a circle around the shoulder.
8. Inversion- moving the sole of the foot inward at the ankle.
9. Eversion- moving the sole of the foot outward at the ankle.
10. Rotation- moving the head around a central axis.
11. Protraction- moving a body part forward and parallel to the ground.
12. Retraction- moving a body part backward and parallel to the ground.
13. Elevation- raising a body part.
14. Depression- lowering a body part.

4.9.1. Subjective data on joints

Muscles- Ask for pain, stiffness, swelling, heat, limitation of movements muscle pain or cramps and weakness.

Bones- Ask for painful bones, deformity, trauma (fracture, sprains, dislocations).

4.9.2. Order of examining joints and muscles

Inspection- Note the size and contour of the joint, inspect the skin and tissues over the joints for colour, swelling and any masses or deformity. Swelling may be due to excess fluid around the joint (effusion) or inflammation of the surrounding soft tissue (bursa, tendons). Deformities include dislocation (bones out of position), sub-location (partial dislocation of a joint), contracture (shortening of a muscle leading to limited movement of joint), or ankylosis (stiffness or fixation of a joint).

Palpation- Palpate each joint, including its skin for temperature, its muscles and bony articulations. Notice any heat, tenderness, swelling, or masses. Joints normally are not tender to palpation. A small amount of fluid is present in the normal joint, but it is not palpable. Palpable fluid is abnormal. Because fluid is contained in an enclosed sac, if you push on one side of the sac, the fluid will shift and cause a visible bulging on another side.

Range of Movement (ROM) - Ask for active range of motion and if you see a limitation, gently attempt passive motion. Joint motion normally causes no tenderness, pain or crepitation. ***Crepitation is an audible and palpable crunching that accompanies movement.***

In muscle examination, ask the person to flex and hold as you apply force. Muscle strength should be equal bilaterally and should fully resist your opposing force.

Temporo-mandibular joint- Place the tips of your first two fingers in-front of each ear and ask the person to open and close the mouth. Instruct the person to open mouth, maximally, partially and on side. Swelling, crepitus and pain indicate abnormality.

Cervical spine- inspects the alignment of the head and neck. The spine should be straight and the head erect. Palpate the spinous process and the sternomastoid and trapezius muscles. They should feel firm, with no muscle spasm or tenderness. Ask the person to do extension, flexion, lateral bending and rotation of the head and neck.

Upper extremities (shoulders) - inspect and compare both shoulders posteriorly and anteriorly. Check the size, contour and equality of joints. Normally, there is no redness, muscular atrophy, deformity or swelling. Palpate both shoulders noting any muscular spasm or atrophy, swelling, heat, or tenderness. Test ROM by doing forward flexion, hyperextension, abduction or adduction.

Elbow - inspects the size and contour of the elbow in both flexed and extended positions. Look for any deformity, redness and swelling. For testing muscle strength, stabilize the person's arm with one hand. Have the person flex the elbow against your resistance applied just proximal to wrist. Then ask the person to extend the elbow against your resistance.

Wrists and hands - Inspect the hands and wrists on the dorsal and palmer sides, noting position, contour and shape. Palpate each joint in the wrist and hands. Facing the person, support the hand with your fingers under it and palpate the wrist firmly with both your thumbs on its dorsum. Move your palpating thumbs side to side to identify the normal depressed areas that overlie the joint space. Normally the joint surfaces feel smooth, with no swelling, bogginess, nodules or tenderness. Palpate the metacarpophalangeal joints with your thumbs. Use your thumb and index finger in a pinching motion to palpate the sides of the interphalangeal joints.

Lower extremity (hip) - In a supine position, palpate the hip joints. Assess ROM by hip flexion with knee straight and knee flexed, external rotation/internal; abduction/ adduction.

Ankle and foot palpation- Using your thumbs, press on the ankle; metatarsophalangeal/ joints and inter-phalangeal joints and test the ROM on dorsiflexion, plantar flexion, inversion and eversion. Assess muscles strength by asking the person to maintain dorsiflexion and plantar flexion against your resistance.

4.10 Unit X- Male Genitalia

1. Inspect the penis and scrotum
2. Palpate the scrotal contents for any mass
3. Check for inguinal hernia

Male Rectum: Inspect the peri-anal area, and using a gloved lubricated finger, palpate the rectal walls and prostate gland for enlarge prostate gland, haemorrhoids and any growth.

4.11. Unit XI- Female Genitalia

1. Inspect the perineal and perianal area
2. Using a vaginal speculum, inspect the cervix and vaginal walls
3. Take specimen if needed

SECTION 5 : MODULE 3 - PROFESSIONAL NURSING CODE OF CONDUCT AND ETHICS

5.1 An overview of Employee and Nurses Professional Code of Conduct and Ethics

Nurses have four fundamental responsibilities: to promote wellness, to prevent illness, to restore health and to facilitate coping. The need for nursing is universal and inherent in it is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect.

Nursing care is respectful of and unrestricted by considerations of age, color, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status.

Nurses render health services to the individual, the family and the community and co-ordinate their services with those of related groups. The people under every nurse's care must be able to trust the nurse with their health and wellbeing and to justify that trust, nurses must:

- make the care of people their first concern, treating them as individuals and respecting their dignity
- work with others to protect and promote the health and wellbeing of those in their care, their families and carers, and the wider community
- provide a high standard of practice and care at all times
- be open and honest, act with integrity and uphold the reputation of their profession

As professionals, nurses are personally accountable for actions and omissions in their practice and must always be able to justify their decisions.

5.1.1 Employee Code of Conduct

Each hospital should devise a set of standards that governs employee conduct. The standards should include what is expected from the employee in their work, their interactions with patients, caregivers, visitor and other staff. These standards/principles should be made known to all employees and packaged in a code of conduct. See below for a sample of code of conduct. Outlined below are core areas that should be covered in an employee code of conduct.

Guidelines for employees to follow when offered gifts: Employees should refuse any gifts, favours or hospitality that might be interpreted as an attempt to gain preferential treatment, not ask for or accept loans from anyone under their care or anyone close to them and must establish and actively maintain clear boundaries at all times with patients, their families and caregivers.

Patient care: Patients have the right to fair and equal access to care from all staff, according to their needs. All employees should care for all patients equally and without prejudice to age, gender, and economic, social, political, ethnicity, religious or other status and irrespective of personal circumstances. They should demonstrate a personal and professional commitment to equality and diversity in caring for patients and ensure that their professional judgment is not influenced by any commercial or preferential considerations.

Confidentiality: All patients have the right to expect that any information they disclose in the course if their care is confidential between themselves and their treatment team. Hospitals should ensure that there is a written hospital information management policy which sets out how the hospital ensures that information held by the hospital on patients, their families and staff is handled confidentially.

Dress Code and Identification: The Hospital should have guidelines which clearly and strictly define dress codes for all employees. Such guidelines should explicitly list each article of clothing, as well as the colour, and condition which is acceptable in hospital settings. The hospital should have colour-coded system– one which clearly and easily allows patients to distinguish between staff. The hospital should also have a policy to ensure that all staff wear their identification badges at all times.

5.1.2 Top 10 Qualities of a Professional Nurse are as follows

a) **Communication skills:** A wonderful nurse has excellent communication skills that include speaking and listening. They are able to follow directions without problem and can easily communicate with patients and families to understand their needs and explain treatments.

b) **Emotional stability:** A superb nurse is very stable emotionally. Nursing is a stressful job and nurses may encounter many traumatic situations including suffering, and death. A superb nurse is one who is able to work without allowing the stress to cause great personal harm.

c) **Empathy:** The best nurses have empathy for the pain and suffering of patients. They are able to feel compassion and provide comfort.

d) **Flexibility:** A great nurse is flexible with regards to working hours and responsibilities. Nurses are often required to work long periods of overtime, late or overnight shifts, and weekends.

e) **Good attention to detail:** An exceptional nurse understands that every step in the nursing field is one that can have far reaching consequences. A great nurse pays excellent attention to detail and is careful not to skip steps or make errors.

f) **Interpersonal skills:** An outstanding nurse has excellent interpersonal skills and works well in a variety of clinical settings and situations. They work well with other nurses, doctors, and other members of the multi-disciplinary team. They also have to deal with patients' and their relatives.

g) **Physical endurance:** A distinguished nurse has strong physical endurance and is able to tolerate standing for long periods of time, lifting heavy objects including patients, subject to Health & Safety and Manual Handling policies, on a daily basis and often working double shifts.

h) **Problem solving skills:** An excellent nurse can think quickly and address problems as or before they arise.

9. **Quick response:** An impressive nurse can respond quickly to emergencies and other situations that arise. Quite often, healthcare work is simply the response to sudden incidences, and nurses must always be prepared.

10. **Respect:** Exemplary nurses respect people and rules. They are mindful of confidentiality requirements and different cultures and traditions. And they respect the wishes of the patient.

A fantastic nurse will have all these qualities, but perhaps most importantly they will be the nurse that patients want to be on shift to look after them. To take care of them, speak up for them, soothe them, monitor them and make sure they are getting the best possible care in the circumstances.

5.2. Implementation Guidance

5.2.1 Definition, purpose, characteristics and components of nurses' professional code of conduct and ethics

According to the Canadian Nurses Association, nurses' professional code of conduct and ethics is a statement of the ethical commitments of a nurse to those they serve[6]. Ethics concerned what ought to be, what is right or wrong, good or bad. It involves the study of reasoning about moral issue. Ethics may be regarded as the practical study of the norms and values which guide the judgment of what is right and what is wrong in human conduct. There are three kinds of judgment applied to human conduct:

- Acts that a human being SHOULD perform
- Acts that a human being SHOULD NOT perform
- Acts that allow the human being a CHOICE of either performing it or not performing it.

The purpose of the nurses' code of conduct and ethics is:

- To inform the public about the minimum standards of the profession and to help them understand professional nursing conduct
- To provide a sign of the profession's Commitment to the public it serves
- To outline the major ethical considerations of the profession
- To provide general guidelines for professional behaviour

- To guide the profession in self regulation
- To remind nurses of the special responsibility they assume when caring for sick

The characteristics of nurses' code of conduct and ethics are as follows:

- The services provided are vital to humanity & the welfare of society
- There is a special body of knowledge which is continually enlarged through research
- The service involves intellectual activities, individual responsibility (ACCOUNTABILITY) is a strong feature
- Practitioners are educated in institutions of higher learning
- Practitioners are relatively independent & control their own policies & activities (Autonomy)
- There is a code of ethics to guide the decisions & conduct of practitioners
- There is an organization (Association) which encourages and supports high standard of practice

Components of Code of Ethics for Registered Nurses in Ethiopia are as follows:

1. Accountability and Responsibility

- The fundamental responsibility of the nurse is four fold: to promote wellness, prevent illness, restore health and to facilitate coping.
- Nurses act in a manner consistent with their professional responsibilities and standards of practice.
- Nurses advocate practice environment conducive to safe, competent and ethical care.
- Nurses work in accordance with dependent, interdependent and collaborative functions of nursing.
- Nurses carefully handle nursing practice on specific ethical issue and resolve the ethical problems and dilemmas systematically.

2. Respect rights and dignity

- The nurse in providing care, unrestricted by consideration of nationality, race, creed, color, age, sex, politics, religion or social status.
- The nurse respects the value, customs and spiritual beliefs of the individual.
- The nurse identifies health needs of the client, helps them to express their concern and obtains appropriate information and service.
- Nurses apply and promote principles of equity and fairness to assist clients in receiving unbiased treatment and a share of health services and resources proportional to their needs.

3. Confidentiality

- Nurses safeguard the trust of the clients that information and health records in the context of professional relationship is shared outside the health care team only with the client's permission or as legally required.

- Nurses maintain privacy during therapeutic and diagnostic procedures.

4. Advocacy

- Nurses sustain a cooperative relationship with other health worker in the team work.
- Nurses value health and well being and assist persons to achieve their optimum level of health in situation of normal health, illness, injury or in the process of dying.
- Nurses promote safety prevent intentional or unintentional harm and take appropriate action to safeguard the individuals when his care is endangered by a coworker or any other person.
- The nurse respects acceptance or refusal right of the patient during therapeutic and diagnostic procedures or research and learning situations upon clients.

5. Professional Development

- The nurse plays the major role in determining and implementing desirable standards of nursing practice and nursing education.
- The nurse should develop professionally through formal and non-formal continuing education.

The nurse participates in professional organizations and advocates equitable social and economic working conditions in nursing.

5.2.2. The aims and principles of Ethics and Professional Code and Conduct:

- The principles of ethics are:
- Autonomy
- Beneficence
- Non malficence
- Justice
- Veracity
- Fidelity
- Confidentiality

According to the European Council of Nurses, the aims of the Code of nurses' professional Conduct are[15]:

- To ensure the safety and protection of those receiving nursing care
- To inform patients and nurses of the common standards of ethics and conduct expected of all practicing nurses.

The key principles of nurses' code of ethics and conduct are:

Quality and excellence

- Nurses have professional competences linked to the good practice of the profession and should perform their duties with due dedication, caution, diligence, dexterity and reasonable care.
- Nurses should behave in such a way as to guarantee mutual trust between themselves and the patient.
- Nurses should abstain from substances that can change their mental or physical ability.
- Nurses should ensure they comply with their Code of Conduct.
- Nurses are responsible for evaluating and improving the quality of the care they provide.
- Nurses should share their knowledge and skills so that either individually or within a team of professionals they can try to identify the main causes for health problems and offer prevention, treatment and rehabilitation.
- Nurses should co-operate to develop health care and their profession by promoting health, participating in the education of the community and prevention of health problems.
- Nurses should actively assess risk for their patients and take action to prevent risks stemming from their professional practice or work environment.

Continuous professional development

- Patients have a right to expect that nurses will maintain their competence throughout their working life.
- Nurses should ensure that they maintain their competence throughout their career, and comply with the requirements for continuous professional development within the country in which they are practising.

Human rights

- Patients have the right to human dignity, which is the principle at the basis of human rights. Human rights have the highest level of importance in this Code and all relevant human rights legislation applies, irrespective of nationality or country specific legislation.
- Patients have the right to be protected by their nurse and never be the victim of acts of torture, cruelty, abuse or other forms of inhumane or degrading treatment by a nurse.
- Nurses should respect the needs and requirements expressed by patients, provided that they are consistent with meeting the principles and provisions of the applicable law, other professional self-regulation instruments and the Code of the country in which they are practising;
- Nurses should provide the necessary care to relieve pain and alleviate suffering, whether it is physical, psychological or environmental;
- Nurses will be mindful of those who are vulnerable and who may be unable to voice their opinion, are fragile, or who may need additional support from the nurse or others because of their circumstances or situation.

Equitable access to quality healthcare

- Patients have the right to fair and equal access to quality healthcare and treatment from nurses, according to their needs.
- Nurses have an overarching responsibility to care for all patients equally and without prejudice to age, gender, and economic, social, political, ethnicity, religious or other status and irrespective of personal circumstances.
- Nurses are committed to recognising health as a fundamental right of the individual and will protect this right through prevention of illness, caring for patients and rehabilitation.
- Nurses have a responsibility to put the patient first and to minimise risk to the patient by providing appropriate and safe clinical care.

Compliance with Code of ethics and conduct

- Patients have the right to expect that nurses will provide high quality care, which is compliant with their code of ethics and conduct and all relevant legislation.
- Nurses have a duty to abide by the Code of the regulatory body of the country they are practising in.
- Nurses should demonstrate by their approach and behaviour that they are honest and trustworthy advocating for the patient and putting him/her first.
- Nurses should commit themselves to meeting their patient or client's need within their scope of professional practice i.e. nurses will only do what they have been trained and educated to do.
- Nurses shall co-operate to promote and develop the nursing profession in the best interests of the patient and the community.
- Nurses should undertake their responsibilities in a competent, professional and self-regulating manner.
- Nurses should be impartial and objective when assessing circumstances and should exercise judgement within their scope of practice, which is based on credible evidence.

Honesty and integrity

- Patients have the right to expect that their nurse is honest and trustworthy, and will care for them with integrity.
- The first priority of nurses should be to advocate for their patients and act in their best interest.
- Nurses should ensure that their actions when dealing with patients, clients and others, including colleagues, are underpinned by honesty, integrity and trustworthiness.
- Nurses should ensure their behaviour does not bring the nursing profession into disrepute or undermine public confidence in the profession.
- Nurses should use their qualification and registration status as a nurse only to undertake their nursing responsibilities and the role of a nurse.
- Nurses should not use their qualification or registration, to promote any commercial product or service.
- Nurses should not compromise their professional judgment or be influenced by any other benefit or commercial consideration.

- Nurses are entitled to receive an appropriate remuneration or fee for the provision of their nursing services but should refuse any personal incentive, gift, benefit, favour, payment or otherwise which might be interpreted as having influence on their professional judgment, integrity, impartiality or trustworthiness.

Relationships with others

- Patients have the right to expect that nurses will fulfill their duties, including relationships with them and others, to a consistent standard and ethos.
- Nurses should base their relationships with patients, colleagues and coworkers on mutual trust and respect,
- Nurses should promote a working environment where respect and transparency prevail, which is free from hostilities and harmful professional competition, and which is characterized by fruitful cooperation and team working among professionals and co-workers.
- Where it is necessary, nurses should advise and guide their colleagues by offering constructive criticism to ensure protection of the public and patient safety. Nurses should consider the most suitable means of raising criticisms and ensure they are addressed.
- If a nurse thinks that one of their colleagues has acted with serious incompetence or contrary to their Code of conduct, they shall inform the regulatory body and the relevant organisation, manager, etc.
- Nurses should not make harmful or disparaging remarks about their colleagues to patients, clients, third parties or others in the interest of self-promotion or professional competition.
- Nurses should respect the ideas of other professionals and should consult them if wishing to use their work for research.

Information

- Patients have a right to expect that nurses will communicate with them and provide information and advice in an appropriate, clear and user-friendly manner.
- Nurses should communicate with patients in a way that can be easily understood by patients. Information and advice must be impartial and based on credible evidence.
- Nurses will be truthful when giving information to patients.

Informed consent

Every adult must be presumed to have the mental capacity to consent or refuse treatment, unless they are

- unable to take in or retain information provided about their treatment or care
- unable to understand the information provided
- unable to weigh up the information as part of the decision-making process.

The assessment as to whether an adult lacks the capacity to consent or not is primarily down to the clinician providing the treatment or care, but nurses and midwives have a responsibility to participate in discussions about this assessment. Nurses have three over-riding professional responsibilities with regard to obtaining consent.

- To make the care of people their first concern and ensure they gain consent before they begin any treatment or care.
- Ensure that the process of establishing consent is rigorous, transparent and demonstrates a clear level of professional accountability.
- Accurately record all discussions and decisions relating to obtaining consent

Valid consent must be given by a competent person (who may be a person lawfully appointed on behalf of the person) and must be given voluntarily. Another person cannot give consent for an adult who has the capacity to consent. Exceptions to this are detailed below.

Emergency situations

An adult who becomes temporarily unable to consent due to, for example, being unconscious, may receive treatment necessary to preserve life. In such cases the law allows treatment to be provided without the person in the care of a nurse or midwife consent, as long as it is in the best interests of that person.

Medical intervention considered being in the persons best interest, but which can be delayed until they can consent, should be carried out when consent can be given. Exceptions to this are where the person has issued an advanced directive detailing refusal of treatment.

Obtaining consent

Obtaining consent is a process rather than a one-off event. When a person is told about proposed treatment and care, it is important that the information is given in a sensitive and understandable way. The person should be given enough time to consider the information and the opportunity to ask questions if they wish to. Nurses should not assume that the person in their care has sufficient knowledge, even about basic treatment, for them to make a choice. The UK Nursing and Midwifery Council (NMC) supports involving people in the care giving processes. It clearly states: "You must uphold people's rights to be fully involved in decisions about their care[21]".

It is essential that they are given sufficient information to enable them to determine whether or not to accept or decline treatment and care. This right is supported in the Code where it states: "You must respect and support people's rights to accept or decline treatment and care.[21]" It is therefore essential that nurses ensure that they: "…share with people, in a way they can understand, the information they want or need to know about their health."

In exceptional cases, for example, where consent was obtained by deception or where not enough information was given, this could result in an allegation of battery (or civil assault in some countries). However, only in the most extreme cases is criminal law likely to be involved.

Who should obtain consent?

The nurse proposing to perform a procedure should obtain consent, although there may be some situations where this may be delegated to another. When choosing to delegate the nurse must:

> "… establish that anyone you delegate to is able to carry out your instructions."
>
> "… confirm that the outcome of any delegated task meets required standards."

Usually the individual performing a procedure should be the person to obtain consent. In certain circumstances, you may seek consent on behalf of colleagues if you have been specially trained for that specific area of practice.

There may be occasions where nurses or midwives, although caring for the person, are not responsible for either obtaining consent or performing the procedure. In these cases the nurse or midwife is often best placed to know and to judge what information the person requires in order to make a decision. Nurses are reminded of the importance of communication within the team and are advised that any concerns regarding a person's understanding of a procedure should be communicated appropriately. Such difficulties in understanding could be as a result of language differences. Interpreters may be required to assist in such cases. Nurses must:

> "Keep your colleagues informed when you are sharing the care of others."
>
> "Make arrangements to meet peoples language and communication needs."

Forms of consent

A person in the care of a nurse may demonstrate their consent in a number of ways. If they agree to treatment and care, they may do so verbally, in writing or by implying (by co-operating) that they agree. Equally they may withdraw or refuse consent in the same way. Verbal consent, or consent by implication, will be enough evidence in most cases. Written consent should be obtained if the treatment or care is risky, lengthy or complex. This written consent stands as a record that discussions have taken place and of the person's choice. If a person refuses treatment, making a written record of this is just as important. A record of the discussions and decisions should be made.

When consent is refused

Legally, a competent adult can either give or refuse consent to treatment, even if that refusal may result in harm or death to him or herself. Nurses must respect their refusal just as much as they would their consent. It is important that the person is fully informed and, when necessary, other members of the health care team are involved. A record of refusal to consent, as with consent itself, must be made. The law and professional bodies recognize the power of advanced directives or living wills. These are documents made in advance of a particular condition arising and show the persons treatment choices, including the decision not to accept

further treatment in certain circumstances. Although not necessarily legally binding, they can provide very useful information about the wishes of a person who is now unable to make a decision.

Consent of people under 16

If the person is under the age of 16 (a minor), nurses must be aware of local protocols and legislation that affect their care or treatment. Consent of people under 16 is very complex, so local, legal or membership organisation advice may need to be sought. Children under the age of 16 are generally considered to lack the capacity to consent or to refuse treatment. The right to do so remains with the parents, or those with parental responsibility, unless the child is considered to have significant understanding and intelligence to make up his or her own mind about it. Children of 16 or 17 are presumed to be able to consent for themselves, although it is considered good practice to involve the parents.

Parents or those with parental responsibility may override the refusal of a child of any age up to 18 years. In exceptional circumstances, it may be necessary to seek an order from the court. Child minders, teachers and other adults caring for the child cannot normally give consent.

Consent of people who are mentally incapacitated

It is important that the principles governing consent are applied just as vigorously to people who are mentally incapacitated. A person may be described as mentally incapacitated for a number of reasons. There may be temporary reasons such as sedatory medicines, or longer term reasons such as mental illness, coma or unconsciousness.

When a person is considered incapable of providing consent, or where the wishes of a mentally incapacitated person appear to be contrary to the interests of that person, nurses and midwives caring for that particular person should be involved in assessing their care or treatment. It is important that nurses and midwives are "aware of the legislation regarding mental capacity, ensuring that people who lack capacity remain at the centre of decision making and are fully safeguarded[21]" The courts in the UK have identified certain circumstances when referral should be made to them for a ruling on lawfulness before a procedure is undertaken. These are:

- sterilization for contraceptive purposes
- donation of regenerative tissue such as bone marrow
- withdrawal of nutrition and hydration from a patient in a persistent vegetative state
- where there is doubt as to the persons capacity or best interests

- Patients have the right to self-determination and free will and that this includes the promotion and protection of their personal autonomy.
- Patients have the right to decide whether or not to accept nursing care (informed consent) or to refuse to receive information, advice or care and that the nurse will respect this decision.

- Nurses should seek valid consent from their patient and must be sure that the patient is legally competent, is informed and that any consent is given voluntarily.
- It is the responsibility of the nurse to provide the relevant information to their patient, which will enable them to make an informed decision.
- Nurses should ensure that they apply the principle of informed consent or refusal to the wishes of the patient at the present time, but also, take into account the interest of the patient where instructions have been given or expressed in the past.
- Where a patient is unable to give valid consent due to not being legally competent the following should be considered:

    - Previous instructions where applicable
    - The patient's wishes, where known
    - The patient's best interests

Mental Health

For people detained under the relevant mental health legislation, the principles of consent continue to apply for conditions not related to the mental disorder. Nurses who are involved in the care or treatment of people detained under the relevant mental health legislation, must ensure that they are aware of the circumstances and safeguards needed for providing treatment and care without consent.

Confidentiality

What is confidentiality?

A duty of confidence arises when one person discloses information to another in circumstances where it is reasonable to expect that the information will be held in confidence. This duty of confidence is derived from:

- common law – the decisions of the Courts
- Statute law which is passed by Parliament.

Confidentiality is a fundamental part of professional practice that protects human rights and is underpinned by:

- 'Everyone has the right to respect for his private and family life, his home and his correspondence.
- There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.'

The common law of confidentiality reflects that people have a right to expect that information given to a nurse is only used for the purpose for which it was given and will not be disclosed without permission. This

covers situations where information is disclosed directly to the nurse and also to information that the nurse obtains from others.

One aspect of privacy is that individuals have the right to control access to their own personal health information. It is not acceptable for nurses to:

- discuss matters related to the people in their care outside the clinical setting
- discuss a case with colleagues in public where they may be overheard
- leave records unattended where they may be read by unauthorized persons.

What is disclosure?

Disclosure means the giving of information. Disclosure is only lawful and ethical if the individual has given consent to the information being passed on. Such consent must be freely and fully given. Consent to disclosure of confidential information may be:

- explicit
- implied
- required by law or
- capable of justification by reason of the public interest

What is disclosure with consent?

Explicit consent is obtained when the person in the care of a nurse agrees to disclosure having been informed of the reason for that disclosure and with whom the information may or will be shared. Explicit consent can be written or spoken. Implied consent is obtained when it is assumed that the person in the care of a nurse or midwife understands that their information may be shared within the healthcare team. Nurses should make the people in their care aware of this routine sharing of information, and clearly record any objections.

What is disclosure without consent?

The term 'public interest' describes the exceptional circumstances that justify overruling the right of an individual to confidentiality in order to serve a broader social concern. Under common law, staff are permitted to disclose personal information in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others. Each case must be judged on its merits. Examples could include disclosing information in relation to crimes against the person e.g. rape, child abuse, murder, kidnapping, or as a result of injuries sustained from knife or gunshot wounds.

These decisions are complex and must take account of both the public interest in ensuring confidentiality against the public interest in disclosure. Disclosures should be proportionate and limited to relevant details.

Nurses should be aware that it may be necessary to justify disclosures to the courts or FMHACA and must keep a clear record of the decision making process and advice sought. Courts tend to require disclosure in the public interest where the information concerns misconduct, illegality and gross immorality.

What is disclosure to third parties?

This is where information is shared with other people and/or organizations not directly involved in a person's care. Nurses must ensure that the people in their care are aware that information about them may be disclosed to third parties involved in their care. People in the care of a nurse generally have a right to object to the use and disclosure of confidential information. They need to be made aware of this right and understand its implications.

Information that can identify individual people in the care of a nurse must not be used or disclosed for purposes other than healthcare without the individuals' explicit consent, some other legal basis, or where there is a wider public interest.

What are Information Sharing Protocols?

These are documented rules and procedures for the disclosure and use of patient information between two or more organizations or agencies, in relation to security, confidentiality and data destruction. All organizations should have these in place and nurses and midwives should follow any established information sharing protocols.

Does confidentiality apply after death?

The duty of confidentiality does continue after death of an individual to whom that duty is owed.

What information must be disclosed to the police?

In Ethiopian law there is no obligation placed upon any citizen to answer questions put to them by the police. However, there are some exceptional situations in which disclosure is required by statute. These include:

- the duty to report notifiable diseases in accordance with the Public Health Act of Parliament
- the duty to inform the Police, when asked, of the name and address of drivers who are allegedly guilty of an offence contrary to the Road Traffic rules
- the duty not to withhold information relating to the commission of acts of terrorism contrary to the national laws
- the duty to report relevant infectious diseases in accordance with the Public Health (Infectious Diseases) Regulations.

Can the police access medical records?

The police have no automatic right to demand access to a person's medical records. Usually, before the police may examine a person's records they must obtain a warrant under the Police and Criminal Evidence Law. Before a police constable can gain access to a hospital, for example, in order to search for information such as medical records or samples of human tissue, he or she must apply to a court judge for a warrant.

The police have no duty to inform the person whose confidential information is sought, but must inform the person holding that information.

What special considerations need to be taken into account when disclosure is being considered?
In some circumstances it may not be appropriate to inform the person of the decision to disclose, for example, due to the threat of a violent response. The nurse may feel that, because of specific concerns, a supplementary record is required containing details of the disclosure. All members of the health care team should be aware that there is a supplementary record and this should not compromise the persons' confidentiality.

What if a nurse or midwife is required to act as a witness in a court case?
If a nurse is summoned as a witness in a court case he/she must give evidence. There is no special rule to entitle the nurse to refuse to testify. If a nurse refuses to disclose any information in response to any question put to him/her, then a judge may find the nurse in contempt of court and may ultimately send him/her to prison.

What if I think there is a risk or breach of confidentiality?
If a nurse or midwife identifies a risk or breach of confidentiality they must raise their concerns with someone in authority if they are unable to take affirmative action to correct the problem and record that they have done so. A risk or breach of confidentiality may be due to individual behaviour or as a result of organizational systems or procedures. The Code states "You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk". Nurses have a professional duty to take action to ensure the people in their care are protected and failure to take such action could amount to professional misconduct on their part

- Patients have the right to expect that any information they disclose is confidential between themselves and their nurses.
- Confidentiality is the cornerstone for building trust between nurses and their patients. Nurses have a responsibility to respect any confidentiality relating to information from their patients or about their patient's matters and conditions.
- Nurses should not disclose confidential information unless in line with the law of the country in which they are practising. Where this is the case, nurses must meet the legal requirements for doing so.

Conflict with moral and ethical beliefs

In the event of conflict caused by deep moral, ethical or other beliefs arising from a request for nursing services, a nurse is encouraged to find a solution through dialogue with relevant parties such as the patient, employer and FMHACA or professional organisation. Where a nurse is unable to find a solution to the above or should they wish to give conscientious objection, they should refer to and be guided by the legal framework in force for the country they are practising in an emergency situation or where there is an

imminent risk to the patient's life, nurses should provide care to the patient regardless of any conflict with their own moral or ethical belief.

Delegation to and supervision of staff

Patients have the right to expect that anyone providing nursing care to them is appropriately trained and competent to provide that care.

- Nurses cannot delegate their nursing function to others but may find it necessary to delegate tasks to others such as another nurse, a health officer or support staff.
- When a nurse delegate's care the nurse is accountable for ensuring the appropriateness of the delegation and that the person to whom the task is being delegated is competent to undertake the task and has adequate supervision or support.
- Nurses retain the ultimate accountability should they delegate tasks to another.

5.2.3 Application of the components and or principles of nurses' code of conduct and ethics

Nurses need to treat people as individuals

- Nurses must treat people as individuals and respect their dignity
- Nurses must not discriminate in any way against those in your care
- Nurses must treat people kindly and considerately
- Nurses must act as an advocate for those in your care, helping them to access relevant health and social care, information and support

Respect people's confidentiality

- Nurses must respect people's right to confidentiality
- Nurses must ensure people are informed about how and why information is shared by those who will be providing their care
- Nurses must disclose information if they believe someone may be at risk of harm, in line with the law of the country in which you are practising

Collaborate with those in your care

- Nurses must listen to the people in their care and respond to their concerns and preferences
- Nurses must support people in caring for themselves to improve and maintain their health
- Nurses must recognize and respect the contribution that people make to their own care and wellbeing

- Nurses must make arrangements to meet people's language and communication needs
- Nurses must share with people, in a way they can understand, the information they want or need to know about their health

Ensure you gain consent

- Nurses must ensure that they gain consent before they begin any treatment or care
- Nurses must respect and support people's rights to accept or decline treatment and care
- Nurses must uphold people's rights to be fully involved in decisions about their care
- Nurses must be aware of the legislation regarding mental capacity, ensuring that people who lack capacity remain at the centre of decision making and are fully safeguarded
- Nurses must be able to demonstrate that they have acted in someone's best interests if they have provided care in an emergency

Maintain clear professional boundaries

- Nurses must refuse any gifts, favours or hospitality that might be interpreted as an attempt to gain preferential treatment
- Nurses must not ask for or accept loans from anyone in their care or anyone close to them
- Nurses must establish and actively maintain clear sexual boundaries at all times with people in their care, their families and carers

Work with others to protect and promote the health and wellbeing of those in their care, their families and carers, and the wider community.

Share information with colleagues

- Nurses must keep their colleagues informed when they are sharing the care of others
- Nurses must work with colleagues to monitor the quality of their work and maintain the safety of those in their care
- Nurses must facilitate students and others to develop their competence

Work effectively as part of a team

- Nurses must work cooperatively within teams and respect the skills, expertise and contributions of their colleagues
- Nurses must be willing to share their skills and experience for the benefit of colleagues
- Nurses must consult and take advice from colleagues when appropriate

- Nurses must treat colleagues fairly and without discrimination
- Nurses must make a referral to another practitioner when it is in the best interests of someone in their care

Delegate effectively

- Nurses must establish that anyone they delegate to is able to carry out their instructions
- Nurses must confirm that the outcome of any delegated task meets required standards
- Nurses must make sure that everyone they are responsible for is supervised and supported

Manage risk

- Nurses must act without delay if they believe that a colleague or anyone else may be putting someone at risk
- Nurses must inform someone in authority if they experience problems that prevent them working within this Code or other nationally agreed standards
- Nurses must report their concerns in writing if problems in the environment of care are putting people at risk

Provide a high standard of practice and care at all times.

Use the best available evidence

- Nurses must deliver care based on the best available evidence or best practice.
- Nurses must ensure any advice their give is evidence based if they are suggesting healthcare products or services
- Nurses must ensure that the use of complementary or alternative therapies is safe and in the best interests of those in their care
- Nurses must keep their skills and knowledge up to date
- Nurses must have the knowledge and skills for safe and effective practice when working without direct supervision
- Nurses must recognise and work within the limits of their competence
- Nurses must keep their knowledge and skills up to date throughout their working life
- Nurses must take part in appropriate learning and practice activities that maintain and develop their competence and performance

Keep clear and accurate records

Nurses must keep clear and accurate records of the discussions they have, the assessments they make, the treatment and medicines they give and how effective these have been

- Nurses must complete records as soon as possible after an event has occurred
- Nurses must not tamper with original records in any way
- Nurses must ensure any entries they make in someone's paper records are clearly and legibly signed, dated and timed
- Nurses must ensure any entries they make in someone's electronic records are clearly attributable to them
- Nurses must ensure all records are kept securely

Be open and honest, act with integrity and uphold the reputation of their profession.

Act with integrity

- Nurses must demonstrate a personal and professional commitment to equality and diversity
- Nurses must adhere to the laws of Ethiopia
- Nurses must inform FMHACA and their employer if they have been cautioned, charged or found guilty of a criminal offence
- Nurses must inform their employer if their fitness to practise is called into question

Deal with problems

- Nurses must give a constructive and honest response to anyone who complains about the care they have received
- Nurses must not allow someone's complaint to prejudice the care they provide for them
- Nurses must act immediately to put matters right if someone in their care has suffered harm for any reason
- Nurses must explain fully and promptly to the person affected what has happened and the likely effects
- Nurses must cooperate with internal and external investigations

Be Impartial

- Nurses must not abuse their privileged position for their own ends
- Nurses must ensure that their professional judgment is not influenced by any commercial considerations

Uphold the reputation of the nursing profession

- Nurses must not use their professional status to promote causes that are not related to health
- Nurses must cooperate with the media only when they can confidently protect the confidential information and dignity of those in their care
- Nurses must uphold the reputation of the nursing profession at all times.

SECTION 6 : MODULE 4 - COMMUNICATION IN NURSING

6.1 An overview of Communication in Nursing

Communication is a process in which people affect one another through exchange of information, ideas and feelings.

- Communication should be accurate, timely and effective
- It includes discussion, reports, records, orders can be oral or written
- Quality of patient care depends on the caregiver's ability to communicate with patient and with colleagues

Communication in 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. There are two main types of communication: verbal and written forms of communication:

- *Written communication:* This includes the written documentation of all findings, progress, care and treatment provided to the patient by the medical team, including the nurses.
- *Verbal communication*: the act of reporting and conversing with other members of the health care team regarding the patient's progress and status.

6.2. Implementation Guidance

6.2.1 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're not sure, then your audience won't be sure either.

To be clear, try to minimize 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're trying to say.

Bad Example

Hi Yidnek,

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 more about her when you have time.

Best,

Yeko

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

Next, what is Tigist doing, specifically, that's so great? We don't know that either. It's so vague that Yidnek 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.

Good Example

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

Hi Yidnek,

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 it 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.

2. 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 Abebaw,

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

3. 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 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.

4. 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.
- Are all names and titles spelled correctly?

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

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're 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's so important to proofread everything!

5. Coherent

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

Bad Example

Rael,

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

As you can see, 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.

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,

Bethlehem

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.

6. 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,

Genet

7. 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's 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.

6.2.2 Written Communication: Nursing Record Documentation

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: As described in Section3.2 above, nurses should record all steps in the nursing process on the appropriate forms:*
• Nursing Admission Assessment Form (Appendix A)
• Nursing Problem Statement List (Appendix B)

• Nursing Care Plan (Appendix D)
• Nursing Patient Progress Report (Appendix E)

6.2.3 Verbal Communication

1) *Reporting to Physicians:* 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.

2) *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

3) *Nurse to Junior Nurse/Health Assistant/Student Report:* At the start of each shift, the nurse is responsible for reporting to the junior nurse/health assistant/student 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.

a) *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.

b) *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.

c) *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.
-

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

4) *Patient Education:* It is important to educate the patient, his/her spouse/partner, and his/her family about the illness and course of treatment being provided as a preventative and/or curative measure. It informs and empowers the patient, thus improving his/her ability to achieve a higher level of wellness and ability to manage specific needs. Efforts to educate the patient should be realistic, relevant and provide time for patient practice and opportunity to seek clarification.

Patient education should also incorporate family members and other caregivers who often play strong role in facilitating patient care in coordination with medical staff. One suggestion to improve the family and staff relationship is through the use of a Patient Caregiver Contract, whereby the relationship is formalized between families/caregivers and medical staff (A sample Patient Caregiver Contract is presented in Appendix F). This allows patient families to act as "aides" and provide certain services (feeding, bathing, ambulating, bringing fresh sheets and food, etc.) within guidelines that are acceptable to medical staff. Such a formalized process can greatly improve the patient's quality of care. It is also important to ensure that such a contract is fully understood by both the patient and caregiver prior to signing.

6.2.4 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.

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.

6.2.5 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.

Procedure

1) *Physician Order***:** A physician's order is required for the administration of all medications. There are several types of orders:

- Standing order: To be carried out as specified until it is canceled by another order (including PRN orders).
- Single order: To be carried out only once, as directed.
- Stat order: To be carried out immediately.
- Verbal order: An order that has been communicated through the phone or verbally.

These orders are reserved for times when the physician is unable to reach the patient's medical record. Verbal orders can only be taken by a nurse, who must immediately transcribe the verbal order into the Physician Order Sheet. 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. *All verbal orders must be co-signed by the physician within 24 hours***.**

Physician orders need to include the following information when they are transcribed into the Physician Order Sheet in order to be considered complete. Orders are not to be carried out unless all of these elements are present. If an element is missing, the physician who issued the order should be called to complete the order.

- Date and time: When the order was written.
- Full name of the medication: Either the chemical or generic name can be used without abbreviations.
- Dosage: Specify the amount of medicine to be given. Abbreviations are discouraged.
- Concentration: If the medication is to be diluted in IV fluid, the amount and type of diluent/s ordered.
- Duration: If the medication is to be given over a period of time, such as IV administrations, the duration of the infusion ordered should be recorded by the physician. Nurses should then translate and document the duration of infusion into number of (micro-) drops per minute.
- Time and frequency: The time of day and how often a medication is to be given, as ordered by the physician. The nurse who transcribes the order will identify the specific time that the medication is to be given by following a standardized schedule.
- Route: For medications that can be given in several ways, the route of administration needs to be clearly written.
- Physician *Signature:* Is to be clearly written immediately following the order.

2) *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.

3) *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.

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.

4) *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.

5) *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.

W**hy 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.

C**haracteristics of Medication Errors**

The three most frequently reported types of errors are[6]:

- Omission errors (failure to administer a prescribed medication);
- Improper dose (medication dose, strength, or quantity different from that prescribed);
- Unauthorised drug errors (the medication dispensed and/or administered was not authorised by the prescriber).

Types of 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
unauthorised 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.

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[10]. 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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SECTION 7: ASSESSMENT TOOL, IMPLEMENTATION CHECKLIST AND INDICATORS

7.1 Assessment tool

In order to determine if the Operational Standards of Nursing 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. The tool is presented in Appendix E of *Chapter 13 Monitoring and Reporting.*

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Supportive Clinical Supervision Guidelines for nurses

Contents

1.0 Introduction and Policy Statement

These guidelines were developed by XXX. The following individuals/groups were consulted during the development:

- Xxx
- Yyy
- Zzz

The guidelines were approved by the Hospital Governing Board[2] on **dd/mm/yyyy** and provide a broad statement of purpose and rational for clinical supervision for nurses.

2. 0 What is 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 consumer protection and safety of care in complex clinical situations"(DOH, 1993) [3]. 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
[ ] Hospital.

3.0 Model of Clinical Supervision

The interactive model of supervision developed by Proctor (1986) [3] 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.

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[2] Hospitals' Governing Boards
[2] Royal College of Nursing (2003) Clinical Supervision in the workplace: Guidance for occupational health nurses. London: RCN.
[3] Department of Health (*1993) A Vision for the Future*. London: HMSO.
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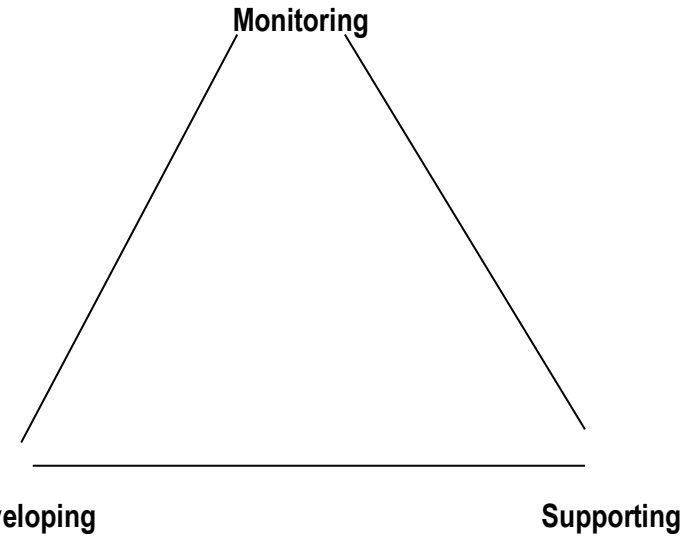
- ***Managerial:*** This focuses on performance monitoring of the nurse/s professional and operational practice. It aims to promote nursing compliance with policies, protocols, procedures and standards and nursing contribution to clinical audit.

3.1 Function and Tasks of Clinical Supervision[8]

• **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'.[8]



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.

4.0 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.

5.0 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.

6.0 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.

7.0 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. [4]

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

8.0 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.

9.0 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.

[4] Winstanley J, White E (2003) Clinical Supervision: Models measures and best practice. Nurse Researcher Vol. 10 (4) p.7-38

In such circumstances this most probably will mean breaking confidentiality with the supervisee. Such action should only be taken after first informing the supervisee.

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Appendix 1

Clinical Supervision Contract

Supervisor

As supervisor I take responsibility for:

Ensuring a safe environment for the supervisee to discuss their practice in their own way

1. Helping the supervisee explore, clarify and learn from their own thinking and feelings and perspectives regarding their practice
2. Giving and receiving open, honest and constructive feedback
3. Sharing with the supervisee information, experience and skills appropriately
4. Challenging professional practice in an open and honest manner

Supervisee

As a supervisee, I will take responsibility for

1. Identifying problems with which I need help and using the time available to deal with them
2. Identifying and communicating the type of resource which is useful to me
3. Becoming aware of my role and scope and its implications to myself and the organisation and profession for which I work for
4. Informing my line manager of my supervision arrangements

Supervisor and supervisee we shall take responsibility for:

1. Arranging when, where and how long each session will be
2. Frequency of supervision sessions
3. The limits to and the maintenance of confidentiality
4. Reviewing regularly, at agreed and predetermined intervals, the usefulness of supervision
5. Knowing the boundaries of the clinical supervisor process
6. Cancellation – agreed when acceptable responses and future alternative arrangements made

Signed……..…….Supervisor Date……..…

Signed……..Supervisee Date……..……

Appendix 2

Clinical Supervisor's Log

Date of meeting: ……..Length of meeting; ….……..……..

Key points Discussed:

Outcome:

Date of next meeting:..…….

Signature of supervisor: ….……..Date: ……

Signature of supervisee: ……..……Date:..……..……

APPENDIX 3

Supervisee's log

Date of session: **Notes: Topics discussed and outcomes**
Date session: **Notes: Topics discussed and outcomes**

APPENDICES: Appendix B – Nursing Process Documentation Forms

Patients' Nursing Care Plan Documentation

Please Complete or Affix Label	**HOSPITAL**
Name: Father Name: Address:- City: Sub city: Kebele: House no. MRN: Age: Tel. No.:	Ward: _____ Bed No.: _____

Personal Details

☐ Male ☐ Female	Nationality: Ethnic group:
	Language:
Marital Status:	Religion:
	Occupation(previous and current):

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.

Health Perception/Management

Patient's understanding of reason of admission:
Significant Others' understanding reason for admission:

Understanding of Medication(what, how and why) Patient is taking *before* admission (incl. "over the counter" and known allergies)

Drug name	Dose	Freq.	Drug name	Dose	Freq.

Role and Relationships

Discharge Arrangements and Other Social Details	
Lives alone?	☐ Yes ☐ No Comments: _____
Employee?	☐ Yes ☐ No Comments: _____
Self employee?	☐ Yes ☐ No Comments: _____
Dependents?	☐ Yes ☐ No Comments: _____
Is patient independent?	☐ Yes ☐ No If no, please state who helps with & how many times per week: Cooking: _____ Washing / Dressing: _____ Shopping: _____ Cleaning: _____ Other: _____ Other: _____
Ability to Pay for treatment:	

_____

Patient Assessment for Activity of Living

1. Cognitive and Perceptual

- Level of consciousness: _____
- Reflexes(Eye , hand grasp and movement of extremities)_____
- Sensorial (eye, ear, nose, tongue and skin) _____
- Pain _____
- Cognition(primary language, speech deficit and any LD) _____

Other Comments:

2. Activity and Exercise

• Breathing – respiratory patterns, lung sounds, cough, oxygen supplement, any respiratory tubes	
• Circulation: Peripheral pulse, cardio vascular check, chest pain, jugular ventilation, history of murmur, peacemaker	

3. Nutrition and Metabolism

- Special diet:
- Pattern of daily food:
- Fluids intake:
- Appetite:
- Weight:
- Nausea and vomiting:
- GI Pain:
- Condition of mucous membrane:
- Dental condition:
- Skin (warm, dry, cold,moist):
- Turgor and mobility:
- Colour (pink, pale, dark, jaundice, cyanose):
- Odeoma:
- Wound/drainage/dressings:
- IV Line:

Other Comments:

4. Elimination-Urine and faeces	Assessment results
• Usual time of bowel movement • Any recent changes in elimination • Any excess perspiration • Bowel sound • Abdominal tenderness • Stoma(type) • Any brut • Use of anything to manage bowels (laxatives, enema, suppositories, home remedies, etc.) • Urinary pattern (frequency, character, amount, incontinence, retention, nocturia, etc.)	

5. Psychological Care

Coping with stress

- Response to stress
- Relaxation methods
- Support groups/ counseling resource

6. Spiritual/Dying

Value and belief:

- Cultural practice: ☐ Yes ☐ No Comments:
- Religious practice: ☐ Yes ☐ No Comments:
- Familial traditions: ☐ Yes ☐ No Comments:
- Would you like your religious leader to be contacted? ☐ Yes ☐ No Comments:

7. Sleeping

Sleep/rest pattern:

- Adequacy of Sleep: ☐ Adequate ☐ Not adequate Comments:
- Difficulty of sleep ☐ Yes ☐ No Comments:
- Factors affecting sleep/rest:

_____

Methods to promote sleep _____

8. Sexuality and Reproductive

Female

Menopausal ☐ Yes ☐ No Comments:

Menstrual pattern:_____Date of LMP: _____

Use of contraceptive? ☐ Yes ☐ No What type: _____

Monthly breast self-examination?

Vaginal discharge/bleeding, lesion?

Male

Monthly testicular examination?

Prostate problems?

Penile discharge?

Summary subjective data	Summary objective data

NAME OF ACCEPTING/RECEIVING NURSE: _____
DATE: _____ TIME: _____

SIGNATURE AND DESIGNATION OF ADMITTING NURSE: _____ DATE: _____ TIME: _____

Nursing Problem Index List

Please Complete or Affix Label	_____ **HOSPITAL**
Name: Father Name: Address:- City: Sub city: Kebele: House no. MRN: Age: Tel. No.:	Ward: _____ Bed No.: _____

Date Identified and Time	No	Problem	Signature and Designation	Date Resolved and Time	Signature and Designation

Nursing Care Plan

Please Complete or Affix Label	_____ **HOSPITAL**
Name: Father Name: Address:- City: Sub city: Kebele: House no. MRN: Age: Tel. No.:	Ward: _____ Bed No.: _____

Date and Time	Problem No	Nursing outcome/Goal	Intervention/Action	Signature and Designation

Nursing Patient Progress Report

Please Complete or Affix Label	_____ **HOSPITAL**
Name: Father Name: Address:- City: Sub city: Kebele: House no. MRN: Age: Tel. No.:	Ward: _____ Bed No.: _____

Date and Time Problem Identified	Problem No	Patient Progress Report / Evaluation	Review Date and Time	Signature and Designation

Appendix C - 2009–2011 North American Association of Nurses Approved Nursing Diagnoses

Activity/Rest
Activity Intolerance
Activity Intolerance, Risk for
Activity Planning, ineffective
Disuse Syndrome, risk for
Diversional Activity, Deficient
Fatigue
Insomnia
Lifestyle, sedentary
Mobility: Bed, Impaired
Mobility: Wheelchair, Impaired
Sleep, Readiness for Enhanced
Sleep Deprivation
Sleep Pattern Disturbed
Transfer Ability, Impaired

Circulation
Autonomic Dysreflexia
Autonomic Dysreflexia, risk for
Bleeding, risk for
Cardiac Output, decreased
Intracranial Adaptive Capacity, decreased
Perfusion, ineffective peripheral tissue
Perfusion, risk for decreased cardiac tissue
Perfusion, risk for ineffective cerebral tissue
Perfusion, risk for ineffective gastrointestinal
Perfusion, risk for ineffective renal
Shock, risk for

Ego Integrity
Anxiety [specify level]
Anxiety, death
Behaviour, risk-prone health
Body image, disturbed
Conflict, decisional (specify)
Coping, defensive
Coping, ineffective
Coping, readiness for enhanced
Decision making, readiness for enhanced
Denial, ineffective
Dignity, risk for compromised human
Distress, moral
Energy field, disturbed
Fear
Grieving
Grieving, complicated
Grieving, risk for complicated
Hope, readiness for enhanced
Hopelessness
Identity, disturbed personal
Post-Trauma Syndrome
Post-Trauma Syndrome, risk for
Power, readiness for enhanced
Powerlessness
Powerlessness, risk for
Rape-Trauma Syndrome
Relationships, readiness for enhanced
Religiosity, impaired
Religiosity, ready for enhanced
Religiosity, risk for impaired
Relocation Stress Syndrome
Relocation Stress Syndrome, risk for
Resilience, impaired individual
Resilience, readiness for enhanced
Resilience, risk for compromised
Self-concept, readiness for enhanced
Self-esteem, chronic low
Self-esteem, situational low
Self-esteem, risk for situational low
Sorrow, chronic
Spiritual Distress
Spiritual Distress, risk for
Spiritual Well-being, readiness for enhanced

Elimination
Bowel Incontinence
Constipation
Constipation, perceived
Constipation, risk for
Diarrhea
Motility, dysfunctional gastrointestinal
Motility, risk for dysfunctional gastrointestinal
Urinary Elimination, impaired
Urinary Elimination, readiness for enhanced
Urinary Incontinence, functional
Urinary Incontinence, overflow
Urinary Incontinence, reflex
Urinary Incontinence, risk for urge
Urinary Incontinence, stress
[Urinary Incontinence, total-retired 2009]
Urinary Incontinence, urge
Urinary Retention [acute/chronic]

Food/Fluid
Breastfeeding, effective
Breastfeeding, ineffective
Breastfeeding, interrupted
Dentition, impaired
Electrolyte Imbalance, risk for
Failure to Thrive, adult
Feeding Pattern, ineffective infant
Fluid Balance, readiness for enhanced
[Fluid Volume, deficient hyper/hypotonic]
Fluid Volume, deficient [isotonic]
Fluid Volume, excess
Fluid Volume, risk for deficient
Fluid Volume, risk for imbalanced
Glucose, risk for unstable blood
Liver Function, risk for impaired
Nausea
Nutrition: less than body requirements, imbalanced
Nutrition: more than body requirements, imbalanced
Nutrition: risk for more than body requirements, imbalanced
Nutrition, readiness for enhanced
Oral Mucous Membrane, impaired
Swallowing, impaired

Hygiene
Self-care, readiness for enhanced
Self-care Deficit, bathing
Self-care Deficit, dressing
Self-care Deficit, feeding
Self-care Deficit, toileting
Neglect, self

Neurosensory
Confusion, acute
Confusion, risk for acute
Confusion, chronic
Infant Behavior, disorganized
Infant Behavior, readiness for enhanced organized
Infant Behavior, risk for disorganized
Memory, impaired
Neglect unilateral
Peripheral Neurovascular Dysfunction, risk for
Sensory Perception, disturbed (specify: visual, auditory, kinaesthetic, gustatory, tactile, olfactory)
Stress Overload

Pain/Discomfort
Comfort, impaired
Comfort, readiness for enhanced
Pain, acute
Pain, chronic

Respiration
Airway Clearance, ineffective
Aspiration, risk for
Breathing Pattern, ineffective
Gas exchange, impaired
Ventilation, impaired spontaneous
Ventilatory Weaning Response, dysfunctional

Safety
Allergy Response, latex
Allergy Response, risk for latex
Body Temperature, risk for imbalanced
Contamination
Contamination, risk for
Death Syndrome, risk for sudden infant
Environmental Interpretation Syndrome, impaired
Falls, risk for
Health Maintenance, ineffective
Home Maintenance, impaired
Hyperthermia
Hypotherma
Immunization Status, readiness for enhanced
Infection, risk for
Injury, risk for
Injury, risk for perioperative positioning
Jaundice, neonatal
Maternal/Fetal Dyad, risk for disturbed
Mobility, impaired physical
Poisoning, risk for
Protection, ineffective
Self-Mutilation
Self-Mutilation, risk for
Skin Integrity, impaired
Skin Integrity, risk for impaired
Suffocation, risk for
Suicide, risk for
Surgical Recovery, delayed
Thermoregulation, ineffective
Tissue Integrity, impaired
Trauma, risk for
Trauma, risk for vascular
Violence, [actual/] risk for other-directed
Violence, [actual/] risk for self-directed
Wandering [specify sporadic or continual]

Sexuality
Child-bearing Process, readiness for enhanced
Sexual Dysfunction
Sexuality Pattern, ineffective

Social Interaction
Attachment, risk for impaired
Caregiver Role Strain
Caregiver Role Strain, risk for
Communication, impaired verbal
Communication, readiness for enhanced
Conflict, parental role
Coping, ineffective community
Coping, readiness for enhanced community
Coping, compromised family
Coping, disabled family
Coping, readiness for enhanced family
Family Processes, dysfunctional
Family Processes, interrupted
Family Processes, readiness for enhanced
Loneliness, risk for
Parenting, impaired
Parenting, readiness for enhanced
Parenting, risk for impaired
Role Performance, ineffective
Social Interaction, impaired
Social Isolation

Teaching/Learning
Development, risk for delayed
Growth, risk for disproportionate
Growth and Development, delayed
Health Behaviour
Health Management, ineffective self
Knowledge, deficient (specify)
Knowledge (specify), readiness for enhanced
Noncompliance [Adherence, ineffective] (specify)
Therapeutic Regimen Management, ineffective
Therapeutic Regimen Management ineffective family
Therapeutic Regimen Management, readiness for enhanced

Appendix D: Patient Caregiver Contract

NAME: _____

MRN: _____

WARD: _____ BED: _____

I. Patient Information

Date: _____ Age: _____ Sex: _____

Reason for Admission: _____

II. Visitor Information

Name(s) of all visitors:

1) _____ Relationship to patient: _____
2) _____ Relationship to patient: _____
3) _____ Relationship to patient: _____
4) _____ Relationship to patient: _____

II. Official Caregiver Information

Name(s) of all patient family member(s), close relative(s) or friend(s) who is/are responsible for patient care. Cannot exceed 2 individuals per patient.

1) _____ Relationship to patient: _____
2) _____ Relationship to patient: _____

III. Hospital Visiting Hours and Regulations:

Official Caregivers: 24 hours a day

Visitors: 1:30 – 2:30 (ET) / 7:30am – 8:30am (GT)
5:30 – 7:30 (ET) / 11:30am –1:30pm (GT)
11 – 2 (ET) / 5:00pm – 8pm (GT)

Official and Non-official Caregiver Regulations:

In the best interest of all patients, staff and visitors, a maximum of TWO visitors are permitted to see a patient at *any one time* (children under 8 years old not included; however all children must be accompanied by an adult). Caregivers and visitors are not permitted to damage and/or take possession of hospital property or equipment. Official caregivers will be held responsible in the event that hospital property or equipment is damaged or stolen. Visitors and official caregivers will be removed from the ward immediately if they interfere with the medical and non-medical staff's ability to perform their jobs, or if they threaten the security of the staff, patients or visitors.

IV. Role of Official Caregivers:

1) To work with ward medical and non-medical staff (cleaners, hospital administrators) in a cooperative and respectful manner
2) To undergo a brief orientation to the ward upon patient admission (including basic infection prevention training and introduction to facilities available for caregiver use)
3) To supply ordered medication (if paying patient)
4) To change patient bed sheets
5) To change patient bedpan in designated area
6) To use toilet and shower properly and clean messes made by self or patient
7) To dispose of liquid and solid waste separately and in provided containers

8) To cooperate with cleaning staff in order to maintain cleanliness of the patient's room and ward hallways
9) To exchange time in the ward and duties ONLY with other official caregivers
10) To assist in minimizing visitors during regular visiting hours in order to avoid overcrowding and spread of infection
11) To inform medical staff and/or ward security guard of the patient's medical problems which are encountered in the ward
12) To assume responsibility for hospital fee upon patient discharge, if patient does NOT have a free paper from his/her kebele

IV. Role of Visitors:

1) To allow ward medical and non-medical staff (cleaners, hospital administrators) to perform their duties in cooperative, respectful manner
2) To undergo a brief orientation to the ward upon patient admission (including basic infection prevention training and introduction to facilities available for caregiver use)
3) To follow visiting hour guidelines
4) To respect the property of all staff, patients, and visitors
5) To conduct appropriate behaviour in the hospital, so as not to disturb the peace and security of all patients, hospital staff, and visitors
6) Should a disagreement occur, to file a formal written complaint to the head of the department ward, rather than to create a direct confrontation
7) To assume responsibility for hospital fee upon patient discharge, if patient does NOT have a free paper from his/her kebele.

I, the undersigned, agree to fulfill the above mentioned responsibilities and regulations as an official caregiver, in order to ensure the best possible care for the aforementioned patient(s). I understand that failure to comply with these responsibilities and regulations will result in my ejection from the ward. I also understand that the failure of non-official caregivers to comply with visiting hours and regulations will result in their ejection from the ward.

1) Print Caregiver Name: _____

Signed: _____

2) Print Caregiver Name: _____

Signed: _____

3) Ward Staff Witness: _____

Signed: _____

Appendix E: Learning Guide on antenatal assessment and care

(To be completed by Learners)

Rate the performance of each step or task observed using the following rating scale:

1. Needs Improvement: Step or task not performed correctly, out of sequence (if necessary), or is omitted

2. Competently Performed: Step or task performed correctly in proper sequence (if necessary) but learner does not progress from step to step efficiently

3. Proficiently Performed: Step or task performed efficiently and precisely in the proper sequence (if necessary)

LEARNING GUIDE FOR ANTENATAL ASSESSMENT AND CARE *(Some of the following steps/tasks should be performed simultaneously.)*					
STEP/TASK	*CASES*				
GETTING READY					
1. Prepare the necessary equipment.					
2. Greet the woman respectfully and with kindness.					
3. Tell the woman (and her support person) what is going to be done, listen to her attentively and respond to her questions and concerns.					
4. Provide continual emotional support and reassurance, as possible.					
HISTORY (ASK/CHECK RECORD)					
Personal Information (First Visit)					
1. What is your name, your age, and your address and phone number? • *If the woman is less than 20 years of age, determine the circumstances surrounding the pregnancy (e.g. unprotected sex, multiple partners, incest, sexual abuse, rape, sexual exploitation, prostitution, forced marriage, forced sex)*					
2. Do you have access to reliable transportation?					
3. What sources of income/financial support do you/your family have?					
4. How many times have you been pregnant and how many children have you had?					

LEARNING GUIDE FOR ANTENATAL ASSESSMENT AND CARE *(Some of the following steps/tasks should be performed simultaneously.)*					
STEP/TASK	*CASES*				
5. Are you having a particular problem at present? If Yes, find out what the problem is and ask the following additional questions: • *When did the problem first start?* • *Did it occur suddenly or develop gradually?* • *When and how often does the problem occur?* • *What may have caused the problem?* • *Did anything unusual occur before it started?* • *How does the problem affect you?* • *Are you eating, sleeping, and doing other things normally?* • *Has the problem become more severe?* • *Are there other signs and conditions related to the problem? If Yes, ask what they are.* • *Have you received treatment for the problem? If Yes, ask who provided the treatment, what it involved, and whether it helped.*					
6. Have you received care from another caregiver? If Yes, ask the following additional questions: • *Who provided the care?* • *Why did you seek care from another caregiver?* • *What did the care involve?* • *What was the outcome of this care?*					
Menstrual and Contraceptive History (Fist Visit)					
7. Do you know the first day of your last menstrual period? If Yes, calculate EDC.					
8. How many more children do you plan to have?					
9. Have you used a family planning method before? If Yes, ask the following additional questions: • *Which method(s) have you used?* • *Did you like the method(s) and why?* • *Which method did you like the most and why? (if more than one method used)* • *Would you like information about other methods?*					
10. Do you plan on using a family planning method after this baby is born? If Yes, ask which method and whether she would like information on additional methods.					
Present Pregnancy (First Visit)					

LEARNING GUIDE FOR ANTENATAL ASSESSMENT AND CARE *(Some of the following steps/tasks should be performed simultaneously.)*					
STEP/TASK	*CASES*				
11. Have you felt the baby move? If Yes, ask the woman when the baby first moved and whether she has felt it move in the last day.					
12. How do you feel about this pregnancy?					
13. How does your partner/family feel about this pregnancy?					
Daily Habits and Lifestyle (First Visit)					
14. Do you work outside the home?					
15. Do you walk long distances, carry heavy loads or do heavy physical labor?					
16. Do you get enough sleep/rest?					
17. Have you had a baby within the last year? If Yes, ask if the woman is currently breastfeeding.					
18. What do you normally eat in a day?					
19. Do you eat any non-food substances such as dirt or clay?					
20. Do you smoke, drink alcohol or use any other possibly harmful substances?					
21. Who do you live with?					
22. Has anyone ever prevented you from seeing family or friends, stopped you from leaving your house, or threatened your life?					
23. Have you ever been injured, hit, or forced to have sex by someone?					
24. Are you frightened of anyone?					
Obstetric History (First Visit)					
25. Did you have any problems during a previous pregnancy or during/following childbirth? • *convulsions (pre-eclampsia/eclampsia) during pregnancy or childbirth* • *caesarean section or uterine rupture during childbirth* • *tears through rectum (or third- or fourth-degree tears) during childbirth* • *postpartum hemorrhage* • *stillbirths, preterm, low birthweight, babies who died before 1 month of age* • *three or more spontaneous abortions*					
26. Have you had any problems breastfeeding (if this is not the woman's first child)?					
Medical History (First Visit)					
27. Do you have any allergies?					

LEARNING GUIDE FOR ANTENATAL ASSESSMENT AND CARE *(Some of the following steps/tasks should be performed simultaneously.)*					
STEP/TASK	*CASES*				
28. Have you been tested for HIV? If Yes, ask whether the result was positive.					
29. Have you had anemia recently (within last 3 months)?					
30. Have you been tested for syphilis? If Yes, ask whether the result was positive and if and when and with what she was treated.					
31. Do you have any chronic illnesses or conditions such as tuberculosis, hepatitis, heart disease, diabetes, or any other serious disease?					
32. Have you ever been in hospital or had surgery?					
33. Are you taking any drugs/medications (including traditions/local preparations, herbal remedies, over-the-counter drugs, vitamins, or dietary supplements)?					
34. Have you had a complete series of five tetanus toxoid (TT) immunizations? If Yes, find out if it has been less than 10 years since the woman's last booster.					
Interim History (Return Visits)					
35. Do you have a problem at present? If Yes, ask follow-up questions under "Personal Information" item 5, above.					
36. Have you had any problems since your last visit?					
37. Has your address or phone number changed since your last visit?					
38. Have your daily habits or lifestyle (workload, rest, dietary intake) changed since your last visit.					
39. Have you received care from another caregiver since your last visit? If Yes, ask who provided the care, what care was provided and what the outcome of care was.					
40. Have you taken drugs/medications prescribed and followed the advice/recommendations (plan of care) provided at your last visit?					
41. Have you had any reactions to or side effects from immunizations or drugs/medications given at your last visit?					
PHYSICAL EXAMINATION (LOOK/LISTEN/FEEL)					
Assessment of General Well-Being (Every Visit)					
1. Observe gait and movements (i.e. walks steadily and without a limp).					
2. Observe facial expression (i.e. is alert and responsive).					
3. Observe general cleanliness (i.e. no visible dirt, no odor. etc.).					
4. Observe skin (i.e. free from lesions and bruises)					
5. Check conjunctiva (mucus membrane on inside of eyelid) for pallor.					
Blood Pressure (Every Visit)					

LEARNING GUIDE FOR ANTENATAL ASSESSMENT AND CARE *(Some of the following steps/tasks should be performed simultaneously.)*					
STEP/TASK	*CASES*				
6. Measure blood pressure while the woman is seated and relaxed: • *If diastolic BP is >90 mm Hg., ask the woman if she has severe headache, blurred vision or epigastric pain, and check her urine for protein.*					
Breast Examination (First Visit/As Needed)					
7. Explain the steps in examination of breasts, abdomen and vagina, and ask her to empty her bladder before beginning the examination.					
8. While she is seated, ask the woman to uncover her upper body and place her arms at her sides.					
9. Visually inspect the overall appearance of the woman's breasts (i.e. contours, skin, nipples, abnormalities): • *If nipples appear inverted test for protractility by placing the thumb and fingers on either side of areola and gently squeezing* • *If the nipple goes in it is inverted*					
Abdominal Examination (Every Visit)					
10. Help her onto the examination table.					
11. Ask the woman to uncover her stomach and lie on her back with her knees slightly bent.					
12. Check abdomen for scars: • *If there is a scar, ask if it is from a caesarean section or other uterine surgery*					
Fundal Height					
13. Measure fundal height: • *If 12-22 weeks, gently palpate the abdomen above the symphysis pubis and estimate weeks of gestation by determining distance between top of fundus and symphysis pubis* • *If more than 22 weeks, place zero line of tape measure on the upper edge of symphysis pubis and stretch it up over the abdomen, at the midline, to the top of the fundus*					
Fetal Lie and Presentation					

LEARNING GUIDE FOR ANTENATAL ASSESSMENT AND CARE *(Some of the following steps/tasks should be performed simultaneously.)*					
STEP/TASK	*CASES*				
14. Carry out fundal palpation: • *Make sure hands are clean and warm;* • *Stand at the woman's side, facing her head;* • *Place both hands on the sides of the fundus;* • *Apply gentle but firm pressure to assess consistency and mobility of the fetal part:* – *the buttocks feel softer and more irregular than head and cannot be moved independently of body;* – *the head feels harder than buttocks and can be moved back and forth with both hands.*					
15. Carry out lateral palpation: • *Move hands smoothly down sides of uterus to feel for fetal back:* – *It will feel firm and smooth in contrast to the small parts, which will feel knobby and easily moveable;* • *Keep dominant hand steady against the side of uterus, while using palm of other hand to apply gentle but deep pressure to explore opposite side of uterus;* • *Repeat procedure on other side of uterus.*					
16. Carry out pelvic palpation: • *Turn and face the woman's feet (the woman's knees should already be bent slightly to relax abdominal muscles):* • *Place hands on either side of uterus with palms below the level of the umbilicus and fingers pointing to symphysis pubis* • *Grasp fetal part snugly between hands* – *If fetal part is above symphysis pubis, feel shape, size, consistency and mobility* – *If head is presenting, a hard mass with a distinctive round surface will be felt* • *Observe the woman's face for signs of pain/tenderness during palpation*					
Fetal Heart					

LEARNING GUIDE FOR ANTENATAL ASSESSMENT AND CARE *(Some of the following steps/tasks should be performed simultaneously.)*					
STEP/TASK	*CASES*				
17. Listen to the fetal heart rate: • *Place fetal stethoscope on abdomen at right angles to it (on the same side that you palpated the fetal back)* • *Place your ear in close, firm contact with fetal stethoscope* • *Move fetal stethoscope around to where fetal heart is heard most clearly* • *Remove hands from fetal stethoscope and listen to fetal heart* • *Listen for a full minute, counting beats again second hand of clock/watch* • *Feel the woman's pulse at wrist, simultaneously, to ensure that fetal heart tones, and not maternal pulse, are being measured*					
Vaginal Examination (First Visit/As Needed)					
18. Ask the woman to uncover her genital area and cover or drape her to preserve privacy and modesty.					
19. Ask the woman to separate her legs while continuing to keep knees slightly bent.					
20. Turn on light and direct toward genital area.					
21. Wash hands thoroughly with soap and water and dry with clean, dry cloth or allow to air dry.					
22. Put new examination or high-level disinfected gloves on both hands.					
23. Touch the inside of the woman's thigh before touching genital area.					
24. Separate labia majora with two fingers, check labia minora, clitoris, urethral opening and vaginal opening, noting signs of female genital cutting, sores, ulcers, warts, nits, lice, blood or foul-smelling discharge, urine, or stool coming from vaginal opening.					
25. Palpate the labia minora: • *Look for swelling, discharge, tenderness, ulcers and fistulas;* • *Feel for irregularities and nodules.*					
26. Look at perineum, noting scars, lesions, inflammation, or cracks in skin.					
27. Check Skene's gland for discharge and tenderness: • *With palm facing upward, insert index finger into vagina and gently push upward against urethra and milk gland on each side and then directly on urethra.*					

LEARNING GUIDE FOR ANTENATAL ASSESSMENT AND CARE *(Some of the following steps/tasks should be performed simultaneously.)*					
STEP/TASK	*CASES*				
28. Check Bartholin's glands for discharge and tenderness: • *Insert index finger into vagina at lower edge of opening and feel at base of each labia majora;* • *Using finger and thumb, palpate each side for swelling or tenderness.*					
29. Hold the labia open and ask the woman to bear down: • *Check for bulging of anterior or posterior vaginal walls.*					
30. Immerse both gloved hands in 0.5% chlorine solution: • *Remove gloves by turning them inside out;* • *If disposing of gloves, place in leak proof container or plastic bag;* • *If reusing gloves, submerge in 0.5% chlorine solution for 10 minutes to decontaminate.*					
31. Wash hands thoroughly with soap and water and dry with clean, dry cloth or allow to air dry.					
32. Help the woman off the examination table.					
TESTING					
1. Do a hemoglobin test (1st visit, at about 28 weeks, and as needed based on signs and symptoms) – (see Learning Guide 1.4: Hemoglobin Test): • *If hemoglobin is less than 7 g/dL, refer woman to hospital* • *If hemoglobin is 7-11 g/dL, give iron/folate 1 tablet daily*					
2. Refer woman to VCT services for HIV test, if she volunteers: • *Provide information about VTC*					
3. Test urine for glucose if woman lives in an area with high prevalence of diabetes/gestational diabetes: • *If urine positive for glucose, refer for treatment*					

Appendix F: Sample Care Plans

Care of Pre-operative Patient

Nursing Diagnosis	Expected Outcome	Nursing Intervention
Knowledge deficit R/T pre-op care.	Patient/parent will verbalize understanding of pre- & post-op care.	1. Implement pre- & post-op teaching program. 2. Document response.
Potential infection R/T surgical procedure.	Infection free post-op.	1. Remove nail polish, make-up. 2. Bathe and shampoo the night before surgery. 3. Betadine scrub to surgical area. 4. Dress in hospital clothing after scrub.
Potential aspiration R/T general anesthesia.	No aspiration.	1. NPO as ordered. 2. Sign at bedside; NPO sticker on patient. 3. Re-emphasize importance of NPO to patient and parent; empty water pitcher and glass from bedside; check crib for bottles.
Potential anxiety R/T surgery.	Decreased anxiety.	1. Explain procedures. 2. Provide time for patient/parent to ask questions, express fears or concerns. 3. Offer reassurance.
Potential alteration of vital functions R/T surgery.	Normal parameters for patient's vital signs established.	1. Obtain baseline assessment of all systems & N/V status within 8 hours pre-op. 2. Assess V.S. within 2 hours pre-op.

Care plan of a patient with Gastro enteritis

ASSESSMENT	DIAGNOSIS	OUTCOME	PLANNING	
			INTERVENTION	RATIONALE
Subjective: Verbalized body weakness. "I am worried about my condition." ***Objective:*** Febrile at 37.5C, watery diarrhea, 2-3X, 1/2 cup per bout, decreased skin turgor. **Medical Diagnosis:** Gastroenteritis	Fluid volume, deficient related to diarrhea, as evidenced by decreased skin turgor. Anxiety related to frequent bouts of watery diarrhea as manifested by patient's statement that he is worried. **What about the t?**	Goal 1: Maintain fluid volume at a functional level. Outcome: 1. Adequate urinary output. 2. Stable vital signs. moist mucous membranes. 3. Moist mucous membranes. 4. Good skin turgor. Goal 2: Patient will report decreased anxiety level regarding condition. Outcome: 1. Verbalize understanding of causative factors and purpose of individual therapeutic interventions and medications. 2. Demonstrate behaviours or lifestyle changes to prevent development or recurrence of illness.	1. Administer IV fluids as indicated. 2. Keep fluids within reach and encourage frequent intake as appropriate. 3. Note preferences regarding fluids and food with high fluid content. 4. Provide tepid sponge bath. 5. Monitor vital signs. 6. Change position frequently. 7. Bathe every other day, provide optimal skin care with emollients. 8. Provide frequent oral and eye care. 9. Administer medications. 10. Discuss factors related to occurrence of diarrhea. 11. Identify actions to take to correct deficiencies. 12. Note signs / symptoms indicating need for emergent / further evaluation and follow-up.	Fluid replacement Fluid replacement To enhance lowering of body temperature. Parameter for management of dehydration. To protect skin. To maintain skin integrity and prevent excessive dryness. To prevent injury from dryness. To limit gastric / intestinal losses (antidiarrheals, anti-infectives), to reduce fever (antipyretics). Provide awareness and education. Promote wellness. To limit extent of illness.

Care of Post-operative Patient

Nursing Diagnosis	Expected Outcome	Nursing Intervention
Knowledge deficit R/T post-operative care.	Patient and family will verbalize and demonstrate understanding of post-operative care.	1. Implement post-operative teaching program. 2. Document response.
Potential anxiety R/T surgery, post-operative care.	Patient and family will cope effectively with surgical post-operative process.	1. Explain procedures. 2. Provide time for questions, expression of concerns and fears. 3. Offer reassurance.
Potential respiratory compromise R/T general anesthesia.	Patient will not experience respiratory compromise.	1. Assess breath sounds-HR/RR at least q shift. 2. Turn, cough and deep breathe q2 hrs. 3. Record vital signs.
Alteration in comfort R/T surgery.	Patient will verbalize/demonstrate relief from pain.	1. Assess for pain and medicate per protocol. 2. Reposition for comfort as ordered/prn.
Potential neurovascular compromise R/T surgical procedure.	Patient will not experience neurovascular compromise	. 1. Assess surgical site or affected extremity for color, capillary refill, sensation, temperature, pulses and active/passive ROM as ordered. 2. Document neurovascular status as ordered. 3. Report any neurovascular compromise to M.D. 4. Position extremity with elevation if ordered. 5. Apply ice or heat as ordered.
Potential alteration in level of consciousness R/T anesthesia.	Patient will exhibit appropriate LOC.	1. Assess LOC q shift.
Potential alteration in fluid balance R/T surgery.	Patient will have adequate fluid intake and urine output.	1. Monitor I/O q hour with IV or foley. 2. Begin ice chips or clear liquids slowly

		as ordered. 3. Maintain IV fluids as ordered. 4. Call M.D. for catheter order if unable to void after surgery. 5. Assess GU status q shift.
Potential alteration in bowel elimination R/T anesthesia and post-operative immobilization	Patient will have BM by post-operative day #4.	1. Mobilize as ordered. 2. Administer laxative of choice or suppository for no BM after 3 days. 3. Assess GI status q shift.
Potential alteration in skin integrity R/T immobility.	Patient will not experience skin breakdown.	1. Assess skin q shift. 2. Provide daily nursing care.

Care of a Patient with an open wound

Nursing Diagnosis	**Expected Outcome**	**Nursing Intervention**
Alteration in skin integrity R/T pressure/infection/ inadequate healing.	Wound will granulate in response to nursing treatment.	1. Dressing change to wound as ordered. 2. Observe size and depth of wound and any drainage with dressing changes and document healing on flowsheet.
Potential infection R/T impaired skin integrity.	Patient's wound will heal without signs of infection.	1. Use sterile technique when doing dressing changes, if appropriate. 2. Observe wound with dressing changes for color, odor and drainage (amount & color) q shift. 3. Monitor temp. at least q 4 hrs. if febrile. Return to routine after afebrile

		x 24 hrs. 4. Notify MD for purulent drainage, increase temp. or foul odor.
Potential knowledge deficit R/T skin care/prevention of pressure sores.	Patient will demonstrate/verbalize understanding of proper skin care in the prevention of pressure sores.	1. Give parent handout on dressing change, if appropriate. 2. Emphasize: frequent position changes; skin checks; proper diet for wound healing. 3. Document verbalization/ demonstration of learning on flowsheet. 4. Assist pt. in ADL's and document daily nursing care delivered.

Appendix G 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.

Characteristics of Medication Errors

The three most frequently reported types of errors are[6]:

- Omission errors (failure to administer a prescribed medication);
- Improper dose (medication dose, strength, or quantity different from that prescribed);
- Unauthorised drug errors (the medication dispensed and/or administered was not authorised by the prescriber).

Types of 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
unauthorised 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.

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[10]. 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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TABLES

Table 1 Nursing Care Standards Checklist

		Yes	No
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 plan.		
5.	Nurse to patient ratios for each service area are defined in the nursing workforce plan.		
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.		

TABLE 2 Nursing Care Indicators

In addition, the following indicators may be monitored on a regular basis to assess the effectiveness/outcomes of implementation of the recommendations provided in EHRIG for Nursing Care chapter

S/N	Indicators	Formula
1.	Pressure sore incident rate	Number of pressure sores/number of admissions*100
2.	Attrition rate of nursing staff	Total number of nurses leaving/total number of nurses at beginning of reporting period * 100
3.	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 nurses at beginning of year * 100
4.	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 often did nurses listen carefully to you? c) During this health facility stay, how often did nurses explain things in a way you could understand?	Total number of inpatients who respond 'always or usually' to the questions listed/ Total number of inpatients respondents*100

Quarterly	HMIS	
Quarterly	HMIS	
Quarterly	HMIS	
Biannual	**Frequency**	**Comment**