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Managing Nursing Care

1

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Learning outcomes

The purpose of this chapter is to explore how nurses manage care; it will take you through a five-stage problem-solving approach known as the nursing process. At the end of the chapter, you should be able to:

- Define the stages of the nursing process
- Undertake a nursing assessment
- Identify nursing diagnoses from the assessment data
- Devise and implement a plan of care
- Evaluate your actions
- Consider the link between evaluation and quality of care.

Throughout the chapter, a working example using a client who is experiencing pain will be used to demonstrate how each of the stages of the nursing process is applied. The chapter also provides an opportunity for you to undertake some exercises that will assist you with your care-planning skills.

■ What is the Nursing Process?

nursing process

a five-stage problem-solving framework enabling the nurse to plan individualised care for a client

The **nursing process** is a problem-solving framework that enables the nurse to plan care for a client on an individual basis. The nursing process is not undertaken once only, because the client's needs frequently change and the nurse must respond appropriately. It is thus a cyclical process consisting of the five stages shown in Figure 1.1. The nursing process originated in the USA and was formally introduced into the UK in 1977 when the then General Nursing Council introduced its revision of the nursing syllabus. It was an attempt to move nursing away from its traditional 'task-orientated' approach to a more scientific and individualised one.

The nurse is an autonomous practitioner whose responsibilities are now governed by the Nursing and Midwifery Council (NMC) *Code of Professional Conduct* (NMC, 2002). This requires nurses to be accountable for the care that they prescribe and deliver with the nursing process, enabling them to document their actions in a logical and rational manner. Today, one's ability to use the nursing process is central to *Making a Difference* (DoH, 1999), *Fitness for Practice* (UKCC, 1999) and therefore *The NHS Plan* (DoH, 2000) and is governed by the learning outcomes of preregistration courses as outlined by the statutory body, the NMC, and embedded in parliamentary statute. This states that conditional to registration is the ability to:

Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social, and spiritual needs of patients, clients and communities

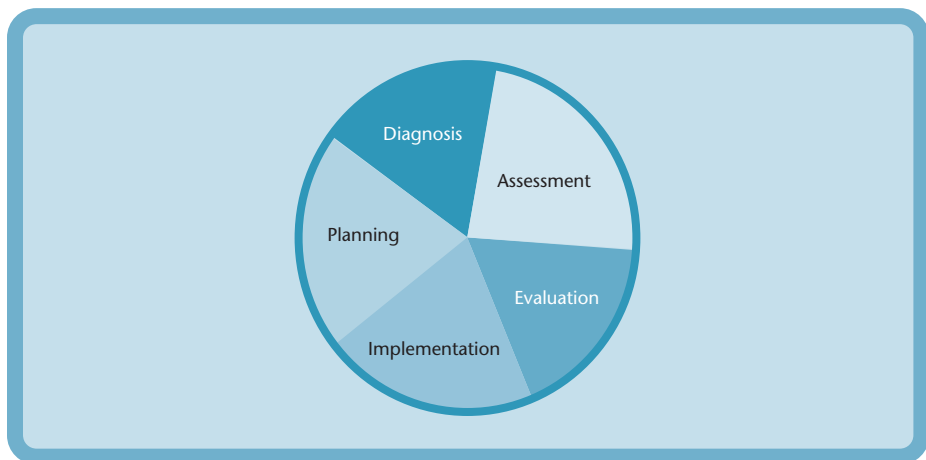


Figure 1.1 ● The nursing process

Provide a rationale for the nursing care delivered which takes account of social, cultural, spiritual, legal, political and economic influences

Evaluate and document the outcomes of nursing and other interventions

(DoH, 2000a)

The Nursing and Midwifery Council (NMC) replaced the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the four National Boards in April 2002. It is likely that the new Nursing and Midwifery Council will retain the standards and codes published by the UKCC until such time as they are revised.

Failure to keep a record of nursing care or to use the nursing process can lead to a breakdown in the quality of care that is provided. The Clothier Report (DoH, 1994), which was published following the inquiry into Beverley Allitt (the nurse who was convicted of the murder of children in a hospital in Grantham, Lincolnshire), noted how:

Despite the availability of a nurse with responsibility for quality management, there were no explicit nursing standards set for ward four. In addition the nursing records were of poor quality and showed little understanding of the nursing process.

The Commission for Health Improvement (CHI) is now responsible for clinical governance reviews in NHS Acute Trusts. In its guidance (CHI, 2001), it states that ‘clinical governance is to ensure patients receive the highest quality of NHS care possible including a patient centred approach and a commitment to quality’. Thus, the importance of understanding and using a systematic approach (such as the nursing process) to the provision of nursing care cannot be overestimated.

There has been some debate within the profession over the number of stages needed in the nursing process, some suggesting four and others five. With a four-stage approach, the nurse does not have time to reflect on the assessment data that have been collected and instead moves from assessment to planning. The five-stage process enables the nurse to identify the client’s nursing diagnosis in order to plan the appropriate care.

The nursing process should not be seen as a linear process: it is a dynamic and ongoing cyclical process (Figure 1.1). Assessment, for example, is not a ‘one-off’ activity but a continuous one. Take the example of the individual who is in pain – it is not enough to make a pain assessment that may warrant an intervention; the nurse then needs to make a reassessment after having evaluated whether the pain-relieving intervention has been successful.

The nursing process is a problem-solving activity. Problem-solving

approaches to decision-making are not unique to nursing. The medical profession uses a specific format based upon an assessment of the body's systems. A number of questions are asked in a systematic manner to enable the doctor to make a diagnosis based upon the information that has been collected. Problem-solving approaches are also taken outside the health-care field. Car mechanics undertake a sequence of activities in order to diagnose what is wrong with your car when you tell them that there is a squeak or a rattle.

■ Stage 1: Assessment

Sources of assessment data

Activity

1

Think about the client and other sources that you may be able to consult to assist you when conducting a comprehensive assessment. Write them down in a list.

Before beginning to consider what sort of information you might need to collect, we need to look at the skills that are necessary to ensure that the data analysed are comprehensive. Assessment is not an easy process as it includes collecting information from a variety of sources. The quality of the assessment will, however, depend on one's ability to put together all the sources at one's disposal. Spend a few minutes on Activity 1.

The sources that you have listed in Activity 1 have probably included the following:

- Your client
- Relatives, friends and significant others
- Current and previous nursing records
- The records of other health professionals such as doctors and physiotherapists
- Statements and information from the police, ambulance personnel, witnesses at an accident scene and others.

Your client

The first and most important source for data collection is obviously the individual whom you are assessing. It will not, however, always be possible to obtain all the information you require, for a number of reasons, so you will also need to consult other people.

Relatives, friends and significant others

If you are assessing a baby, most of the verbal information you require will be obtained from his or her parent(s) or guardian(s). With a child, you will need to qualify some of your information through the same source. In the case of an adult who is unconscious or is having difficulty breathing, you will again need

to obtain data from friends, relatives, ambulance personnel, the police and so on. The same applies if the client has difficulty understanding as a result of dementia or severe learning disabilities.

Nursing, medical and other records

It will not always be possible to have immediate access to existing records, especially in an emergency or with a first consultation, but these sources hold valuable information that you need to analyse. They provide details that may assist and prompt you. If the client has been admitted to a hospital, you may have a letter from the GP, district nurse, health visitor or community psychiatric nurse. Similarly, on discharge from hospital, you will provide discharge information if community-based professionals need to be involved. Telephone calls to these professionals, visits and case conferences may also feature.

Skills

Having considered some of the sources at your disposal, we now need to think about what other factors have a bearing on a successful assessment. Spend a few minutes on Activity 2.

As we are beginning to see, the process of assessment is a complex one. Although we have identified some of the sources of information, the quality of the information collected depends upon a number of other factors. In your list from Activity 2, you may have included:

- Listening
- Observing
- The use of verbal and non-verbal communication and open and closed questions
- Physical examination
- Measurements.

Listening

One of the most important features of an assessment interview is the nurse's ability to listen to the client. This means giving the client time to answer questions. You will appreciate from your own life experience that when you are asked a question, you want time to think and then answer without interruption. A premature interruption may lead to clients withholding information or not feeling that you are really interested in what they have to say. Although it is important for you to focus on the information you require and not digress, the

Activity

2

Spend a little while thinking about what sorts of skill you need in order to conduct your assessment. Write them down in list form.

CONNECTIONS

In Chapter 11 you will find a detailed examination of how the nurse can most effectively use some of these skills. You may wish to consult this before reading on.

fact that Mrs Jones has been admitted as an emergency and is meant to be on the school run in an hour will be the only thing of interest to her until you are able to contact someone who can collect her children.

Observation

CONNECTIONS

Chapter 6 explains some causes of cyanosis and identifies the difference between central and peripheral cyanosis.

Observation can in itself provide the nurse with a great deal of information. The bluish tinge (cyanosis) seen around the mouths, nailbeds and faces of some breathless patients may be indicative of respiratory distress and will be an indication of how little oxygen is circulating in their blood. A yellowish tinge to the skin (jaundice) may be indicative of biliary disease. Similarly, facial and other body expressions may give you an indication of pain.

closed questions

those designed to elicit a simple 'yes' or 'no' answer

open questions

those in which clients can express their answers in as many words as they choose

Open and closed questioning

Both these methods of communication need to be used when collecting information. The use of **closed questions** allows the client who is, for example, breathless, anxious, in pain or depressed to answer with a simple 'yes' or 'no'. **Open questions**, however, will allow you to provide your clients with a full opportunity to tell you the history of their illness or pain.

Physical examination

CONNECTIONS

Chapter 8 briefly outlines the structure and function of the skin. Chapter 10 classifies wounds and has a section on wound assessment.

The physical examination of clients allows you to observe and make a judgement about their symptoms. You will be able to determine the integrity (state) of the skin, which is an important consideration in an immobile client. Physical damage such as wounds can be seen, as can even the small puncture marks left by an intravenous drug abuser. Skin that feels very warm and moist to the touch may be a sign of pyrexia.

Measurements

CONNECTIONS

Chapter 6 explores blood pressure and explains how to take an arterial blood pressure reading.

Measurements come in many forms, for example the taking of a blood pressure, pulse or temperature. Also included here is the use of other assessment tools such as a nutritional analysis, a pressure sore risk calculator (for example Norton or Waterlow) or a pain chart.

Data collection

As we have seen, nurses must, in order to be able to plan care for their clients, be able to gather information that will enable them to make informed decisions.

But what information do nurses need to gather, what questions should they ask and how much do they need to know? The answer is determined on an individual basis, the nurse collecting both subjective and objective information. Before looking in detail at what information should be collected, undertake Activity 3.

From the activity, in addition to name, age and date of birth, you may have collected some of the following information:

Physical health information

- Current and past health problems
- Nutritional and dietary information
- Patterns of activity and rest
- Stamina
- Physical parameters
- Factors affecting health (cigarettes, alcohol and so on)
- Dental, hearing, vision and so on
- Elimination patterns
- Sexual history.

Psychological information

- How does the client react to stress, challenge and so on?
- What are the person's hopes, expectations, demands?
- Communication
- Values and beliefs.


Social health information

- What is the person's lifestyle?
- Employment/unemployment details
- Family or other responsibilities
- Leisure
- Exercise
- Social environment/networks.

How did you decide what you needed to ask, how did you decide to word the questions, and did you collect everything to enable you to feel that you had conducted a thorough assessment?

Framework for assessment

One way of organising the information that you need to collect is by using a nursing framework. The 'activities of living' framework devised by Roper et al.


Activity
3

Select a friend or relative and ask them if you can spend about 20 minutes undertaking a health assessment.

Now take a blank piece of paper and collect the information that you feel is important when making some decisions about your chosen person's health status.

Chart 1.1 ● The activities of living

- Maintaining a safe environment
- Breathing
- Eliminating
- Controlling body temperature
- Working and playing
- Sleeping
- Communicating
- Eating and drinking
- Personal cleansing and dressing
- Mobilising
- Expressing sexuality
- Dying

(2000) uses a list of the client's activities of living (Chart 1.1) as a framework for assessment, the nurse systematically collecting the physical, psychological, socio-cultural and economic aspects of these activities.

Breathing, one of the activities of living, will now be used as a framework to demonstrate the type of information that the nurse needs to collect during an assessment. At any given time during the assessment process, it may be necessary to concentrate more on one activity than another.

Breathing

CONNECTIONS

Chapter 6 provides methods of respiratory assessment.

The information that the nurse needs to collect about this and any other activity of living depends on the answers to certain trigger questions. You may, for example, start off by asking your client whether she has any problems with breathing. Even though the answer may be 'no', you would, as a professional, need to investigate further. The client whom you are assessing may not feel that she has a problem with breathing, but consider the following questions:

1. 'Do you smoke?' The answer here may be 'yes' even though the client has said she has no problems with breathing. Indeed, she may still feel that she does not have any problems. This is, however, a trigger for further questioning.
2. 'Do you suffer from any breathlessness?' The answer at the outset may again be 'no', but if you ask about running up the stairs or running for a bus, the client may admit that, yes she does then, but this is because she does not usually do any exercise.
3. Taking this one step further allows the nurse to extract even more information about the status of the client's breathing: 'Do you cough?' The answer may be 'no', but when prompted the client may admit to coughing for a little while in the morning, although this clears rapidly and she thinks nothing of it.

If the client is a normal healthy young adult, the nurse may at this stage still perceive that the client does not actually have a problem with breathing in the

short term even though she is partaking in health-damaging behaviour. In the long term, however, the consequences are obvious. At this stage in the assessment process, it may be sufficient to make a note of the information gathered so far; when it comes to planning care, the action that will be prescribed will then include health education about smoking. This will be expanded in the section on planning and implementation below.

Summary and worked example

This section has introduced you to the nursing process and looked in some detail at assessment. The activities should have enabled you to experience some of the issues that you need to consider when undertaking a nursing assessment. We have examined the skills that the nurse needs to use when assessing clients, and we have been introduced to one assessment framework that may assist the nurse during the process. By way of a summary of the information that needs to be gained when undertaking an assessment, the following section takes pain as an example and outlines the questions and methods that can be employed when assessing a client's pain. This will be revisited as we consider the other four stages of the nursing process later in the chapter. Having read this summary, you may like to return to the client profile that you chose and identify the information you feel would be important for your chosen profile. Alternatively, you might like to take the opportunity to participate in the assessment process during your practice placements in the common foundation programme.

■ Pain Assessment

The assessment of pain is a complex activity that involves a consideration of the physical, psychological and cultural aspects of the individual. Because pain is a subjective experience, the nurse needs to be able to summarise the information gained against some objective criteria. This is essential for diagnosis and for evaluating the effectiveness of interventions. Only the person experiencing the pain knows its nature, intensity, location and what it means to them. One of the most seminal, widely used and accepted definitions of pain was put forward by McCaffery (1979), who suggests that pain is 'whatever the experiencing person says it is and exists whenever he says it does'.

Assessments of the patient's pain experience

To begin with, it is essential to identify the characteristics of the client's pain. This means that the nurse should consider:



Activity

4

Read the client profiles in Casebox 1.1 on the next page. Choose one of the profiles and, for any two of the activities of living, write down the information that you would need to collect during a nursing assessment.

CONNECTIONS

Chapter 6 deals with pain arising from circulatory problems.

- *The type of pain:* is it crampy, stabbing, sharp? How the client describes the pain may help in diagnosing its cause. Myocardial (heart) pain is often described as stabbing, but biliary pain as cramping or aching
- *Its intensity:* is it mild, severe or excruciating? Pain assessment scales are helpful here. The nurse can ask the patient to rate the pain on a scale of 0 to 10, zero being no pain and 10 intolerable pain. With children, a range of pictures showing a child changing from happy to sad can be used. Colour 'mood' charts, with a series of colours from black through grey to yellow and orange, have also been used and are very useful for clients who have difficulty grasping numbers or articulating exactly what their pain is like
- *The onset:* was it sudden or gradual? Find out when it started and in what circumstances. What makes it worse? What makes it better? What was the patient doing immediately before it happened?
- *Its duration:* is it persistent, constant or intermittent?
- *Changes in the site:* there may be tenderness, swelling, discolouration, firmness or rigidity. With appendicitis, a classic sign is the movement of pain

Casebox 1.1

Joan Harris is a 69-year-old lady who tripped and fell over a protruding pavement slab this morning while out shopping. She has been admitted to the orthopaedic ward of her local NHS Trust hospital suffering from a fractured neck of femur. Mrs Harris is pale and is anxious about who will look after her cat while she is in hospital. She is complaining of severe pain in her hip and knee, and has grazes and cuts to her lower leg.

Amanda Cohen is 29 years old and has profound learning disabilities. She lives in staffed residential accommodation with two other young women. For 2 weeks, Amanda has been showing

signs of distress – hitting her face, lifting her jumper and crying. It was at first thought that this might be because of premenstrual tension. After a while, however, someone thought to arrange a dental inspection under anaesthetic: the dentist found a particularly nasty dental abscess. (Adapted from NHSE, 1993)

Andrew Holly is 5 years old and has been admitted to the accident and emergency department of the local NHS Trust hospital. He is complaining of a very sore and painful arm, is very withdrawn and is sobbing. He is accompanied by his mother, his 2-year-old sister and their newborn baby brother.

Alison Simpson, 21 years old, lives in a hostel for people with mental health problems. She has no close family, having left home at 18. She finds it difficult to develop relationships and is suspicious of people who try to befriend her. Alison is very withdrawn and has on two occasions attempted to take her own life through an unsuccessful paracetamol overdose. She was found this morning slumped in a corner, covered in blood and complaining of extreme pain in her left hand. On the floor nearby was a razor blade, and on examination she had severe lacerations to her left forearm.

Chart 1.2 ● Common symptoms of disease that influence the response to pain

- Anorexia
- Malaise and lassitude
- Constipation
- Diarrhoea
- Nausea and vomiting
- Cough
- Dyspnoea
- Inflammation
- Oedema
- Immobility
- Anxiety and fear
- Depression
- Dryness of the mouth

from the umbilicus to the right iliac fossa. In a myocardial infarction (a heart attack), pain classically radiates down the arm, and with biliary pain it can radiate to the shoulder

- *Its location:* ask the patient to be as specific as possible, for example indicating the site by pointing
- *Any associated symptoms:* Chart 1.2 shows some of the common symptoms of disease that can influence the response to pain
- *Signs* such as redness, swelling or heat.

Summary

Table 1.1 provides a summary of some of the issues to consider when assessing pain. In essence, this section demonstrates how much detail the nurse needs to collect when making a full assessment of the client's pain. Consider your own experiences of pain, both personally and from clients you have nursed in clinical practice, and reflect on how comprehensive the assessment was then.

Table 1.1 Assessment of pain

Initial sympathetic responses to pain of low-to-moderate intensity	Parasympathetic responses to intense or chronic pain	Verbal responses	Muscular and postural responses
Increased blood pressure	Decreased blood pressure	Crying	Increased muscle tone
Increased heart rate	Decreased heart rate	Gasping	Immobilisation of the affected area
Increased respiratory rate	Weak pulse	Screaming	Rubbing movements
Decreased salivation and gastrointestinal activity	Increased gastrointestinal activity	Silence	Rocking movements
Dilated pupils	Nausea and vomiting		Drawing up of the knees
Increased perspiration	Weakness		Pacing the floor
Pallor	Decreased alertness		Thrashing and restlessness
Cool, clammy skin	Shock		Facial grimaces
Dry lips and mouth			Removal of the offending object

■ Stage 2: Nursing Diagnosis

nursing diagnosis

the second stage of the nursing process, often described as a 'nursing problem', for which the nurse can independently prescribe care

The second stage of the nursing process is making a **nursing diagnosis**. This enables the nurse to translate the information gained during the assessment and identify the nursing problems. In order to avoid confusion, it is worth noting that 'diagnosis' is not a concept unique to medicine: car mechanics diagnose mechanical problems, teachers diagnose learning difficulties, and consequently nurses diagnose nursing problems.

The language of nursing diagnosis originated in North America in the 1970s in an effort to move the art, science and theoretical basis of nursing forward. The benefits in a clinical setting have been positively described by Mills et al. (1997) and Hogston (1997).

Nursing diagnosis is a critical step in the nursing process, depends on an accurate and comprehensive nursing assessment and forms the basis of nursing care-planning. Nursing diagnosis is the end-product of nursing assessment, a clear statement of the patient's problems as ascertained from the nursing assessment increasingly being referred to as a nursing diagnosis (Roper et al., 2000). Gordon (1987), for example, suggests that a nursing diagnosis 'Describes actual or potential problems that nurses, by virtue of their education and experience, are capable and licensed to treat'. More recently, Weber (1991) stated that a nursing diagnosis is 'A statement that describes the actual or potential health problems of a client based on a complete holistic assessment. The problem/s must be at least partially resolved through nursing interventions.' Furthermore, the International Council of Nurses has, for the purposes of the International Classification for Nursing Practice, defined a nursing diagnosis as 'a label given by a nurse to the decision about a phenomenon which is the focus of nursing intervention' (ICN, 1999). A visit to the website at www.icn.ch is recommended for more detailed information.

Chart 1.3 ● Key components of a nursing diagnosis

A nursing diagnosis:

- is a statement of a client's problem
- refers to a health problem
- is based on objective and subjective assessment data
- is a statement of nursing judgement
- is a short concise statement
- consists of a two-part statement
- is a condition for which a nurse can independently prescribe care
- can be validated with the client

Source: Adapted from Shoemaker (1984), Bellack and Edlund (1992) and Iyer et al. (1995).

This provides a reasoned argument for defining patients' problems as nursing diagnoses and was the definition adopted by Hogston (1997) in an article published on nursing diagnosis in the UK. In summary, the key components of what constitutes a nursing diagnosis are outlined in Chart 1.3.

Making a nursing diagnosis

Nursing diagnoses can be actual or potential. Actual diagnoses are those which are evident from the assessment, for example pain caused by a fractured neck of femur. Potential diagnoses, on the other hand, are those which could or will arise as a consequence of the actual diagnoses. For example, an individual who is normally active but is confined to bed is at risk of becoming constipated or developing a pressure sore. In this instance, two potential diagnoses arise:

- a potential risk of constipation as a result of enforced bedrest
- a potential risk of pressure sore development from enforced bedrest.

■ Stage 3: Planning Nursing Care

There are two steps to the planning stage:

- Setting goals
- Identifying actions.

A **goal** is a statement of what the nurse expects the client to achieve and is sometimes referred to as an objective. In other words, goals are the intended outcomes and can be short term or long term. Goals are client centred and must be realistic, being stated in objective and measurable language. They help both nurse and client to define how the nursing diagnosis will be addressed. Goals serve as the standard by which the nurse can evaluate the effectiveness of the nursing actions.

When writing goals, they need to conform to the MACROS criteria; they should be:

- Measurable and observable so that the outcome can be evaluated
- Achievable and time limited
- Client centred
- Realistic
- Outcome written
- Short.

Activity

5

Return to the two activities of living that you assessed during Activity 4. Try to identify one actual and one potential nursing diagnosis. Use the guidelines in Chart 1.3 to ensure that your diagnoses meet the criteria.

CONNECTIONS

Chapter 5 considers the causes, diagnosis and treatment of constipation.

goal

the intended outcome of a nursing intervention, sometimes referred to as an objective

Activity

6

For the diagnoses that you identified during Activity 4, try to identify one short-term and one long-term goal for your chosen client. Remember to ensure that they meet the MACROS criteria.

Using the example of pain, the short-term goal will be that the client will state that he is comfortable and pain free within 20 minutes. The long-term goal, however, is that the client will state within 12 hours that he feels in control of his pain. (It is important to remember to take account of the non-verbal clues discussed earlier – is the client really pain free?) With the move to shorter hospital stays and the emphasis on care in the community, it may not always be necessary to formulate both long- and short-term goals for all problems. It is, however, always better to have a number of short-term goals that are reached so that new goals can be set rather than having a long-term goal that takes weeks to achieve. With Mrs Harris (see Casebox 1.1 above), who will have surgery for her hip, this will be a series of goals that progress her towards full mobility following her operation, for example: ‘Mrs Harris will walk one way to the toilet unaided by [enter date]. Mrs Harris will be able to climb one set of stairs by [enter date].’ This avoids a long-term goal that reads ‘Mrs Harris will be fully mobile by [enter date].’

Action planning

The next stage is to plan the nursing care that will ensure that clients achieve their goals. This is where the nurse prescribes nursing actions that can then be implemented and evaluated. In ‘care-planning’ language, these are the nursing actions – the prescribed interventions that are put into effect in order to solve the problem and reach the goal. It is against these actions that the nurse may, when evaluating care, have to make some adjustments if the actions have not been effective. In today’s NHS, when we are seeing a decreasing number of registered nurses against an increase in those of bank and agency nurses and unqualified health-care support workers, documenting the prescribed nursing care ensures a degree of continuity. In this way, the care plan can be seen as the diary of the client’s nursing care. When planning nursing care, use the REEPIG criteria, which will ensure that your plan of care is:

- *Realistic*: it is important that the care can be given within the available resources, otherwise it will not be achievable
- *Explicit*: ensure that statements are qualified. If you suggest that a dressing needs changing, state exactly when. This will ensure that there is no room for misinterpretation
- *Evidence based*: nursing is a research-based profession. When planning nursing care, the research findings that underpin the rationale for care must be considered
- *Prioritised*: start with the most pressing diagnosis. Given that time is of the essence, the first priority may be, for example, to plan care for the client’s pain

- *Involved*: the plan of care should involve not only the client, so that he or she is aware of why such care is needed, but also the other members of the health-care team who have a stake in helping the client back to health, for example physiotherapists and dietitians
- *Goal centred*: ensure that the care planned meets the set goals.

Returning now to the example of pain, the nurse needs to make decisions about what sorts of intervention will most effectively relieve Mrs Harris's pain. This involves not only decisions about prescribed medications, but also other considerations such as how often the pain assessment tool should be used and what alternative non-pharmacological methods, such as comfort through pillows, the use of skin traction for the leg and distraction therapy, can be implemented. The nursing care plan for Mrs Harris may therefore detail the following nursing actions:

- Give the prescribed analgesic and monitor its effects. Record them on the pain chart
- Apply skin traction
- Nurse on a bed equipped with a pressure-reduction mattress
- Ensure 2-hourly changes of position by attaching a trapeze pole to the bed, and encourage Mrs Harris to change her position regularly
- Ensure that Mrs Harris has a supply of chosen reading/writing materials and access to the television and radio.

■ Stage 4: Implementation

Implementation is the 'doing' phase of the nursing process. This is where the nurse puts into action the nursing care that will be delivered and addresses each of the diagnoses and their goals. The nurse will undertake the instructions written in the care plan in order to assist the client in reaching these goal(s). This will involve a process of teaching and helping clients to make decisions about their health. It also involves deciding upon the most appropriate method for

Chart 1.4 ● Other members of the health-care team

- | | |
|-------------------------------|--------------------------|
| ● Physiotherapist | ● Social worker |
| ● Community psychiatric nurse | ● Occupational therapist |
| ● Speech therapist | ● Dietitian |
| ● Health visitor | ● Key worker |
| ● District nurse | ● School nurse |
| ● Podiatrist | ● GP |

Activity

7

Return to the client for whom you chose to identify nursing diagnoses and goals. Consider what nursing care you would need to plan in order to achieve those goals.

CONNECTIONS

Chapter 8 examines the development of pressure sores and methods of prevention.

providing nursing care, and the liaison and involvement of other health professionals. Look at the list of health professionals in Chart 1.4. Do you know what their primary roles and functions are and when you might need to involve them?

■ Managing Nursing Care in the Clinical Environment

A number of different approaches to the delivery of nursing care are available to nurses. These include task allocation, patient allocation, team nursing, primary nursing, the key worker and caseload management. The benefits or otherwise of each of these methods need to be considered in the light of the skill mix of available staff (that is, the number and grade of qualified and unqualified staff) and what it is that the nursing team wants to achieve. It is difficult to evaluate the right approach without considering the benefits or drawbacks of each of these methods. The published reports of clinical governance reviews by the CHI (see above) will also consider the management and organisation of nursing care.

Task allocation

task allocation

the provision of nursing care that centres on a range of tasks allocated to nurses/support workers

Task allocation (also known as functional nursing) is a highly ritualistic method of organising care that centres on nurses and support workers being assigned tasks. With this system, one nurse will be assigned to undertake the observations of temperature, pulse, blood pressure and respiration. Another nurse undertakes all the dressings, whereas another takes care of the drugs. This is a very fragmented method of providing nursing care that will ensure that the client receives aspects of care from a multiplicity of nurses and support workers, akin to a production line process. The emphasis on tasks naturally removes the notion of individualised client care and is as such incompatible with the nursing process.

Client allocation

client allocation

individualised care provided by a named nurse, often assisted by a support worker

One step removed from task allocation is **client allocation**. Here, total care for a number of clients is undertaken by one nurse, often assisted by a support worker. Although this system means that there is an emphasis on total client care being delivered by an individual nurse for a designated period of time, continuity of care may become compromised if the same clients are not cared for on a regular basis by the same nurse. With this system, extra attention needs to be paid to the detail in the nursing care plan because of the number of nurses who may have contact with a client.

Team nursing

Team nursing occurs where a designated group of clients is cared for by a team of two or more nurses (at least one of whom is a registered nurse) who accept collective responsibility for the assessment, planning, implementation and evaluation of the clients' care. Although each team will be headed by a team leader, each registered nurse is accountable for his or her actions in accordance with the Code of Conduct (NMC, 2002). This is important to remember in an effort to counteract any criticism surrounding who is ultimately responsible under a system of collective responsibility.

There is a plethora of literature available on team nursing, although much of it compares team nursing with primary nursing and is now rather dated. The literature suggests that many nurses who have striven towards a system of primary nursing have used team nursing as a 'stepping stone' (Wilson, 1991). The seminal research undertaken by Chavigny and Lewis (1984) set out to compare primary and team methods of care delivery and to estimate their effect on both quality and cost. The research found that team nursing tended to promote more client contact than did primary nursing, that clients' satisfaction was high but that there were no significant differences in cost or quality. In contrast, the research conducted by Reed (1988) concluded that, compared with team nursing, primary nursing afforded an increase in the quality of care and increased job satisfaction for nurses.

Walsh and Ford (1989) have described how team nursing and client allocation evolved as the successor to task allocation on the premise that being cared for by a team rather than an array of nurses led to more holistic care. They suggested that team nursing really resembles a small-scale version of task allocation, especially if there is a lack of continuity between shifts when the same team may not be on duty, leading to fragmentation of care. Consequently, there has to be a commitment to ensure that tasks are not assigned to each team member.

Team nursing has received a positive press from student nurses. Lidbetter's (1990) small-scale study describes how students working in a hospital ward practising team nursing spent more time working alongside a qualified nurse and rated their skill acquisition and their evaluation of the effectiveness of client care higher than did those from a ward practising primary nursing. Students were also, as a learning experience, afforded the opportunity to assume the role of team leader, under supervision.

Primary nursing

Primary nursing has been described as a professional patient-centred practice (Manley, 1990). In this approach, the primary nurse accepts full responsibility

team nursing

care provided by a team of nurses/support workers led by a 'team leader'

primary nursing

care provided on an individual basis by a named nurse who, in its purest form, holds 24 hour accountability for the package of care

and accountability for his or her clients during their stay. In its purest form, the implication is that the primary nurse has 24 hour responsibility 7 days a week (Manthey, 1992). In reality, a team of associate nurses continues to provide nursing care under the direction of the primary nurse and in his or her absence. Again, accountability and autonomy rest with the individual registered nurse under the Code of Conduct (NMC, 2002). There is a great deal of literature on the efficacy of primary nursing, some of the discussion centring on the difference between primary nursing and the named nurse approach. For a full and lively debate on the issue, the reader is referred to the chapter on primary nursing in *New Rituals for Old* by Ford and Walsh (1994).

Person-centred planning

Popular in the field of learning disabilities, a person-centred approach to planning care is advocated in the White Paper *Valuing People* (DoH, 2001a). Person-centred planning starts with the individual, is seen as ‘a mechanism for reflecting the needs and preferences of a person with learning disability and covers issues such as housing, education employment and leisure’ (DoH, 2001a). At the time of writing, central guidance is to be published and readers are referred to the White Paper and the Department of Health website (www.doh.gov.uk/learning-disabilities) for further information.



Activity

8

From your own experiences in clinical practice, what method(s) of care organisation have you experienced? Write down two positive aspects and then consider whether one of the other methods described above would have been suitable and why.

Caseload management

This is the most popular method of organising nursing care in the community setting. It revolves around the designated named nurse with extended qualifications in health visiting/district nursing who acts as the caseload manager. Caseloads are normally organised either geographically or by GP attachment, each caseload manager leading a team of qualified nurses and health-care support workers. Continuity of care is maintained because the teams are organised to ensure that a member of the team is available every day of the week; as such, it is less affected by the demands of the shift system. Each registered nurse is accountable for his or her own actions (NMC, 2002), the caseload manager being responsible for ensuring that the skill mix and resources are adequate.

■ Stage 5: Evaluation

At the beginning of this chapter, it was noted that the stages of the nursing process need to be seen as ongoing rather than as once-only activities. This means that the final stage, evaluation, is in reality the end of the beginning and where the process in essence restarts. One of the key components of quality nursing

practice is the nurse's ability to make a clinical judgement based upon a sound knowledge base. Evaluation is about reviewing the effectiveness of the care that has been given, and it serves two purposes. First, the nurse is able to ascertain whether the desired outcomes for the client have been achieved. Second, evaluation acts as an opportunity to review the entire process and determine whether the assessment was accurate and complete, the diagnosis correct, the goals realistic and achievable, and the prescribed actions appropriate. The nursing process provides nurses with a tool by which client outcomes are regularly monitored, and can be seen as a vehicle for improving the quality of nursing care and ultimately benefiting the client (Fitzpatrick et al., 1992).

Increased health-care costs require managers throughout the professions to reduce expenditure and seek the most cost-effective options. The population at large are also more informed about health-care matters and are arguably less passive recipients of health care, demanding a detailed and open explanation for their care (Hogston, 1997). It is therefore the responsibility of each nurse to ensure that the prescribed care takes account of these issues. Given that nursing records are legal documents that could be used in a court of law, extreme care and accuracy are essential when completing the care plan to which the registered nurse puts her signature.

In order to raise standards of care, and in keeping with the clinical governance agenda, the government has published benchmarks in eight fundamental aspects of care (DoH, 2001b), one of which focuses on record-keeping. Readers should familiarise themselves with this particular benchmark. It is important to note that the document stresses that the 'eight aspects are by no means an exhaustive account of every fundamental aspect of care, but it represents those elements identified by patients and professionals as crucial to the quality of a patient's care experience' (DoH, 2001b; www.doh.gov.uk/essenceofcare).

Methods of evaluating nursing care

Having discussed the importance of evaluation and the place it has in maintaining quality, it is important to consider some of the methods that nurses can use. First of all, undertake Activity 9.

Your list from Activity 9 may have included some of the following:

- Nursing handover
- Reflection
- Patient satisfaction or complaint
- Reviewing the nursing care plan.

Activity

9

How do you think that nursing care is evaluated? You may have witnessed some methods in your own clinical placements; write them down as a list. If you have not, try to think generally about how you evaluate any service you have received – buying a meal or an item from a shop, for example.

Nursing handover

You may have had experience of a nursing handover, which is where a team of nurses hand over information about the nursing care of clients to another group of nurses, usually at the end of a shift, for example from day care to night care. Using the nursing care plan as the focus, nurses share information about the clients and their planned care. This serves as a valuable forum for evaluating care through a discussion of its effectiveness. The variety of experiences and professional expertise held by a number of nurses allows a sharing of that information. The importance of nursing handover was stated by the Audit Commission (1992) as being critical for maintaining continuity of client care.

Reflection

CONNECTIONS

Chapter 13 reviews types of reflection, thoughtful practice and reflection in practice settings.

The role of reflection in quality and evaluation has been discussed in some detail in the literature, and Chapter 13 discusses the concept in more detail. Reflection can, however, be both formal and informal. You probably reflect on your experiences both socially with other friends who are nurses and more formally in lecturer-led tutorials. This leads to an analysis of your actions and some of the ways in which you could have done things differently or which you would want to repeat. The use of critical incident analysis, for example, enables nurses to evaluate a given situation or event; this is a tool that is used by qualified nurses in their personal portfolios, which must be kept in order for the nurses to be eligible for triennial re-registration (see Chapter 13).

Patient satisfaction

The appreciation that is sometimes offered by clients through, for example, a letter is an indicator of how satisfied individuals have been with their nursing care. In contrast, a letter of complaint may lead to an investigation into the reasons why a client has not been satisfied with the care received. Although the number of letters of complaint appears to be on the increase, this is probably the result of a culture comprising a more informed public. In many ways, such letters lead to an analysis of what went wrong; this may not necessarily be a result of poor nursing care but of other environmental factors. Hopefully, however, such publicity allows those who have control over resources to evaluate the priorities.

Health-care providers are now required to publish statistics on indicators of quality ranging from, for example, how long clients have to wait in accident and emergency departments to the number of clients who receive a visit from the

community nurse within the 2 hour appointment time. In the same vein, letters and cards of satisfaction should be closely monitored.

Reviewing the nursing care plan


This is where the nurse evaluates the effectiveness of the care that has been given against the set goals and writes an evaluation statement. When evaluating care, it is useful to ask yourself a series of questions about each of the stages of the nursing process, which will provide you with answers about your plan of care:

- Have the short-term goals been met?
- If the answer is 'yes', has the diagnosis been resolved? If so, it no longer needs to be addressed
- If the answer is 'no', why have the goals not been met? Did they meet the MACROS criteria?
- Was the planned care realistic? Did it meet the REEPIG criteria?
- Has a new diagnosis arisen or a potential diagnosis become an actual one?
- Was the method of care delivery appropriate?
- Was there effective communication within and between the nursing staff and other members of the multidisciplinary team?
- How satisfied was the client with the care?

Finally, take a look at the completed care plan for Mrs Harris outlined in Figure 1.2 and compare it with your own completed care plan.

Nursing diagnosis:	Pain due to fractured neck of femur.
Goal: Short term:	Mrs Harris states that she is comfortable with a pain scale rating below 2 within 15 minutes.
Goal: Long term:	Mrs Harris feels that she is in control of her pain and that it is no longer a major concern for her within 24 hours.
Nursing actions:	<p>Give the prescribed analgesic and monitor its effects.</p> <p>Apply skin traction.</p> <p>Nurse on a bed equipped with a pressure-relieving mattress.</p> <p>Ensure 2-hourly changes of position by attaching a trapeze pole to the bed, and encourage Mrs Harris to change her position regularly.</p> <p>Ensure that Mrs Harris has a supply of chosen reading/writing materials and access to the television and radio.</p>
Evaluation:	Mrs Harris states that she is comfortable and her pain scale rating remains below 2.

Figure 1.2 ● Worked example of a care plan for Mrs Harris



Activity
10

Review the assessment, nursing diagnosis, goal(s), planned care and method of implementation for your chosen client and then write an evaluation statement. Remember to ask the questions outlined in the text.

■ Information Technology and Care-planning

The input of information technology to health care is having a significant impact on the NHS as advanced computerised information systems record and evaluate everything from finance to personal records. From your own experiences, you may already have seen laptop/palm-top and office-based computers that can record client details and an analysis of nurses' workload. As the NHS network expands, all health-care workers are able to access electronic records, email and increasingly the World Wide Web. This will provide nurses with rapid access to client data such as previous nursing records. There are also currently a number of care-planning computer packages used by different NHS Trusts.

Computerised care-planning offers the nurse a number of advantages. It is quick, because there are a number of templates for common nursing diagnoses. Although these are sometimes criticised for moving towards a more communal rather than an individualised approach to nursing care, each of the templates has a menu of options that can be tailored to the individual client. The ability to raise at the push of a button a client's previous records is also an advantage and generally allows a more rapid search than does a paper-based system.

Computerised care-planning is, however, only as effective as the person who operates the system and generates the care plan. The skills of assessment, identifying nursing diagnoses and goal-setting, and the required nursing actions, can only be effective if the nurse has a sound knowledge base and uses the skills outlined within this chapter. The profession should, and indeed does, welcome the move to more electronic-based systems, if only because the approach is fast and usually efficient. The government has published its strategy through the NHS Information Authority (2002); a visit to its interactive website at www.nhsia.nhs.uk is recommended in order to appreciate the rapid advances in this area.

■ Chapter Summary

This chapter has introduced you to a systematic method for delivering nursing care through the framework known as the nursing process. You have been introduced to the five basic stages of assessment, diagnosis, planning, implementation and evaluation. Using the vehicle of structured activities, you have been offered the opportunity to develop a care plan for a chosen client.

At this stage, you may feel that the nursing process is a complex activity that demands a great deal of thought and practice, but your skills and experiences will continue to grow and develop as your professional career continues. Working through a structured chapter such as this is no substitute for practice and experience, but the principles of care-planning and the issues you need to

consider are offered as the basis of accountable nursing practice. You may, for example, have been surprised at how complex and comprehensive the process of assessment is. The depth of material that you needed to collate when undertaking your assessment may have led you to reflect on the importance of probing and accurate questioning. As you progress in your chosen professional career, you will find that your ability to plan care will become greater. The important point to remember is that the whole practice and process of nursing is ever changing, new strategies, treatments and knowledge arriving almost daily. New research informs nursing practice and must be incorporated into one's professional repertoire. The process of nursing, like the process of learning, is an ongoing rather than a once-only activity.

● Test Yourself!

1. Name the stages of the nursing process.
2. Give two reasons for using the nursing process.
3. What sort of information needs to be collected during a nursing assessment?
4. How many types of nursing diagnosis are there?
5. What are the two stages of the planning phase?
6. What criteria should goals conform to?
7. How can the nursing care plan be evaluated?

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