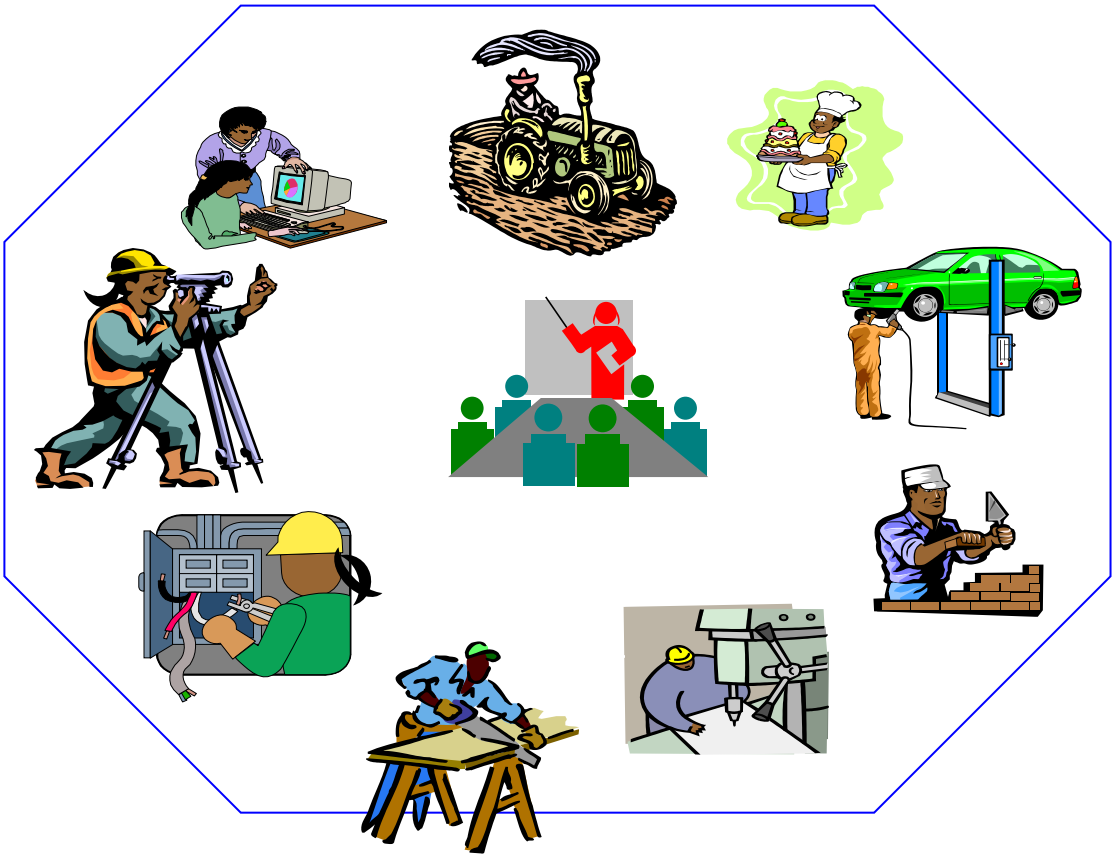
Nursing -Level-IV

Based on Dec, 2018 Version OS and Dec, 2019 Version 1 Curriculum



Module Title: - Perform Nursing Assessment

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Instruction sheet

This learning guide is developed to provide you the necessary information regarding the following content coverage and topics:

Introduction to nursing assessment

Collecting Subjective and objective data

Identifying actual and potential patient problems

Holistic Approaches of nursing health history taking

Keeping records in patient chart

This guide will also assist you to attain the learning outcomes stated in the cover page. Specifically, upon completion of this learning guide, you will be able to:

Introduce nursing assessment

Define terminologies

Describe types of assessment,

Describe Purpose of assessment

Collecting Subjective and objective data

Identify actual and potential patient problems

Nurse holistic approaches of health history taking

Keep records in patient chart

Learning Instructions

Read the specific objectives of this Learning Guide and Follow the instructions described in number 3 to 6.

Read the information written in the information “Sheet 1, Sheet 2, Sheet 3, and sheet 4”.

Accomplish the “Self-check 1, Self-check 2, Self-check 3, and Self-check 4” in page 4, 14,

5. Ask your trainer for the answers key only after you finished answering the Self-check.

Information Sheet-1	Perform nursing assessment

1.1. Introduction to nursing assessment

1.1.1 Definition of terms

Nursing

Definition:-"It is the diagnosis and treatment of human responses to actual or potential health problems"(ANA1980).

It is assisting the individual, sick or well in the performance of thoseactivities contributing to health or its recovery (to peaceful death) that he will perform unaided, if he had the necessary strength, will or knowledge and to do this in such a way as to help him gain independence as rapidly as possible (Virginia Henderson 1960).

Nursing is the art and science that involves working with individual, families, and communities to promote wellness of body, mind, and spirit. It is a dynamic, therapeutic and educational process that serves to meet the health needs of the society, including its most vulnerable members.

1.1.2 Concepts of health and illness

The World Health Organization defines health as "a state of complete physical, mental and social well-being, not merely the absence of disease and infirmity. This definition considers the total persons state of health and wellness as essential component. Health and illness is a relative concept, which is perceived differently by different individuals. Wellness is not only the absence of disease; therefore, any definition of health should consider the different dimensions influencing health. The concept of health and wellness must allow for an individual variability. Health is a dynamic state in which the person is constantly adapting to changes in the internal and external environment. Various models on the concept of health and wellness exist. Some are based on the presence and absence of disease and others on holism, health beliefs and wellness.

Models of Health and illness:-Health models have been developed to help describe the concepts and relationships involved in health and illness.

a. **Host –agent-environment model:-** according to this model health is an ever-changing state and health and illness depends on interaction of host, agent and environmental factors. These factors are constantly in interaction and a combination of factors increases the possibility of illness. When the agent, host and environment variables are in equilibrium health is maintained. On the other hand when the balance is disrupted disease occurs.

b. The Health illness continuum model:- according to this model, health is a constantly changing state, with high level wellness and death being in the opposite ends of a graduated scale, or continuum. The nurse must be aware that a client may place himself/herself at different points on the continuum at any given time depending on how well he/she believes himself to be functioning for his illness

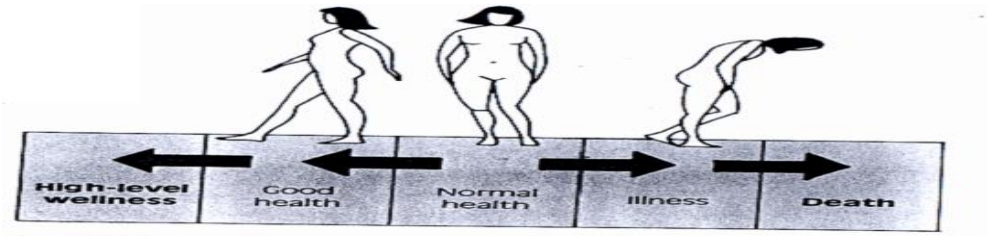


Figure2. The health illness continuum model

c. High-level wellness model:-This model describes high-level wellness as functioning to one's maximum potential while maintaining balance and purposeful direction in the environment. The concept of high level of wellness can be applied to the individual, family, community, environment, and society. In High-level wellness model human beings are viewed as having five aspects

1. Each individual is functioning as a total personality

2. Each person possess dynamic energy

3.Each person is at peace with inner and outer worlds

4. Each person has a relationship between energy use and self integration

5. Each person has an inner world and an outer world

These five processes help the person know who and what he/she is. This model is holistic, allowing the nurse to care for the total person with regard for all dimensional factors affecting the person's state of being as he/she strives to reach maximum potential.

d. Health Belief Model:-The health belief model is based on what people perceive, or believe, to be true about them in relation to health. This model is based on three components: perceived susceptibility to a disease, perceived seriousness of a disease and perceived value of action.

This model states that whether or not a person practices a particular health behavior can be understood by knowing two factors: the degree to which the person perceives a personal health threat and the perception that a particular health practice will be effective in reducing that threat. The perception of a personal health threat is itself influenced by at least three factors: general health values, which include interest, and concern about health; specific beliefs about vulnerability to a particular health problem; and beliefs about the consequence of the health problem. Whether or not the perception of a threat leads to changing health behavior also depends on whether a person thinks a particular health practice will be effective against the health problem in question and whether or not the cost of undertaking that measure exceeds the benefits of the measure. The health belief model enable nurses to understand why people practice health behavior and also to predict some of the circumstances under which people's health behavior will change.

Factors affecting Health and illness

1. Physical dimension-genetic make up, age, developmental level, race and sex
2. **Emotional dimension-**how the mind and body interact to affect to body function and to respond to body conditions also influence s health. Eg. long term stress affects the body systems, anxiety affects health habits and conversely calm acceptance and relaxation can actually change body responses to illness.

3. **Intellectual dimension-**encompasses cognitive abilities, educational background and past experiences.
4. Environmental dimensions-the environment has many influences on health and illness. Housing sanitation, climate, pollution of air, food and water are aspects of the environmental dimension.
5. **Sociocultural dimensions-** health practices are strongly influenced by a person's economic level, life style, family and culture.

6. **Spiritual dimensions-** spiritual and religious beliefs and values are important components of how a person behaves in health and illness.

Nursing in wellness and holistic health care Nurses carry out wellness promotion activities on primary, secondary and tertiary levels

Preventing activities

Primary prevention: is a care directed toward health promotion and specific protection against illness. E.g. Immunization, family planning and health education

Secondary Prevention: focuses on health maintenance for clients experiencing health problems on prevention of complication or disabilities. E.g. Nursing care for hospitalized clients, early detection and treatment of health problems

Tertiary prevention: is aimed at helping rehabilitate clients and restore them to a maximum level of functioning following an illness. E.g. teaching a diabetic client how to recognize and prevent complications

1.1.3 Historical background of nursing

It is difficult to trace the exact origin of the nursing profession. However, moral action is the historical basis for the creation, evolution and practice of nursing.

A. Nursing in ancient civilization:-The early record of ancient civilization offers little information about those who care for the sick. During this time beliefs, about the cause of disease were embedded in superstition and magic and thus treatment often involved magical cures.

- Ancient Egyptians developed community planning and strict hygienic rules to control communicable diseases. The first recorded Nurses were seen
- In the Babylonian civilization, there were references to tasks and practices traditionally provided by nurses. Nurses are mentioned occasionally in old Testament as women who provide care for infant, for the sick and dying and as midwives who assisted during pregnancy and delivery
- In ancient Rome, care of the sick and injuries was advanced in Mythology and reality. Although medicine as a science was developed there was little evidence of establishing a foundation for nursing.
- The ancient Greeks gods were believed to have special healing power. In 460 BC Hippocrates born and credited with being the Father of medicine.

- He proved that illness had natural cause and not to be of a religious or magical cause. Hippocrates first proposed such concepts as physical assessment, medical Ethics, patient – centered care and observation and reporting.
- He emphasized the importance of patient care that contributed a lot for the groundwork of nursing.
- In ancient India, male nurses staffed early Hospitals and women served as midwives and nursed ill family members.

B. Nursing in the middle Ages: - During this time, monasticism and other religious groups offered the only opportunities for men and women to pursue careers in nursing. It was the Christian value of "love thy neighbor as the self" that had a significant impact on the development of western nursing. The principle of caring was established with Christ's parable of Good Samaritan providing care for a tired and injured stranger.

In the third and fourth centuries several wealthy matrons of Roman empire, including Marcella, Fabiola and Paula, converted to Christianity and used their wealth to provide house of care and healing (the fore runner of hospital) for the poor, the sick and homeless. Women were not the sole providers of nursing service in the third century in Rome. There was an organization of men called the parabloani Brotherhood. This group of men provided care to the sick and dying from the great plague in Alexandria.

C. Dark Age of Nursing: - In this period Monasteries were closed and the work of women in religious order was nearly ended. The few women who cared for the sick during this time were prisoners or prostitutes who had little or no training in nursing. Because of this, nursing was considered as the most minimal of all tasks, and had little acceptance and prestige.

The development of modern Nursing

Three images influenced the development of modern nursing. Ursuline Sisters of Quebec organized the first training for nurses. Theodore Flender revived the deaconess movement and opened a School in Kaiserwerth, Germany, which was training nurses.

Elizabeth Fry established the institute of Nursing Sisters. But in the latter half of eighteenth century Florence nightingale the founder of modern nursing changed the form and direction of nursing and succeeded in establishing it as a respected profession. She was born to wealthy and intellectual family in 1820. In spite of opposition from her family and restrictive societal code for affluent young English woman to be a nurse Nightingale believed she was "called" by God to help others and to improve the wellbeing of mankind. In 1847 she received three month's training at Kaiserwerth. In 1853 she studied in Paris with sister of charity, after which she returned to England to assume the position of super intendment of a charity hospital.

Nightingale worked to free nursing from the bonds of the church. She saw nursing as a separate profession from the church, yet she began her career as the result of the mystic experience. During the Crimean war, Florence nightingale was asked to recruit a contingent of female nurses. The Jamaica nurse Mary Grant was the first nurse recruited to provide care to the sick and injured in the Crimean war. The achievements of Florence nightingale in the war were so outstanding that she was recognized by the queen of England who awarded her the Order of Merit. When she returned to England she established the nightingale school of nursing, which was opened in 1860. The school served as a model for other training schools. Its graduates traveled to other counties to manage hospitals and nursing training programs.

History of Nursing Ethiopia:- In ancient Ethiopia illness was considered to be punishment from sins or magic. Most tribes and people had a medicine man or women called "Hakims" or wegasha" who performed rituals, using various plants and herbs to heal the sick. The religious people were also providing care for the sick or injured in the monks' hospital in Debrelibanos. In late 19th century before nurses training started, foreign nurses were practicing in the health care delivery system of Ethiopia. In 1917 Sister Karin Holmer came as trained nurse to Ethiopia. In 1908, Emperor Menelik II established the 1st Governmental public health services, now known as ministry of public health, which is established in 1948. In 1909, the first hospital Menelik II was built in Ethiopia. Later on his Imperial majesty Hailesilassie established different Hospitals in deferent regions including Addis Ababa. The first clinic was established at the hot spring at Eilet near Messwa in which sick people used to come for bathing. The Dejasmatch Balcha Hospital was established in 1948 under the agreement with Soviet Red Cross. Ethiopian government provided the building.The Princes Tsehai memorial Hospital was opened in 1951, as a tribute initially from the British people as friendships with Ethiopia and with strong Ethiopian participation as memorial to late princes Tsehai nowknown as Army Hospital.

The growth of hospitals made it necessary to start the training of Ethiopians to assist in staffing hospitals and clinics. As a first step training, facilities for medical auxiliary personnel were made available in the Menelik II Hospital.

Training of Medical personnel:-Before the Italian occupation with exception of a mission school for midwives in Eritrea (the former province of Ethiopia) the only training in the public health personnel consisted of auxiliary medical training in several hospitals and missions.

Ethiopian Nurses:-Princess Tsehai, the emperor youngest daughter was the first graduated national nurse from Ormand street hospital London.

In 1948 the Ethiopian Red cross nursing school established by his Imperial majesty in theprivate Hospital Bet-Saida which later changed to Hales lassie I Hospital. Then during the Derg regime, this hospital is changed its name to Yekatit 12 hospital, which still exists In 1950, the school of nursing was established at Empress Zewditu memorial hospital for male and female nurses. In March 1953, the first eight nurses from

Ethiopian Red Cross of nursing and nine from Empress Zewditu memorial hospital were graduated. In 1951, two school of Nursing was established: one at the princess Tsehai memorial only for female nurses and the other one was in Nekemt at the Teferie Mekonnen Hospital. In 1959 the post basic training started at princess Tsehai memorial hospital for midwifery nursing and four nurses graduated in 1960. In 1954 the Gonder Health College and training center opened and gave training to community nurses. In 1958 fifteen (15) community nurses graduated from this center.

The Nursing Process

Definition:- **nursing process** is a deliberate problem-solving approach for meeting people's health care and nursing needs. Although the steps of the nursing process have been stated in various ways by different writers, the common components cited are assessment, diagnosis, planning, implementation, and evaluation. The ANA's *Scope and Standards of Practice* includes an additional component entitled outcome identification, defined as identification of expected outcomes for a plan that is tailored to the patient's needs. The sequence of steps in this process is assessment, diagnosis, outcome identification, planning, implementation, and evaluation. For the purposes of this text, the nursing process is based on the traditional five steps and delineates two components in the diagnosis step: nursing diagnoses and collaborative problems. After the diagnoses or problems have been determined, the desired outcomes are often evident. The traditional steps are defined as follows:

1.1.5 Types of assessment

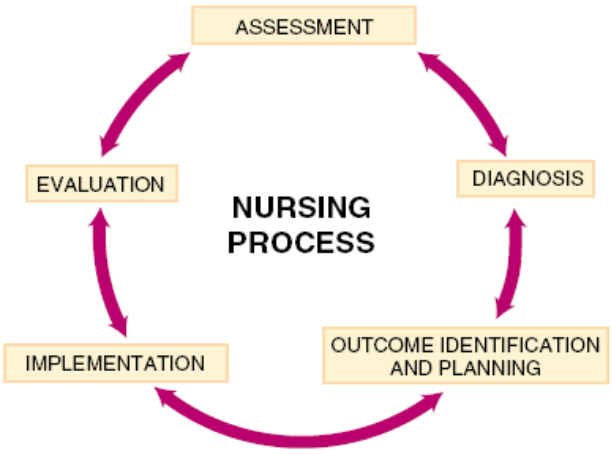


Fig. 4 Components of nursing process

1. ***Assessment***: The systematic collection of data through interview, observation, and examination to determine the patient's health status as well as any actual or potential health problems (Analysis of data is included as part of the assessment. Data are gathered through the health history and the physical assessment. In addition, ongoing assessment and monitoring are crucial to remain aware of changing patient needs and the effectiveness of nursing care.

1.1.4 Purpose of assessment

To identify the client's health status, actual or potential health problems or needs.

To establish plans to meet the identified needs and.

To deliver specific nursing interventions to meet those needs.

Characteristics of Nursing process

It is the frame work for providing Nursing care to pt, family and community.

It is orderly and systematic.

It is interrelated.

It provide individualized care.

It is patient centered.

It is cyclical.

Goal directed

Systematic and organized

Dynamic and always changing

Widely applicable to clients, families and groups

Adaptable to changing client situations

Interpersonal and interactive

The type and scope of information needed for assessment are usually determined by the health care setting and needs of the client. Three types of assessment are

- Comprehensive
- focused, and
- ongoing

A. Comprehensive Assessment

A comprehensive assessment is usually completed upon admission to a health care agency and includes a complete health history to determine current needs of the client. This database provides a baseline against which changes in the client's health status can be measured and should include assessment of physical and psychosocial aspects of the client's health, the client's perception of health, the presence of health risk factors, and the client's coping patterns.

B. Focused Assessment

A focused assessment is an assessment that is limited in scope in order to focus on a particular need or health care problem or potential health care risks. Focused assessments are not as detailed as comprehensive assessments and are often used in health care agencies in which short stays are anticipated (e.g., outpatient surgery centers and emergency departments), in specialty areas such as labor and delivery, and in mental health settings or for purposes of screening for specific problems or risk factors (e.g., well-child clinics). See the accompanying display for sample questions used to assess a client experiencing labor

C. Ongoing Assessment

Systematic follow-up is required when problems are identified during a comprehensive or focused assessment. An **ongoing assessment is an assessment that** includes systematic monitoring and observation related to specific problems. This type of assessment allows the nurse to broaden the database or to confirm the validity of the data obtained during the initial assessment.

Ongoing assessment is particularly important when problems have been identified and a plan of care has been implemented to address these problems. Systematic monitoring and observations allow the nurse to determine the response to nursing interventions and to identify any emerging problems.

Types of Data

Client data include information that the client communicates concerning perceptions of his or her own health status, as well as specific observations made by the nurse. These two types of information are referred to as subjective and objective data.

Subjective data:

- Are data from the client's point of view and include feelings, perceptions, and concerns.
- The data (also referred to as symptoms) are obtained through interviews with the client.
- They are called subjective because they rely on the feelings or opinions of the person experiencing them and cannot be readily observed by another.

Objective data:

Are observable and measurable (quantitative) data that are obtained through observation, standard assessment techniques performed during the physical examination, and laboratory and diagnostic testing. These data (also called signs) can be seen, heard, or felt by someone other than the person experiencing them. Assessments that are comprehensive and accurate include both subjective and objective data.

Examples of objective information include:

A. Temperature (37.3°C), Pulse rate (100 b/m), Respiration (18 T/m), Blood pressure (130/76 mm/hg).

B. Positive bowel sounds.

C. Flushed face.

Sources of information

I. **Primary sources**-

- The primary source of information during assessment is the clients themselves.
- The information obtained from the client is relatively accurate and very important.

II. **Secondary sources**- secondary sources of information during assessment can be:

- Family members.
- Other significant others.
- Patient records.
- Other health care team.
- Laboratory results.
- X-ray results.
- Literature review.

1.1.5. Holistic Approaches of nursing health history taking

History taking

Health History The purpose of obtaining a health history is to provide you with a description of your patient's symptoms and how they developed. A complete history will serve as a guide to help identify potential or underlying illnesses or disease states.

In addition to obtaining data about the patient's physical status, you will obtain information about many other factors that impact your patient's physical status including spiritual needs, cultural idiosyncrasies, and functional living status.

The basic components of the completehealth history are

A. Biographic data

B. Chief complaints

C. History of present illness

D. Past health history

E. Personal and social history

F. Family history

G. Functional inquiry/ review of system

A. Biographic data

These are data, which includes:

1. Date and Time of History
2. Identifying data
    - Age, sex ethnic origin, birthplace, occupation, religion, educational status, address and marital status
    - Source of referral or letter of referral if any
    - Source of history (patient, family, friends)

B. Chief complaints:-

The main part of the history starts with the patients chief complaints. It is the main problem or issues that bring the person to the attention of the health care providers. This category includes two questions: "What is your major health problem or concerns at this time?" and "How do you feel about having to seek health care?

The chief complaints are also one or more symptoms or other concerns for which the pts is seeking care or advice; it addresses the primary reason. When possible these complaints should be written in the patient's own words

C. History of present illness (HPI):- It describes the current illness for which the patient is seeking medical help. The most important part of the history. It is a clear, chronological account of the problems for which the patient is seeking care. The structural /narrative in HPI should include.

- ✓ The onset of the problem
- ✓ The setting in which it develops

- ✓ Manifestations of the problem

- The principal symptoms should be described in terms of
  - ✓ Location
  - ✓ Quality
  - ✓ Quantity or severity
  - ✓ Timing (onset, duration, frequency)
  - ✓ The setting in which they occur
  - ✓ Factors that aggravate or relieve them
  - ✓ Associated manifestations

OR

- OLD CART

D. Past medical history (PMH)

- This explores prior illness, injuries, childhood illness, operations, hospitalizations and medical interventions
- During this time, you may ask questions like:
- Medical: Illnesses such as diabetes, hypertension, hepatitis, asthma, or HIV; hospitalizations
- Surgical: Dates, reasons for surgery, and types of operations or treatments
- Accidents: type, dates, treatment and residual disability of major accidents
- Psychiatric: Illness and time frame, hospitalizations, and treatments

E. Personal History

This provides a picture of the patient's background, occupations, home environment, worries, personality, and alcohol and tobacco consumption. In general, personal history provides a profile of the patient. It include

- ✓ Patient's early development: (place of birth, childhood)
- ✓ Education, occupation (employment status, current and relevant previous occupations)
- ✓ Marital status, living arrangements, habits (alcohol, drugs, tobacco, chat)

F. Family History:- these provides data concerning hereditary diseases and familial illnesses. It should describe each of the immediate family members (father, mother, siblings and children). Their number, age, health and if dead, age and causes of death. It should mention if there is any occurrence if tuberculosis, DM, HTN, heart disease, renal disease, arthritis, anemia, mental illness or any illness similar to that of the patient.

G. Review of Systems: - revision of all the systems of the body. Think about asking series of questions going from “head to toe.” You ask about common symptoms in each major body system and thus try to identify problems that the patient has not mentioned.

Physical Examination: - physical examination is a process to obtain objective data from the patient. The purpose of the physical examination is to determine changes in a patient’s health status and how to respond to a problem as well as promote healthy lifestyles and wellbeing. Physical examination or clinical examination is the process by which a health care provider investigates the body of a patient for signs of disease.

Examination tools

Guidelines	Example
Flashlight or penlight	To assist viewing of the pharynx and cervix or to determine the reactions of the pupils of the eye
Laryngeal or dental mirror	To observe the pharynx and oral cavity
Nasal speculum	To permit visualization of the lower and middle turbinates; usually, a penlight is used for illumination
Ophthalmoscope	A lighted instrument to visualize the interior of the eye
Otoscope	A lighted instrument to visualize the eardrum and external auditory canal (a nasal speculum may be attached to the otoscope to inspect the nasal cavities)
Percussion (reflex) hammer	An instrument with a rubber head to test reflexes
Tuning fork	A two-pronged metal instrument used to test hearing acuity and vibratory sense
Vaginal speculum (various sizes)	To assess the cervix and the vagina
Cotton applicators	To obtain specimens
Disposable pads	To absorb liquid
Gloves (sterile and unsterile)	To protect the nurse
Lubricant	To ease insertion of instruments (e.g., vaginal speculum)
Tongue blades (depressors)	To depress the tongue during assessment of the mouth and pharynx

Note: From Fundamentals of Nursing: Concepts, Process, and Practice, *6th ed., by B. Kozier, G. Erb, A. Berman, & K. Burke, 2000, Upper Saddle River, NJ: Prentice Hall Health.*

Techniques of physical assessment

- ❖ Inspection
- ❖ Palpation
- ❖ Percussion
- ❖ Auscultation

INSPECTION

Inspection is the most frequently used assessment technique. When you are using inspection, you are looking for conditions you can observe with your eyes, ears, or nose. Examples of things you may inspect are skin color, location of lesions, bruises or rash, symmetry, size of body parts and abnormal findings, sounds, and odors. Inspection can be an important technique as it leads to further investigation of findings

During the time of inspection:

- Expose the area being inspected while draping the rest of the client
- Look before touching
- Use adequate lighting
- Provide a warm room for examination
- The use of ophthalmoscope ,speculum, x-ray ,lab tests facilitate inspection

PALPATION

Palpation is another commonly used physical exam technique, requires you to touch your patient with different parts of your hand using different strength pressures. During light palpation, you press the skin about ½ inch to ¾ inch with the pads of your fingers. When using deep palpation, use your finger pads and compress the skin approximately 1½ inches to 2 inches. Light palpation allows you to assess for texture, tenderness, temperature, moisture, pulsations, and masses. Deep palpation is performed to assess for masses and internal organs.

PERCUSSION

Percussion is used to elicit tenderness or sounds that may provide clues to underlying problems. When percussing directly over suspected areas of tenderness, monitor the patient for signs of discomfort. Percussion requires skill and practice.

The method of percussion is described as follows: Press the distal part of the middle finger of your nondominant hand firmly on the body part. Keep the rest of your hand off the body surface. Flex the wrist, but not the foreman, of your dominant hand. Using the middle finger of your dominant hand, tap quickly and directly over the point where your other middle finger contacts the patient's skin, keeping the fingers perpendicular. Listen to the sounds produced .

These sounds may include:

- ✓ Tympany
- ✓ Resonance
- ✓ Hyperressonance
- ✓ Dullness
- ✓ Flatness

Tympany sounds like a drum and is heard over air pockets.

Resonance is a hollow sound heard over areas where there is a solid structure and some air (like the lungs).

Hyperressonance is a booming sound heard over air such as in emphysema.

Dullness is heard over solid organs or masses.

Flatness is heard over dense tissues including muscle and bone

AUSCULTATION

Auscultation is usually performed following inspection, especially with abdominal assessment. The abdomen should be auscultated before percussion or palpation to prevent production of false bowel sounds. When auscultating, ensure the exam room is quiet and auscultate over bare skin, listening to one sound at a time. Auscultation should never be performed over patient clothing or a gown, as it can produce false sounds or diminish true sounds. The bell or diaphragm of your stethoscope should be placed on your patient's skin firmly enough to leave a slight ring on the skin when removed.

Physical examination.

- **General appearance**
  - ✓ Observe the general state of health.
  - ✓ Check the pt
  - ✓ His breathing: fast, slow, painful, distressed/ not
  - ✓ Sign of dehydration – sunken eye ball, dry-lip
  - ✓ Level of consciousness
  - ✓ Is he confused or alert
  - ✓ Is he answering well or not
  - ✓ Posture, dressing, personal hygiene, facial expression.

Result will be: - Well looking – if there is no relevant finding

Acutely sick looking

With signs of distress

In pain Highly fatigue etc.

Chronically sick looking

Emaciated, Weak.

Vital signs

✓ A physiologic response which tells as the recent condition of the body system

- Blood pressure
- Pulse
- Respiration
- Temperature

The HEENT Examination

The head

Hair: Note the quantity, distribution, texture and pattern of loss of any Fair (pail) hair in hyperthyroidism, Coarse (uncouth) hair in hypothyroidism.

Scalp: look for scaliness, lumps, nevi, or other lesions

Skull: Observe the size and counter of the skull, note any deformities and look for lumps or other lesions

Face: Note the patients facial expressions and contours, observe for asymmetry, edema, and masses

The eye: inspection and palpation

- Visual acuity
- Visual fields
- Eye lids
- Conjunctiva and sclera
- Cornea and pupil
- Extra ocular movements

Assessment of the Ears

Look for:- Size, shape, skin condition, and tenderness

External canal (redness, swelling, discharge)

Tympanic membrane [color & characteristics (amber, redness), air/fluid levels]

Hearing acuity (also examined as you collect the patient's history)

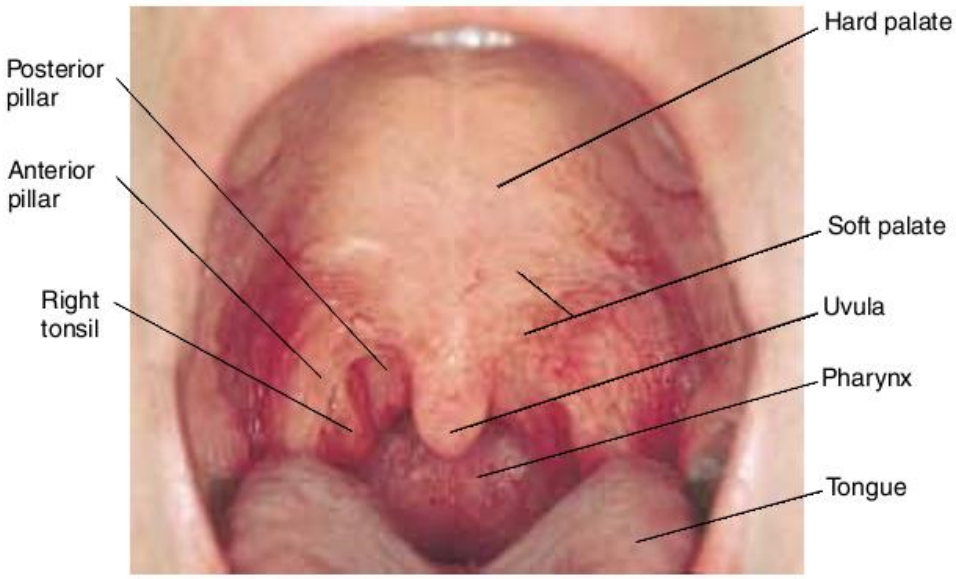
The nose

▪ Inspect the anterior and inferior surface of the nose for tenderness and symmetry or deformity. Tenderness of the nasal tip suggests local infection. Inspect the inside of the nose and the inferior and middle turbinate, the nasal septum and the narrow nasal passage between them

Mouth and Throat :- Begin with the anterior structures and move posterior. Use a tongue blade to retract structures and a bright light for visualization

Lips: - Inspect the lips for color, moisture, ulcers, lamp, pallor or cyanosis, cracking or lesions. Retract the lips and note their inner surface.

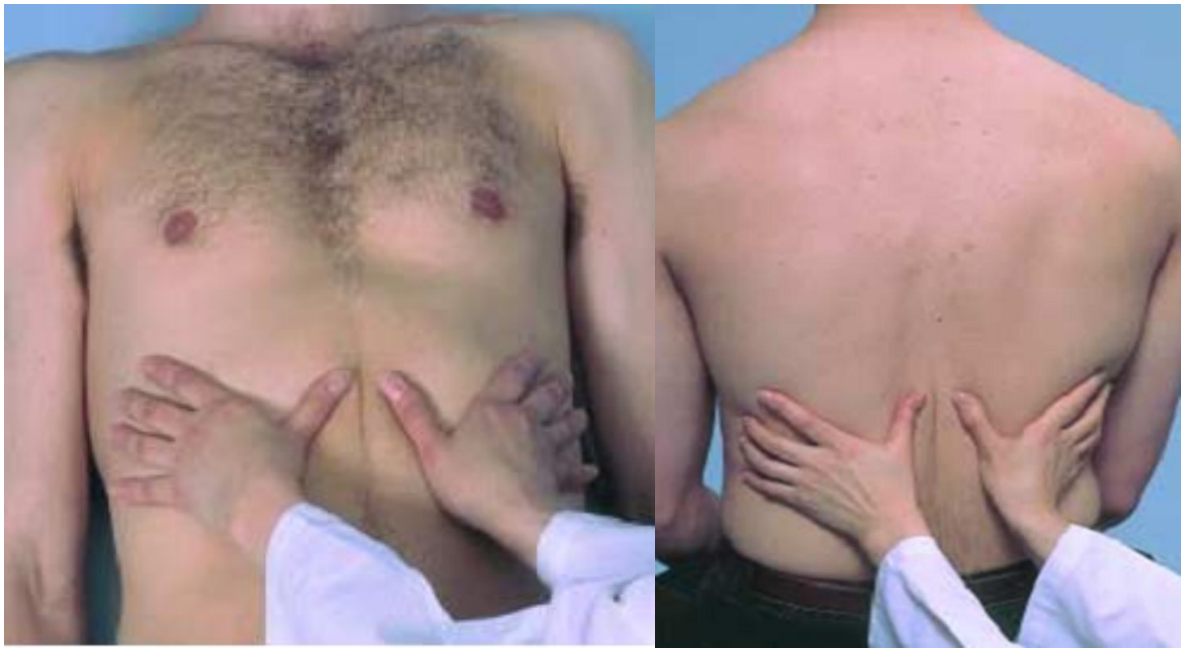
Abnormal= pallor with anemia, cyanosis with hypoxemia, herpes simplex, other lesions.



Examination of the Respiratory System

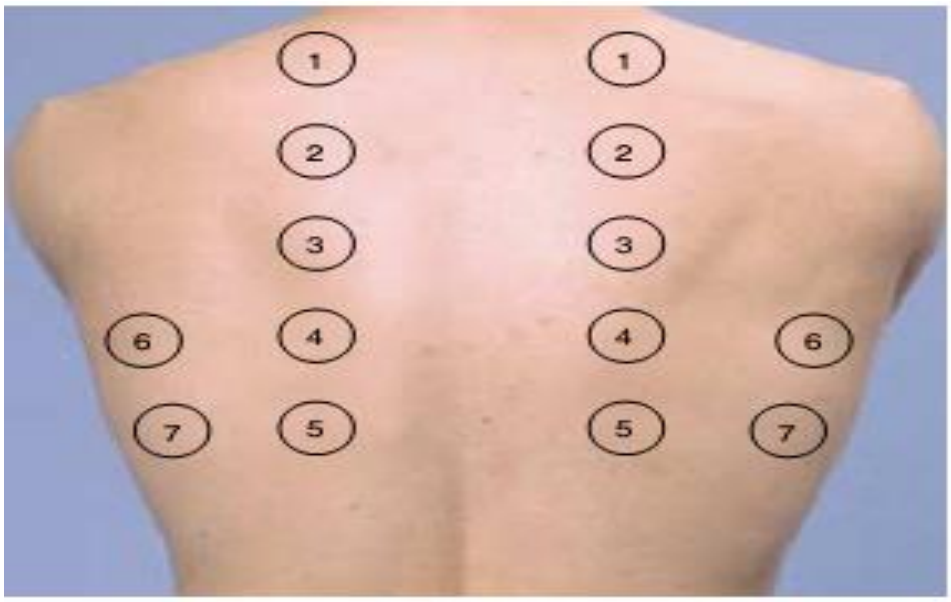
The posterior chest: -

- 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.



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, tympany is evident over the gastric space.



LOCATIONS FOR PERCUSSION AND AUSCULTATION

Auscultate the Anterior chest

Auscultate the lung fields over the anterior chest from the apex in the supraclavicular 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.

A. Breath sounds / Lung sounds

The turbulent flow of air in the trachea and large airways generates noise, and normal breath sounds have been classified in to three categories.

1. Bronchial breath sound (BBS) Louder, and higher in pitch

The expiratory sounds lasts **longer than** the inspiratory ones with short silent gap

Normally heard over the **manubrium**, if heard

2. Broncho vesicular sounds (BVS) Are Intermediate,

Inspiratory and expiratory sound are **equal** length and a silent period between them may not be present.

Location:

Anteriorly, on 1st and 2nd intercostal space and posteriorly, between the scapula

3. Vesicular breath sound (VBS) soft, low pitched sounds

Inspiratory sound lasts **longer than** expiratory ones.

Normally heard throughout the entire lung except over upper sternum and between scapulas.

B. Adventitious (Added) sounds

a. Discontinuous sound

Crackles (sometimes called rales)

Are intermittent, non-musical (explosive) and brief sound caused by the rapid movement of air, which, occur when an air way opens.

Fine crackles: are soft, high pitched and very brief.

Coarse crackles: are somewhat launder lower in pitch in and not quite so brief.

b. **Continuous sounds**

Notably longer than crackles and are musical

Wheezes; - is the musical sound made by air passing through an airway that is narrowed and on the point of closure.

They are often audible at the mouth as well as through the chest wall. Wheezes are relatively high pitched and have a hissing or shrill quality. This is Common in – Asthma, COPD, and Bronchitis.

Stridor: - Wheeze that is entirely or predominantly inspiratory.

It is often louder in the neck than over the chest wall. It indicates a partial obstruction of the larynx or trachea, and demands immediate attention

Rhonchi: - Are relative low pitched and have a snoring quality, it Suggests secretions in large airways. Clearing of crackles, wheezes, or rhonchi after cough suggests that secretions caused them, as in bronchitis or atelectasis.

Pleural rub (friction rub); - Is a sound linked to creaking leather, which is thought to be generated by inflamed pleural surfaces rubbing each other during respiration.

Examination of the Cardiovascular system

Normal Heart Sounds

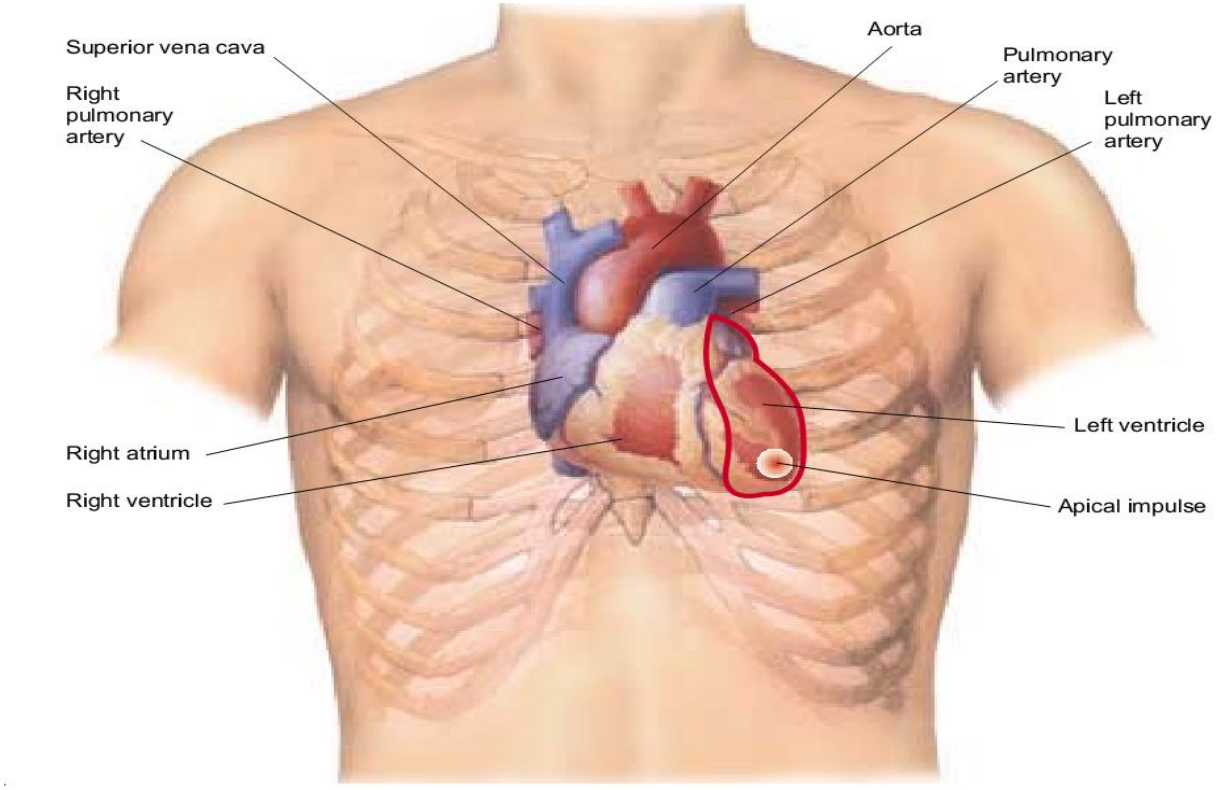
The first heart sound (S1) occurs with the closure of the AV valves and signaling the beginning of the systole. You can hear S1 over all the pericardium, but usually it is loudest at the apex. The second heart sound (S2) occurs with closure of the semi-lunar valves and signals the end of the systole.

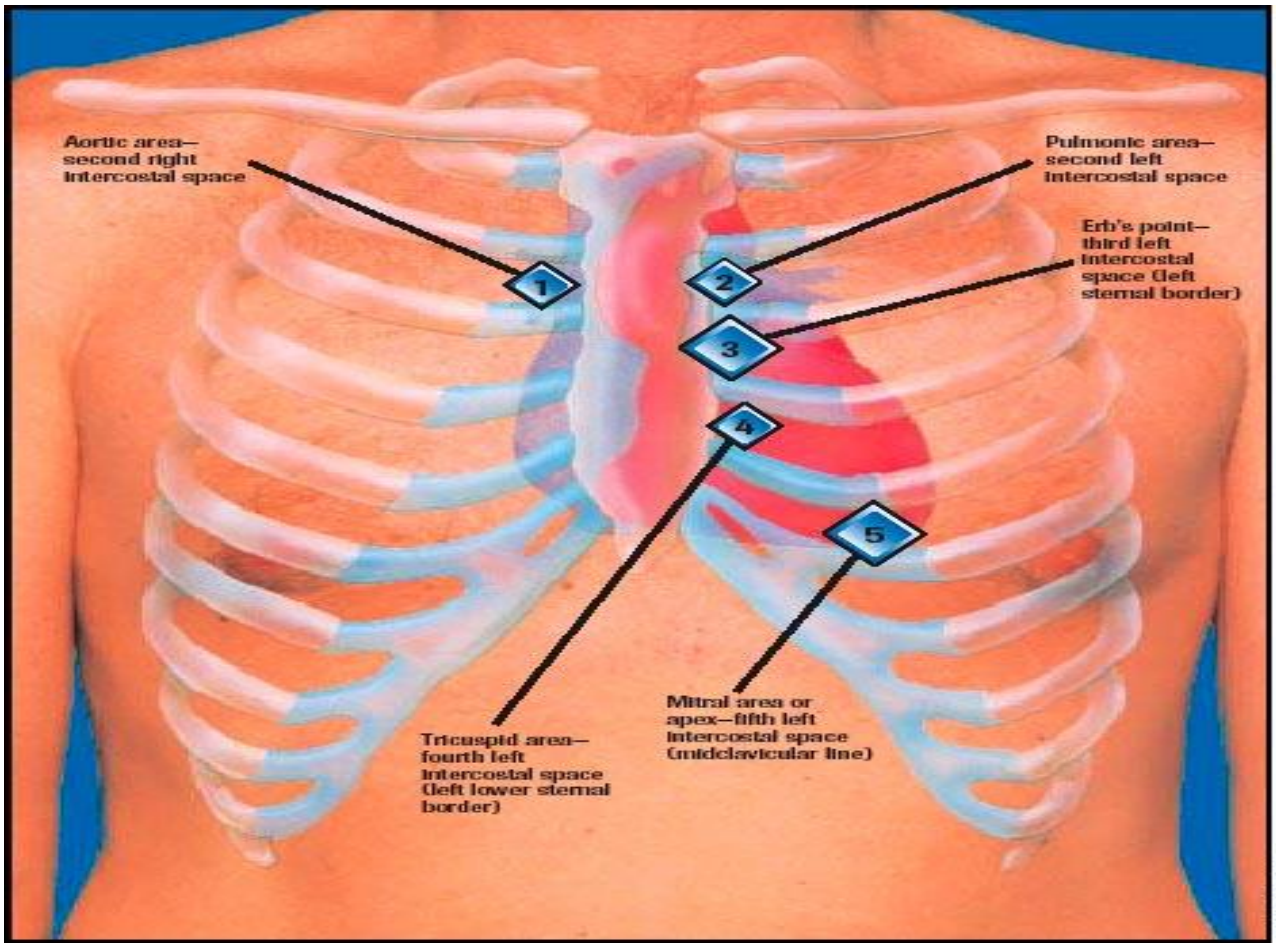
For subjective data, ask the patient for chest pain, dyspnea, orthopnea, cough, fatigue, cyanosis or pallor, edema and nocturia.

Auscultatory areas where you will listen for different cardiac areas

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

Auscultatory areas





Abdominal examinations

Subjective Data- appetite, dysphagia, food intolerance, abdominal pain, nausea/vomiting, bowel habits, rectal conditions, and past abdominal history.

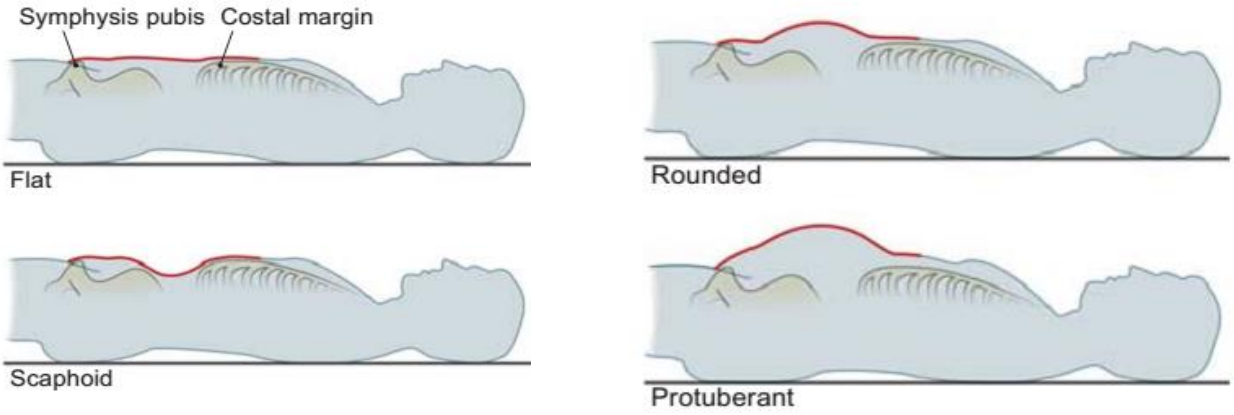
Objective Data- equipment needed- Stethoscope, small centimetre ruler, and skin marking pen.

Method of Examination

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.

Abnormal- bulges, masses, hernia



Shapes of abdomen

Auscultation- auscultate bowel sounds and vascular sounds.

Begin in the RLQ at the ileocecal valve, because bowel sounds are always present here normally. The frequency of which has been estimated at from **5 to 34 per** minute) and sometimes you may hear borborygmi (long prolonged gurgles of hyperperistalsis)

Percussion

Percuss general tympany, liver span, and splenic dullness.

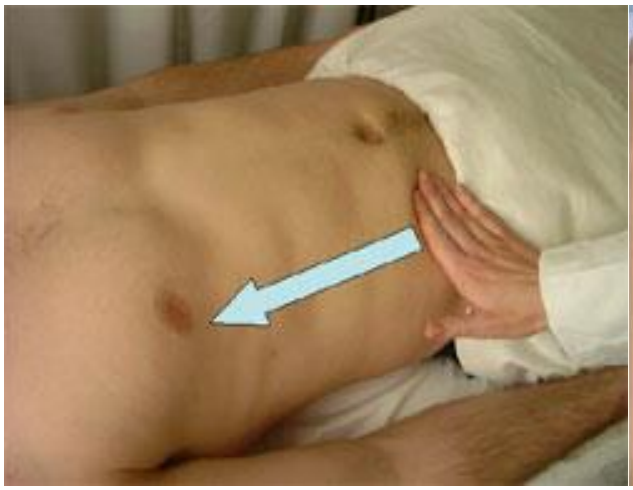
Percuss to assess the relative density of abdominal contents to locate organs, and to screen for abnormal fluid or masses

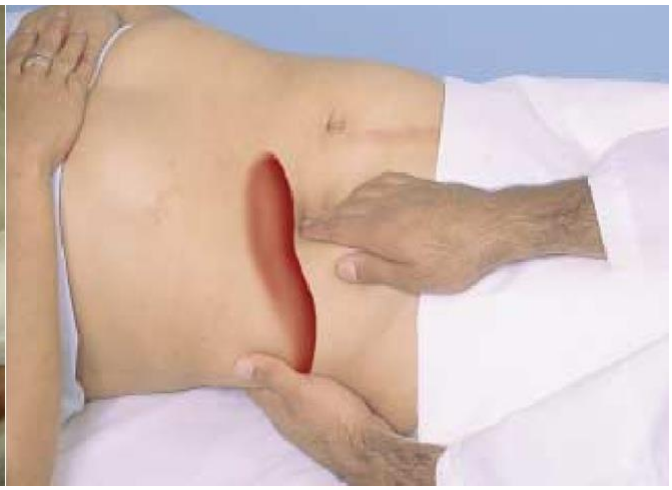
Palpation

Before you palpate the patient's abdomen ask if they are in any pain and if so, leave this area to last. Ask the patient to inform you if they experience any pain during the examination.

There are two type f palpations (light and deep palpation)

Begin with light palpation





Examination of nervous system

Subjective Data: - head ache, head injury, dizziness, seizure, tremors, weakness or incoordination, numbness or tingling, difficulty swallowing, and 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:

- Mental status
- Cranial nerves
- Motor system
- Sensory system
- Reflexes.

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

Mental Status assessment

Level of Consciousness (LOC): alert, somnolent, stuporous, comatose.

Orientation: person, place, time

Memory:-Immediate, recent and remote

Cranial nerves tests

Cranial Nerve I – olfactory Nerve Test

The sense of smell in those who report loss of smell

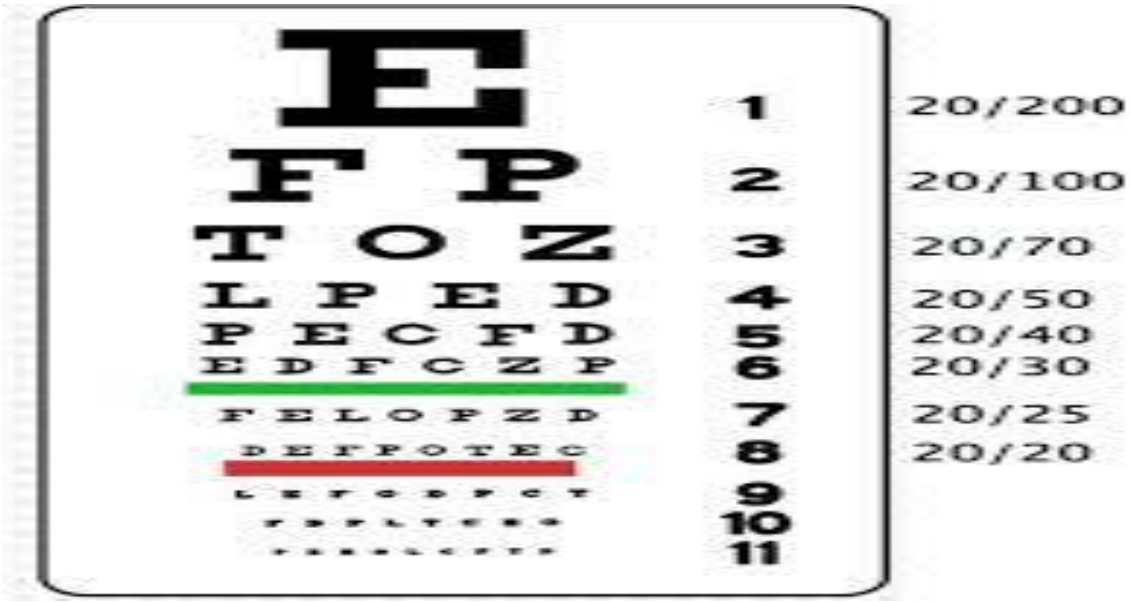
Cranial Nerve II- Optic Nerve – Test visual acuity**.**

Snellen eye chart

Normal visual acuity is 20/20.

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.

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.

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.

Motor system assessment

Motor function- Test motor strength and compare bilaterally.

Muscle strength:-Test muscle strength by asking the patient to move actively against your resistance or to resist your movement. Example: Impaired strength is called weakness (paresis). Absence of strength is called **paralysis** (plegia).

Examination of the Sensory System

To evaluate the sensory system the examiner will test several kinds of sensation;

Pain: use safety pin and ask the patient "is this sharp or dull" or, when making comparisons, "dose this feel the same as this?"

Example;

Analgesia: refers to absence of pain sensation,

Hypoalgesia: refers to decreased sensitivity to pain,

Hyperalgesia: to increased sensitivity

Temperature: Omit it if pain sensation is normal, but include it if there is any abnormality, and ask the patient to identify hot or cold substances (water)

Light touch; Touch the patient's skin with a fine wisp of cotton, and ask the patient to respond whenever a touch is felt, and compare one side to the other side. Example;

Anesthesia: is absence of touch sensation,

Hypoesthesia: is decreased sensitivity, and

Hyperesthesia: is increased sensitivity

Reflexes:- Biceps Reflex**,** Brachioradialis reflex**,** Quadriceps Reflex (Knee jerk)**,** Achilles Reflex – (Ankle Jerk)

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.

Normally: - the breast is conical, symmetrical, no lesions, redness, no retraction, discharge.

The nipples everted, pointed the some direction. Areola & nipples are darker than

The breast examination should include the area above the clavicle to the 6^{th} or 7^{th} rib and from sternum to mid-axillary.

Use the techniques of **inspection** and **palpation**. The examination is performed in several positions:

- Sitting arm at side,
- Sitting arm overhead, for **inspection**
- Sitting hand on hip,
- Sitting leaning forward,

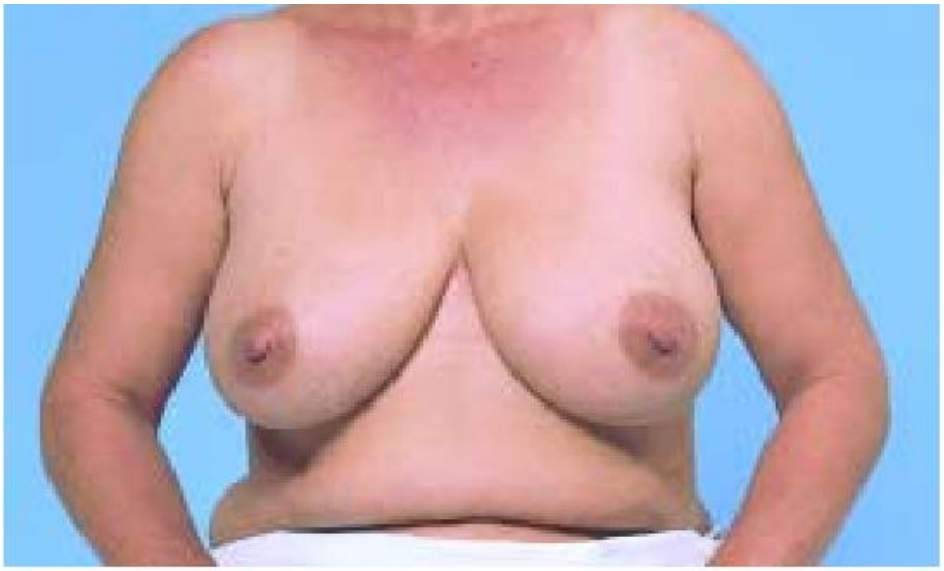
Supine with pillow under shoulder for palpation

Normally the breasts are:

Soft Nipple elastic and

Non tenderness No discharge.

Hard, irregular, poorly circumscribes nodules fixed to the skin or underlying tissue strongly suggest ca.



ARMS AT SIDES

Palpation technique

One or more soft, small (< 1cm), non –tender LN s are frequently felt. Enlarged axillary's nodes are most commonly due to infection of the hands or arm to recent immunization or skin tests in the arm, or part of a generalized lymphadenopathy.

Nodes that are: - Large (≥1 cm) and

Firm or hard, matted together,

Or fixed to the skin or to under-lying tissues suggest malignant involvement.

(1) **Health Perception and Health Management Pattern:** Data collection is focused on the person's perceived level of health and well-being, and on practices for maintaining health.

- What is your opinion about health?
- Are you immunized about seven target diseases?
- Last immunization?
- Do you have any allergy? If yes then type of allergy.
- Any surgery in past? What type of surgery?
- Last physical examination & for what purpose.
- Are you using any medicine recently?
- Do you know about these medicines?

(2) **Nutrition and Metabolism Pattern:** Assessment is focused on the pattern of food and fluid consumption relative to metabolic need.

- Ask about their skin, scalp and nails?
- What is your diet menu?
- Any food restriction regarding disease point of view?
- Any food restriction regarding religious point of view?
- Any food like or dislike?
- Any food allergy?

(3) **Elimination Pattern:** Data collection is focused on excretory patterns (bowel, bladder, skin). Excretory problems such as incontinence, constipation, diarrhea, and urinary retention.

Urine:

- Color of urine, amount, frequency, odor and any discharge.
  Any urinary problem, dysurea, Anurea, Oligourea, , polyuria.

Defecation:

- Are you using any laxative? If yes which?
- Any problem during passing defecation?

(4) **Activity and Exercise Pattern:** Assessment is focused on the activities of daily living requiring energy expenditure, including self-care activities, exercise, leisure activities respiratory and cardiac system.

- Do you any breathing problem?
  In which apnea, hypoxia, hypoxemia, hypercapnia.
- Do you have cough? (Productive or non productive)
- Any changes in heart beat during exercise?

(5) **Cognition and Perception Pattern:** Assessment is focused on the ability to thinking, decision making, and problem solving.

- Orientation about time place and person.
- Any difficulty in sentence making?
- Loss of memory.

(6) **Sleep and Rest Pattern:** Assessment is focused on the person's sleep, rest, and relaxation practices. Dysfunctional sleep patterns, fatigue, and responses to sleep deprivation may be identified.

- Sleeping hour?
- Are you using nap (evening type sleeping).
- What do you feel after waking? (Fresh, headache, drowsy).
- Are you using any medication for sleeping?
- Do you have any exercise or walking at night?

(7) **Self-Perception and Self-Concept Pattern:** Assessment is focused on the person's attitudes toward self, including identity, body image, and sense of self-worth.

- What is your self perception about yourself?
- Are you satisfied with your self body image?
- Do you like grooming?

(8) **Roles and Relationships Pattern:** Assessment is focused on the person's roles in the family and relationships with others.

- What is your role in family?
- If you are in hospital then who will perform your responsibilities?
- All the family members are cooperative with you?
- Who is decision maker in your family?

(9) **Sexuality and Reproduction Pattern:** Assessment is focused on the person's satisfaction or dissatisfaction with sexuality patterns and reproductive functions.

- When you first notice changes in your menarche (first menses is called menarche)
- Do you have any sexual problem? (loss of libido)
- Active sex (direct sex with male and female)
  Passive sex (sex without male and female partner)
  Digital sex (Artificial dimy etc)
- Reproductive: Infertility

(10) Coping and Stress Tolerance Pattern: Assessment is focused on the person's perception of stress and on his or her coping strategies Support systems are evaluated, and symptoms of stress are noted.

- If you have stress then what is your coping mechanism towards stress?
  Crying, angry, violence, (what is your opinion regarding that)

(11) Values and Belief Pattern: Assessment is focused on the person's values and beliefs (including spiritual beliefs).

- What is your religion?
- Do you offer prayer?

1.1.6 Patient preparation for physical assessment

1.4. Identifying actual and potential patient problems

When identifying a nursing diagnosis for a particular patient, nurses must first identify the commonalities among the assessment data collected. These common features lead to the categorization of related data that reveal the existence of a problem and the need for nursing intervention. The identified problems are then defined as specific nursing diagnoses. Nursing diagnoses represent actual or potential health problems, state of health promotion, or potential risks that can be managed by independent nursing actions.

It is important to remember that nursing diagnoses are not medical diagnoses; they are not medical treatments prescribed by the physician, and they are not diagnostic studies. Rather, they are succinct statements of specific patient problems that guide nurses in the development of the plan of nursing care.To give additional meaning to the nursing diagnosis, the characteristics and etiology of the problem are identified and included as part of the diagnosis.

1.5. Keeping records in patient chart

For example, the nursing diagnoses and their definingcharacteristics and etiology for a patient who has anemia may include the following: Activity intolerance related to weakness and fatigue Ineffective peripheral tissue perfusion related to decreased hemoglobin Imbalanced nutrition: less than body requirements related to fatigue and inadequate intake of essential nutrients

After the health history and physical assessment are completed, the information obtained is recorded in the patient's permanent record. These records are more commonly becoming electronic (i.e.electronic health records [EHRs]). The ANA (2009) advocates that when EHRs are used, "patients should receive written, easily understood notification of how their health records are used and when their individually identifiable health information is disclosed to third parties" (p. 1). It is imperative that the patient's right to privacy and confidentiality are not violated through the use of EHRs. Regardless of whether the record is in a traditional paper format or an EHR, it must provide a means of communication among members of the health care team and facilitate coordinated planning and continuity of care (Perez-Rivas et al., 2015). The record fulfills other functions as well. It serves as the legal and business record for a health care agency and for the professional staff members who are responsible for the patient's care. Various systems are used for documenting patient care, and each health care agency selects the system that best meets its needs.It serves as a basis for evaluating the quality and appropriateness of care and for reviewing the effective use of patient care services. It provides data that are useful in research, education, and short- and long-range planning.

Self-check-1	

Instructions*:* Answer all the questions listed below. Illustrations may be necessary to aid some explanations/answers. Write your answers in the sheet provided in the next page.

Review questions

Part I

1. the most frequently used assessment technique is:
   A.Palpation
   B.Inspection
   C.Percussion
   D. Auscultation

2. Factors that impact your patient's physical status include spiritual needs, cultural idiosyncrasies,
   and functional living status.
   A. True B. False

3. Nurses use physical assessment skills to:
   A. Obtain baseline data
   B. Enhance the nurse-patient relationship
   C. Both of the above

4. _____ is relative low pitched and have a snoring quality, it Suggests secretions in large airways.
   A. Stridor
   B. Rhonchi
   C. Wheezing
   D. All of the above

Part II writes short answer

1. Why do you think the definition of health and illness is relative?
2. Discuss the contribution of health models in explaining health and illness relationships and interactions
3. What are the factors influencing health –illness status.
4. In Ethiopia, how do you think sociocultural and spiritual development affect health?

Answer Sheet

Name: _____ Date: _____

Short Answer Questions

Score = _____
Rating: _____

Part one 1. ___ **2.** ___ **3.**____ **4.**____

1._____
_____
_____

2._____
_____
_____
_____

3._____
_____

4._____
_____

Note: **Satisfactory rating 4 > points Unsatisfactory < 4 below pointsYou can ask you teacher for the copy of the correct answers.**

L G #13 LO #- 2 Develop nursing diagnosis

Instruction sheet

This learning guide is developed to provide you the necessary information regarding the following content coverage and topics:

- Definition
- Characteristics of nursing diagnosis (Vs medical diagnosis)
- Types of Nursing Diagnoses
- Components of nursing diagnosis
- Prioritizing problem based on the assessment
- Developing nursing diagnosis using NANDA
- Keeping records in patient care

This guide will also assist you to attain the learning outcomes stated in the cover page. Specifically, upon completion of this learning guide, you will be able to:

- Definition Nursing Diagnosis
- Characterize of nursing diagnosis (Vs medical diagnosis)
- Describe types of Nursing Diagnoses
- Describe components of nursing diagnosis
- Prioritize problem based on the assessment
- Develop nursing diagnosis using NANDA
- Keep records in patient care

Learning Instructions:

1. Read the specific objectives of this Learning Guide.
2. Follow the instructions described in number 3 to 6.
3. Read the information written in the “Information Sheets”. Try to understand what are being discussed. Ask your trainer for assistance if you have hard time understanding them.
4. Accomplish the “Self-check.
5. Ask from your trainer the key to correction (key answers) or you can request your trainer to correct your work. (You are to get the key answer only after you finished answering the Self-check 1).

Information Sheet-1	Develop nursing diagnosis

2.1. Nursing Diagnosis

2.1.1. Definition

- Nursing diagnosis is a clinical judgment about an individual, family or community response to actual or potential health problems/life process.
- Nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.
- Nursing diagnoses are those problems for which nurses can legally prescribe definitive interventions independently

Purposes of the Nursing Diagnosis- the nursing diagnosis serves the following purposes:

- Identifies nursing priorities
- Directs nursing interventions to meet the client's high priority needs
- Provides a common language and forms a basis for communication and understanding between nursing professionals and health care team.
- Guides the formulation of expected outcomes for quality assurance requirements of third party payer.
- Provides a basis for evaluation to determine if nursing care was beneficial to the client and cost effective.
- Help when making staff assignment.

2.1.2. Types of Nursing Diagnoses

1. **Actual nursing diagnosis**:-describe a human response to a health problem that is being manifested.
2. **Potential nursing diagnosis**: describes human responses to health conditions that may develop in a vulnerable individual, family, or community.

3. **Possible nursing diagnosis**: is made when there is no enough evidence to supports the presence of the problem, but the nurse thinks that is highly probable and wants to collect more information.

2.1.3. Components of nursing diagnosis

- **Diagnostic label**: the name of the nursing diagnosis as listed in the NANDA list.
- **Etiology:** is the related cause or contributor to the problem. The diagnostic label and etiology are linked by the term related to (RT).
- ***Descriptive words***: terms may be added to clarify specific nursing diagnoses. These descriptive words are called **qualifiers.**

It include acute, chronic, decreased, depleted, disturbed, dysfunctional, enhanced, excessive, impaired, increased, ineffective, intermittent, potential for, and risk.

- ***Defining characteristics***: are signs and symptoms, subjective and objective data.
  - This part is joined to the first two components with the connecting phrase **"**as evidenced by" (AEB).

2.1.4. Characteristics of nursing diagnosis (Vs medical diagnosis)

Nursing Diagnosis	Medical Diagnosis
• Focus on unhealthy responses to health and illness. • May change from day to day as the patient's responses change • Describe problems treated by nurses within the scope of independent nursing practice.	• identify diseases • Remains the same for as long as the disease is present • Describe problems for which the physician directs the primary treatment.

2.2. Prioritizing problem based on the assessment

When identifying a nursing diagnosis for a particular patient, nurses must first identify the commonalities among the assessment data collected. These common features lead to the categorization of related data that reveal the existence of a problem and the need for nursing intervention. The identified problems are then defined as specific nursing diagnoses. Nursing diagnoses represent actual or potential health problems, state of health promotion, or potential risks that can be managed by independent nursing actions. It is important to remember that nursing diagnoses are not medical diagnoses; they are not medical treatments prescribed by the physician, and they are not diagnostic studies. Rather, they are succinct statements of specific patient problems that guide nurses in the development of the plan of nursing care. To give additional meaning to the nursing diagnosis, the characteristics and etiology of the problem are identified and included as part of the diagnosis. For example, the nursing diagnoses and their defining characteristics and etiology for a patient who has anemia may include the following:

- ✓ Activity intolerance related to weakness and fatigue
- ✓ Ineffective peripheral tissue perfusion related to decreased hemoglobin
- ✓ Imbalanced nutrition: less than body requirements related to fatigue and inadequate intake of essential nutrients

2.3. Developing nursing diagnosis using NANDA

Nursing diagnoses, the first taxonomy created in nursing, have fostered autonomy and accountability in nursing and have helped to delineate the scope of practice. Many state nurse practice acts include nursing diagnosis as a nursing function, and nursing diagnosis is included in the ANA's *Scope and Standards of Practice* (2015a) and the standards of nursing specialty organizations. NANDA International (NANDA-I; formerly known as the North American Nursing Diagnosis Association) is the official organization responsible for developing the taxonomy of nursing diagnoses and formulating nursing diagnoses that are acceptable for study. Approved nursing diagnoses, designed by nurses, are compiled and categorized by NANDA-I in a taxonomy that is updated to maintain currency. The revised diagnostic labels identified by NANDA-I

The diagnostic statement. The client may present with more than one problem. Therefore, the nursing diagnosis may be made up of multiple *diagnostic statements.* Each

diagnostic statement has two or three parts depending on the healthcare facility.

The three-part statement consists of the following components:

- Problem
- Etiology
- Signs and symptoms, a two-part diagnostic statement consists of the problem, and signs and symptoms.

Problem:-the problem portion of a statement describes- clearly and concisely a health problem a client is having. Use one of the NANDA approved nursing diagnostic labels to state the problem

Etiology: - the etiology part of the diagnostic statement is the cause the problem. Etiology may be physiologic, psychological, sociologic, spiritual, or environmental.

Sign and symptoms- the third part of the diagnostic statement summarizes data. You may need to include several signs and symptoms. For instance, the client with pneumonia had cough with thick sputum, abnormal breath sounds, increased respiration, and difficulty breathing.

Rules for Writing Diagnostic Statements for Nursing Diagnoses

1. For Actual Diagnoses- Use a three part statement using the PRS/PES 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 pattern ***related to*** possible fear of transmitting the herpes Virus.

Collaborative Problems

In addition to nursing diagnoses and their related nursing interventions, nursing practice involves certain situations and interventions that do not fall within the definition of nursing

diagnoses.

These activities pertain to potential problems or complications that are medical in origin and require collaborative interventions with the physician and other members of the health care team. The term *collaborative problem* is used to identify these situations.

Collaborative problems are certain physiologic complications that nurses monitor to detect changes in the status or onset of complications. Nurses manage collaborative problems using physician-prescribed and nurse-prescribed interventions to minimize complications. When treating collaborative problems, the primary nursing focus is monitoring patients for the onset of complications or changes in the status of existing complications. The complications are usually related to the disease process, treatments, medications, or diagnostic studies.

The nurse recommends nursing interventions that are appropriate for managing the complications and implements the treatments prescribed by the physician. According to Carpenito, collaborative problems do not have patient goals; therefore, the approach to evaluation is different from a nursing diagnosis. .After the nursing diagnoses and collaborative problems have been identified, they are recorded on the plan of nursing care.

2.4. Keeping records in patient care

2.1.1. Documentation

Definition: Documentation is defined as written evidence of interactions between and among health professionals, clients, their families, and health care organizations

Purpose:- Through documentation someone ensures:

- ✓ Accurate data needed to plan the client's care in order to ensure the continuity of care
- ✓ A method of communication among the health care team members responsible for the client's care
- ✓ Written evidence of what was done for the client, the client's response, and any revisions made in the plan of care
- ✓ Compliance with professional practice standards (e.g., American Nurses Association)

- ✓ Compliance with accreditation criteria (e.g., the Joint Commission on Accreditation of Healthcare Organization [JCAHO]).

- ✓ A resource for review, audit, reimbursement, education, and research
- ✓ A written legal record to protect the client, institution, and practitioner

2.1.2. Charting

Definition: Charting is written record of history, examinations tests, diagnosis, prognosis, therapy and response to therapy.

Purpose

- ➢ For diagnosis or treatment of a patient while in the hospital
- ➢ After discharge if patient returns for treatment at a future time.
- ➢ For maintaining accurate data on matters demand by courts.
- ➢ For providing material for research.
- ➢ For serving as an information in the education of health personnel, (Medical students, interns, nurses, dietitians. Etc.]
- ➢ For securing needed vital statistics
- ➢ For promoting public health

General rules for charting

A. *Spelling:* Make certain you spell correctly (including medicine labels).

B. Accuracy: Records must be correct in every way. The nurse must be absolutely honest in his or her charting. Mid- statements or changing records may involve the nurse in criminal act.

C. *Completeness:* There must be no omission of important information however; unnecessary words and statement should be avoided.

D. Exactness**:** Use the exact word that describes the conditions. Do not use a word you are not sure of.

E. Objective information: The nurse records what he/she "sees" avoid saying "condition better," or "pulse improved". Record the actual condition. Also expressions do not show much thought on the part of the nurse.

F. Legibility**:** Print as plainly and distinctly as possible. Do not use any fancy words. There should be no question to the words and figures used. This is especially true when recording temperature, pulse, respiration and dosage of medicine.

G. Neatness: No blotches on chart sheets. No wrinkling of sheets. Proper spacing of items and words. Begin each statement with a capital letter. Place a period after all abbreviations and at the end of each statement.

H. Errors: If an error is made, use a ruler and draw one line through it, print nearly above “Error” and sign your name. No erasing and using correction fluid is permitted on the chart.

I. Each nurse should do her/his own charting, that is, she/he should name and the father’s initial.

J. Composition: Chart carefully, composition and spelling must be correct. Consult a dictionary when in doubt. Only approved abbreviations can be used on nursing record. If in doubt consult the supervisor. Do not use chemical formulas for drug as KMNO4 instead of potassium permanganate.

K. Sentences: and not be complete but, they must be clear, avoid as needless repetition of word “Pt”. Remarks should reflect as nearly as possible the patient’s condition. (Watch your grammar).

L. Temperatures should be recorded on the graphic sheet.

M. All orders should be written and signed. Verbal or telephone should be written in the order sheet and signed by the doctor on the next visit.

N. Time of charting: Charting must be done immediately after procedure or observation. This is an absolute must. Chart the hour, as possible state order must be recorded with the exact hour the treatment or medication given. The exact time of sleeping pills and narcotics must also be given. Do not record events taking place at different hours on the same line. Be sure to write A.M or P.M. when charting the hour. Twelve noon is written 12 M.D and twelve midnight is written 12 M.N Be careful not to confuse Ethiopian and European time.

O. Space: Do not crowd notations nor skip lines unnecessarily.

P. Color of ink: All charting must be done in black or blue – black important events are charted in red on the graphic sheet. E.g. Transfusion, vaccination, day of surgery.

Q. Chart headings: All headings are to be filled in when the patient is admitted, thereafter, each sheet, which is added, must be properly filled out. No nurse shall

every chart on a sheet that is not properly filled out even though someone else may have done so.

R. Even though some one else has failed to do his duty, it will not excuse another for making same mistake. Always give the complete name, the name of the doctor, the room number and also the hospital chart number if there is one.

S. Orders of assembling patients chart
    a. Order sheet
    b. Doctor's progress notes
    c. Nursing notes
    d. Temperature graph
    e. Laboratory reports
    f. Input and out put note

T. Patients or relatives and friends of patients are not allowed to read the chart.

U. Sign each entry with your full legal name and with your professional credentials, or per your institutional policy.

V. Never change another person's entry, even if it is incorrect.

W. Use quotation marks to indicate direct client responses (e.g., "I feel lousy").

X. Document in chronological order (if chronological order is not used, state why).

N.B: The order of assembling chart may differ from hospital to hospital.

Self-check-1	

Instructions*:* Answer all the questions listed below. Illustrations may be necessary to aid some explanations/answers. Write your answers in the sheet provided in the next page.

Part I Choose the best answer

1. ._____ is the is made when there is no enough evidence to supports the presence of the problem, but the nurse thinks that is highly probable and wants to collect more information
   A. Actual nursing diagnosis
   B. B. Potential nursing diagnosis
   C. C. Possible nursing diagnosis
   D. _____ are signs and symptoms, subjective and objective data.
   A. Diagnostic label
   B. Etiology
   C. Descriptive words
   D. Defining characteristics
   E. Which one is incorrect about nursing diagnosis
   A. Focus on usually response to health and illness
   B. May change from day to day as the patients response change
   C. Identify disease
   D. Describe problems treated by nurses within the scope of independent nursing practice

Part II writes short answer

1. Discuss the steps of nursing process in the

2. Explain purpose of documentation

3. List and discus about components of nursing diagnosis

4. Discus about Characteristics of nursing diagnosis versus medical diagnosis

Answer Sheet

Name: _____ Date: _____

Short Answer Questions

Part one 1. ___ 2. ___ 3.____

1._____

2._____

Note: **Satisfactory rating 4 ≥** points **Unsatisfactory < 4 below points you can ask you teacher for the copy of the correct answers.**

Score = _____
Rating: _____

L G #14	LO #- 3 Develop nursing Plan

Instruction sheet

This learning guide is developed to provide you the necessary information regarding the following content coverage and topics:

- Definition
- Components of planning
- Identifying resource implications
- Prioritizing problem
- Goals/expected outcomes
- Developing appropriate interventions
- Keeping records in nursing care plan format

This guide will also assist you to attain the learning outcomes stated in the cover page. Specifically, upon completion of this learning guide, you will be able to:

- Prioritized problems based on basic life need
- Identify goals/expected outcomes
- Select appropriate interventions for the problems
- Identified resource implications to implement the plan
- Keep records are in nursing care plan format

Learning Instructions:

1. Read the specific objectives of this Learning Guide.
2. Follow the instructions described below in page-5 to 14.
3. Read the information written in the information “Sheet 1, Sheet 2”.
4. Accomplish the “Self-check 1, Self-check t 2 **in page -5, and 14.**

Information Sheet-1	Definition

1.1. Definition

Planning is the third step of the nursing process and includes the formulation of guidelines that establish the proposed course of nursing action in the resolution of nursing diagnoses and the development of the client's plan of care. Planning is development of measurable goals and outcomes as well as a plan of care designed to assist the patient in resolving the diagnosed problems and achieving the identified goals and desired outcomes. Once the nursing diagnoses have been developed and client strengths have been identified, planning can begin. The well-developed plan of care communicates the client's past and present health status and current needs to all members of the healthcare team involved in providing care. It identifies problems solved and those yet to be solved, can provide information about approaches that have been successful, and notes patterns of client responses to interventions. In legal terms, the plan of care documents client care in areas of liability, accountability, and quality improvement. It also provides a mechanism to help ensure continuity of care when the client leaves a care setting while still needing services.

Planning has *three phases*.

1. ***Initial planning*** involves development of beginning of care by the nurse who performs the admission assessment and gathers the comprehensive admission assessment data and comprehensive plan of care.
2. ***Ongoing planning*** entails continuous updating of the client's plan of care. Every nurse who cares for the client is involved in ongoing planning.
3. ***Discharge planning*** involves critical anticipation and planning for the client's needs after discharge.

The planning stage is where interventions are identified to reduce, resolve or prevent the patient's problems while supporting the patient's strengths in an organized goal directed way (Kozier et al, 2008). Care needs to be prioritized on the needs of the patient and the seriousness of the problems identified.

In action planning the actual care that is going to be implemented needs to be clearly stated. Hogston (2011) advises using the REEPIG criteria to ensure that care is of the highest standards. Firstly, that the care planned is Realistic given available resources. Secondly, that the care planned is explicitly stated. Be clear in exactly what needs to be done so there is no room for misinterpretation of instructions. Thirdly, Evidence based. That there is research that supports what is being proposed. Fourthly, that the care being planned is Prioritized. The most urgent problems being dealt with first. Fifth, is to involve both the patient and other members of the multidisciplinary team who are going to be involved in implementing the care. And lastly, Goal centered, that the care planned will meet and achieve the goal set. Refer:**..\2018; Medical - surgical.pdf**

Self-Check -1	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1._____ is the development of measurable goals and outcomes as well as a plan of care designed to assist the patient in resolving the diagnosed problems. (**2 points**)

A. Assessment
C. Implementation
B. Planning
D. Evaluation

2. The planning phase of the nursing process correlates with which step of the scientific method? **(2 points)**

A. Brainstorming
C. Developing solutions
B. Data analysis
D. Implementing the decision

3. List out the purposes of planning at least three points. **(3 points**)

4. Write the phase of planning **(3 points)**

Note: **Satisfactory rating - 10 and 10 points** **Unsatisfactory - below 10 and 10 points**

You can ask your teacher for the copy of the correct answers.

Answer Sheet

Name: _____Date: _____

Short Answer Questions

Score = _____

Rating: _____

Information Sheet-2	Components of planning

1.1. The component of planning phase:

• The list of nursing diagnoses is prioritized.

• Client-centered long- and short-term goals and outcomes are identified and written.

• Specific interventions are developed

• The entire plan of care is recorded in the client's record.

- Once the list of nursing diagnoses has been developed from the data, decisions must be made about priority. Critical thinking enables the nurse to make decisions about which diagnoses are the most important and need attention first. Certain needs are basic to all people. Some of these needs are more important than others. To set priorities, look at the identified problems and ask some ***key questions like***:
    - What problems need immediate attention (ex. Life threatening problems, pain, and discomfort)?
    - What problems have simple solutions?
    - What problems must be referred?
    - What problems must be recorded on the plan of care?

Once an essential need is met, people often experience a need on a higher level of priority. Addressing needs by priority reflects Maslow hierarchy of needs (see Fig. 1-1). Maslow ranked human needs to include physiologic needs, safety and security, sense of belonging and affection, esteem and self-respect, and self-actualization. Self-actualization includes self-fulfillment, desire to know and understand, and aesthetic needs. Lower-level needs always remain; however, a person's ability to pursue higher-level needs indicates movement toward psychological health and well-being (Maslow, 1954). Such a hierarchy of needs is a useful framework that can be

applied to many nursing models for assessment of a patient's strengths, limitations, and need for nursing interventions.

Figure 1-1 • This scheme of Maslow hierarchy of needs shows how a person moves from fulfillment of basic needs to higher levels of needs, with the ultimate goal being integrated human functioning and health**.**

There are a number of frameworks used to prioritize nursing diagnoses; however, those diagnoses involving life-threatening situations are given the highest priority. For example, the following nursing diagnoses would be stated in this order of priority:

• Ineffective Airway Clearance related to excessive and thick secretions and pain secondary to surgery and inability to cough effectively; respirations: 25, shallow, wheezing

• Risk for Injury (falls) related to unsteady gait

• Imbalanced Nutrition: Less Than Body Requirements related to nausea and vomiting

Client-centered goals are established in collaboration with the client whenever possible. A goal is an aim, intent, or end. Goals are broad statements that describe the intended or desired change in the client's behavior. Goal statements refer to the diagnostic label (or problem statement) of the nursing diagnosis. If the client or significant others are unable to participate in goal development, the nurse assumes that responsibility until the client is able to participate. Client-centered goals assure that nursing care is individualized and focused on the client(1).

1.2. Goals/Expected Outcomes

Expected outcomes are specific objectives related to the goals and are used to evaluate the nursing interventions. They must be measurable, have a time limit, and be realistic.

Once goals and expected outcomes have been established, nursing interventions are planned that enable the client to reach the goals. This is more effective because client-centered goals focus on the desired result of the plan of care, which is that the client benefit from nursing care. . Hogston (2011) identifies two steps in the planning stage, setting goals and identifying actions. Goals need to be set, both short term and long term. SMART goals should be identified which are Specific, Measurable, Achievable, Realistic and Timely (Hamilton and Price, 2013). These are all done in collaboration with the patient.

Expected outcomes of the nursing interventions, identified either as long term or short term, are written in terms of the patient's behaviors and the time period in which the outcomes are to be met. The outcomes must be attainable and quantifiable. Resources for identifying appropriate expected outcomes include the Nursing Outcomes Classification (NOC) (see Chart 3-8) and standard outcome criteria established by health care agencies for people with specific health problems. These outcomes can be associated with nursing diagnoses and interventions and can be used when appropriate. However, the NOC may need to be adapted to establish realistic criteria for the specific patient involved. The expected outcomes

that define the patient's desired behavior are used to measure the progress made toward resolving the problem. The expected outcomes also serve as the basis for evaluating the effectiveness of the nursing interventions and for deciding whether additional nursing care is needed or whether the plan of care needs to be revised.

Establishing Goals After the priorities of the nursing diagnoses and expected outcomes have been established, goals (immediate, intermediate, and long-term) and the nursing actions appropriate for attaining the goals are identified. The patient and family are included in establishing goals for the nursing actions. Immediate goals are those that can be attained within a short time frame.

Intermediate and long-term goals require a longer time frame to be achieved and usually involve preventing complications and other health problems and promoting self-care and rehabilitation. For example, goals for a patient with a nursing diagnosis of impaired physical mobility related to pain and edema following total knee replacement may be stated as follows:

Immediate goal: Stands at bedside for 5 minutes 6 to 12 hours after surgery

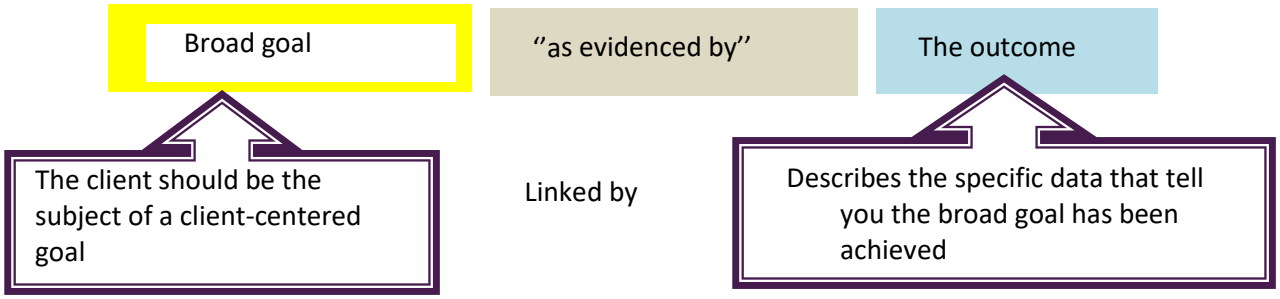
Intermediate goal: Ambulates 15 to 20 minutes with walker or crutches in hospital and home

Long-term goal: Ambulates independently 1 to 2 miles each day.

Guideline to Determine Client Centered Outcomes

- Be realistic in establishing goals
- Establish both short and long term goals
- The outcomes describe behavior or actions that demonstrates the desired improvement
- Follow the rules for writing outcomes statements:
    - Derived from nursing diagnosis
    - Clear and specific
    - Action verb
    - Criteria
    - Specific time

Client-centered Goal has 2 parts



Broad goal	"as evidenced by"	The outcome
Hailu will demonstrate effective airway clearance	as evidenced by	The 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.

Goals vs Outcome

Objectives

Outcomes

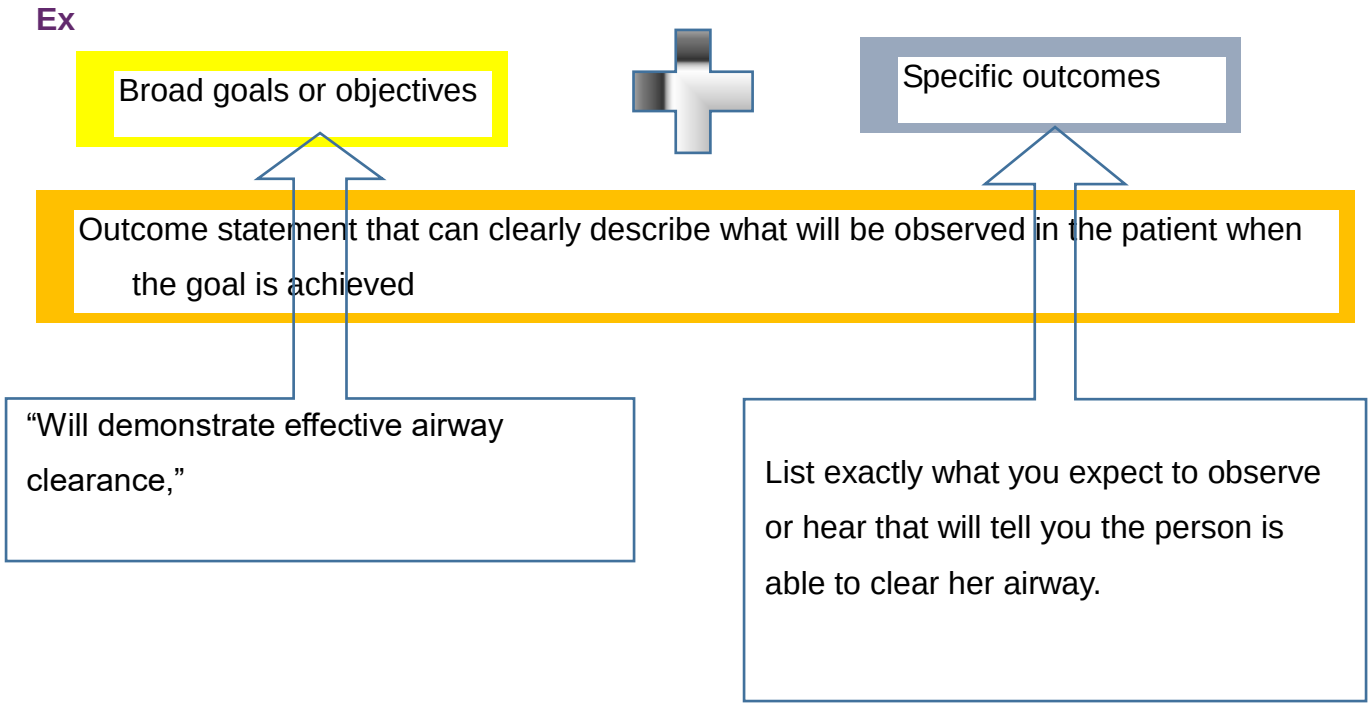
Often used interchangeably

Goals

They are all statements of what is expected to be accomplished by a certain time.

More general

More specific



1.3. Developing Appropriate Intervention

Nursing Interventions are activities performed by the nurse to:

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

.In planning appropriate nursing actions to achieve the desired goals and outcomes, the nurse, with input from the patient and significant others, identifies individualized interventions based on the patient's circumstances and preferences that address each outcome. Interventions should identify the activities needed, who will implement them, as well as the frequency.

Determination of interdisciplinary activities is made in collaboration with other health care providers as needed. The patient's medications and other prescribed treatments should be integrated into the plan of care to assist the nurse in determining how all interventions contribute to resolution of the identified problems.

The nurse identifies and plans patient education and demonstration as needed to assist the patient in learning certain self-care activities.

Planned interventions should be ethical and appropriate to the patient's culture, age, developmental level, and gender. Standardized interventions, such as those found on standardized care plans or in the Nursing Interventions Classification (NIC) can be used. It is important to individualize prewritten interventions to promote optimal effectiveness for each patient. Actions of nurses should be based on established standards. A nursing intervention is the activity that the nurse will execute for and with the client to enable accomplishment of the goals. Nursing interventions refer directly to the related factors in the actual nursing diagnoses and the risk factors in risk nursing diagnoses. If the nursing interventions can remove or reduce the related factors and the risk factors, the problem can be resolved or prevented. Nursing interventions also refer to the diagnostic label for possible diagnoses and focus on data needed to confirm or eliminate the diagnosis. For each nursing diagnosis there may be a number of nursing interventions. Nursing interventions are individualized and are stated in specific terms. Examples of nursing interventions are:

• Turn, cough, and deep breathe q 2 h.

• Teach "nipple care when breastfeeding".

• Weigh client at each visit.

Once the interventions have been determined for each diagnosis, the interventions are recorded on the client's plan of care. As is true with other steps in the nursing process, the list of interventions is not static. As the nurse interacts with the client, assesses responses to interventions, and evaluates those responses, interventions may change. The Nursing Interventions Classification (NIC) is an in-depth, evidence based taxonomy of interventions that includes independent and collaborative interventions. These interventions are performed in a variety of health care settings. Intervention labels are terms such as hemorrhage control, medication administration, or pain management.

Listed under each intervention are multiple discrete nursing actions that together constitute a comprehensive approach to the treatment of a particular condition. Not all actions are applicable to every patient; nursing judgment and critical thinking will determine which actions to implement. The following is an example of a nursing intervention(2).

Ventilation Assistance: - Promotion of an optimal spontaneous breathing pattern that maximizes oxygen and carbon dioxide exchange in the lungs

Activities

Maintain a patent airway.

Position to alleviate dyspnea.

Position to facilitate ventilation–perfusion matching (“good lung down”), as appropriate. Assist with frequent position changes, as appropriate.

Position to minimize respiratory efforts (e.g., elevate head of bed and provide over bed table for patient to lean on). Monitor the effects of position change on oxygenation (e.g., arterial blood gases, SaO2, $S\bar{v}$-O2).

Encourage slow deep breathing, turning, and coughing.

Assist with incentive spirometer, as appropriate. Auscultate breath sounds, noting areas of decreased or absent ventilation and presence of adventitious sounds.

Monitor for respiratory muscle fatigue.

Initiate and maintain supplemental oxygen, as prescribed.

Administer appropriate pain medication to prevent hypoventilation.

Ambulate three to four times per day, as appropriate.

Monitor respiratory and oxygenation status. Administer medications (e.g., bronchodilators and inhalers) that promote airway patency and gas exchange.

Teach pursed lips breathing techniques, as appropriate.

Teach breathing techniques, as appropriate.

Initiate a program of respiratory muscle strength and/or endurance training, as appropriate. Initiate resuscitation efforts, as appropriate.

Self-Check -2	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. A nurse is formulating a plan of care for a client receiving enteral feedings. Which nursing diagnosis is of the highest priority? (**3 points**)

A. Altered nutrition, less than body requirements

B. High risk for aspiration

C. High risk for fluid volume deficit

D. Diarrhea

2. Which of the following problems should be treated immediately? Correct answer is**? (3 points)**

A. Altered nutrition, less than body requirements

B. High risk for aspiration

C. High risk for fluid volume deficit

D. Diarrhea

3. Which of the following is of highest priority for a nurse on a general medical unit? **(4 points)**

A. Patient with chest pain

B. Patient with nose bleed

C. Patient with productive cough & wheezing

D. All

Note: **Satisfactory rating - 10 points** **Unsatisfactory - below 10 points**

You can ask you teacher for the copy of the correct answers.

Answer Sheet for

Choices 1. _____ **2.** _____ **3.** _____

Name: _____ Date: _____

Short Answer Questions

Score = _____

Rating: _____

L G #15	LO #- 4 Implement nursing plan

Instruction sheet

This learning guide is developed to provide you the necessary information regarding the following content coverage and topics:

- Implementation
- Caring out responsibilities
- Performing Procedures using standard manuals and guidelines
- Keeping records in nursing care plan format

This guide will also assist you to attain the learning outcomes stated in the cover page. Specifically, upon completion of this learning guide, you will be able to:

- Carry out responsibilities as per the plan
- Follow procedures using standard manuals and guidelines
- Keep records in nursing care plan format

Learning Instructions:

1. Read the specific objectives of this Learning Guide.
2. Follow the instructions described below 5 to 11.
3. Read the information written in the information “Sheet 1, Sheet 2, Sheet 3, and Sheet 4”.Accomplish the “Self-check 1, Self-check t 2, Self-check 3, and Self-check 4” **in page - 5, 7, 9 and 11** respectively.

Information Sheet-1	Implementation

1.1. Implementation

The implementation phase of the nursing process involves carrying out the proposed plan of nursing care. The nurse assumes responsibility for the implementation and coordinates the activities of all those involved in implementation, including the patient and family, and other members of the health care team so that the schedule of activities facilitates the patient's recovery. The plan of nursing care serves as the basis for implementation as such: The immediate, intermediate, and long-term goals are used as a focus for the implementation of the designated nursing interventions. Implementation includes:-Performing, assisting or directing the performance of activities of daily living (ADL), ambulation, eating, dressing, bathing, brushing, grooming and toileting.

- Counseling and teaching the client or family
- Providing direct care;
- Delegating, supervising and evaluating the work of staff members;
- Recording and exchanging information relevant to the client's continued care.

Types of nursing intervention:-Nurses function during Intervention-

- Independent Interventions
- Dependent Interventions
- Collaborative or Interdependent Interventions

Independent Interventions

These are actions that the nurse is able to initiate independently. The following would be an example of a health promotion nursing intervention, which is an independent nursing action:-Mrs. James has started a new medication for her high blood pressure. She is concerned about the side-effects and is refusing to take the medication. The nurse intervenes by educating the patient on the purpose of the medication, the side-effects of the medication and the possible consequences of high blood pressure.

Dependent Interventions

These interventions will require an order from another health care provider such as a physician: Mrs. James's blood pressure is consistently 180/100.

The nurse reports this to the physician. The physician orders an antihypertensive medication for the patient. The nurse administers the oral medication to the patient as ordered.

Collaborative or Interdependent Interventions

These are going to require the participation of multiple members of the health care team: Mrs. James reveals to the nurse that she consumes a diet very high in sodium. The nurse includes diet counseling in the patient care plan. To help the patient even more, the nurse enlists the help of the dietician that is available in their facility to spend time with Mrs. James to educate her on the role that diet plays in the control of high blood pressure.

- Implementation is nursing action. Therefore, statements involving implementation always start with a verb.

Self-Check -1	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1._____ is the phase of nursing process involves carrying out the proposed plan of nursing care. (**3 points**)

A. Planning C. Evaluation

B. Implementation D. Documentation

2 Implementation is **(2 points)**

A. a series of steps by which the nurse sets priorities and goals

B. carrying out the nursing interventions in a systematic way

C. purposeful mental activity by which ideas are evaluated

D. assessing the patient's response to the nursing interventions

3. Write the types of nursing intervention **(5points**)

Note: **Satisfactory rating - 10 points** **Unsatisfactory - below 10 points**

You can ask you teacher for the copy of the correct answers.

Answer Sheet 1._____ 2_____ 3_____

Name: _____ Date: _____

Short Answer Questions

Score = _____

Rating: _____

Information Sheet-2	Caring Out Responsibilities

1.1. Caring out Responsibilities

While implementing nursing care, the nurse continually assesses the patient and the patient's individual response to the nursing care. Revisions are made in the plan of care as the patient's condition, problems, and responses change and when reordering of priorities is required. It is focused on resolving the patient's nursing diagnoses and collaborative problems and achieving expected outcomes, thus meeting the patient's health needs. The following are examples of nursing responsibilities during interventions: Reposition the patient every 2 hours, Teach and reinforce the use of guided imagery to reduce pain prior to invasive procedures, Monitor oral and intravenous fluid intake to ensure that 2000 mL of fluids has been received, Position the client in an upright position in a chair for 15 minutes before meals, Apply lanolin to the patient's lips every 2 hours and as needed (i.e., [prn]),Teach the patient and family the correct way to apply a wedge splint prior to sleep, critical thinking, and good decision-making skills are essential in the selection of appropriate evidence-based and ethical nursing interventions. All nursing interventions are patient focused and outcome directed and are implemented with compassion, skill, confidence, and a willingness to accept and understand the patient's responses.

Self-Check -2	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. A registered nurse (RN) delegates to a licensed practical nurse the task of monitoring intake and output for all patients who have been treated for heart failure on a cardiac medical unit. The unit manager is reviewing the effectiveness of heart failure management on the unit. Delegation is included in which component of the nursing process? **(5 points)**

A. Implementation

B. Planning

C. Develop solutions

D. Nursing Diagnosis

2. List out the responsibilities of nurses during implementation process. (**5 points**)

Note: **Satisfactory rating – 10 points** **Unsatisfactory - below 10 points**

You can ask you teacher for the copy of the correct answers.

Answer Sheet

Name: _____ Date: _____

Short Answer Questions

1____ 2.____ 3. _____

Score = _____

Rating: _____

Short Answer

1_____

_____

Information Sheet-3	Performing Procedures Using Standard Manuals and Guidelines

1.1. Performing Procedures Using Standard Manuals and Guidelines

Although many nursing actions are independent, others are interdependent, such as carrying out prescribed treatments, administering medications and therapies, and collaborating with other health care team members to accomplish specific expected outcomes and to monitor and manage potential complications.

Requests or prescriptions from other health care team members should not be followed blindly but must be assessed critically and questioned when necessary. The implementation phase of the nursing process ends when the nursing interventions have been completed.

Self-Check -3	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. Which one of the nursing activities are independent? **(3 Points)**

   A. Carrying out prescribed treatment
   B. Administering medication and therapies
   C. Monitor and manage potential complications
   D. Lab investigation

Note: **Satisfactory rating – 9 points** **Unsatisfactory - below 9 points**

You can ask you teacher for the copy of the correct answers.

Answer Sheet 1. _____

Name: _____ Date: _____

Short Answer Questions

Score = _____

Rating: _____

L G #16 LO #- 5 Perform nursing evaluation

Instruction sheet

This learning guide is developed to provide you the necessary information regarding the following content coverage and topics:

- Evaluating Nursing Process according to Outcome Criteria
- Re-assessment whether the expected outcome are achieved or not
- Keeping records in nursing care plan format

This guide will also assist you to attain the learning outcome stated in the cover page.

Specifically, upon completion of this Learning Guide, you will be able to:

- Evaluate Nursing process according to outcome criteria
- Apply re-assessment whether the expected outcomes are achieved or not
- Keep Records in nursing care plan format

Learning Instructions:

1. Read the specific objectives of this Learning Guide.
2. Follow the instructions described below 6 to 13.
3. Read the information written in the information “Sheet 1, Sheet 2, and Sheet 3”.
4. Accomplish the “Self-check 1, Self-check 2, and Self-check 3” **in page -6, 8, and 13.**

Information Sheet-1	Evaluating Nursing Process according to Outcome Criteria

1.1. Evaluating Nursing Process according to Outcome Criteria

Evaluation, the final step of the nursing process, allows the nurse to determine the patient's response to the nursing interventions and the extent to which the objectives have been achieved. Regular review of the effect of nursing interventions and the treatment regimen on the patient's health status and expected health outcomes.

The plan of nursing care is the basis for evaluation. The nursing diagnoses, collaborative problems, priorities, nursing interventions, and expected outcomes provide the specific guidelines that dictate the focus of the evaluation. Through evaluation, the nurse can answer the following questions:

Were the nursing diagnoses and collaborative problems accurate?

Did the patient achieve the expected outcomes within the critical time periods?

Have the patient's nursing diagnoses been resolved? Have the collaborative problems been resolved?

Do priorities need to be reordered?

Have the patient's nursing needs been met?

Should the nursing interventions be continued, revised, or discontinued?

Have new problems evolved for which nursing interventions have not been planned or implemented?

What factors influenced the achievement or lack of achievement of the objectives? Should changes be made to the expected outcomes and outcome criteria?

Objective data that provide answers to these questions are collected from all available sources (e.g., patients, families, significant others, health care team members). These data are included in patients' records and must be substantiated by direct patient observation before the outcomes are documented. Chart 3-10 gives an example of a plan of nursing care that has been developed

for a 22-year-old woman admitted to a postoperative surgical unit after having an emergent laparoscopic appendectomy.

The plan of care is subject to change as a patient's needs change, as the priorities of needs shift, as needs are resolved, and as additional information about a patient's state of health is collected. As the nursing interventions are implemented, the patient's responses are evaluated and documented, and the plan of care is revised accordingly. A well developed, continuously updated plan of care is the greatest assurance that the patient's nursing diagnoses and collaborative problems are addressed and their basic needs are met.

Process of Evaluating Client Responses

- Collecting data related to the desired outcomes
- Comparing the data with outcomes
- Relating nursing activities to outcomes
- Drawing conclusions about problem status
- Continuing, modifying, or terminating the nursing care plan.

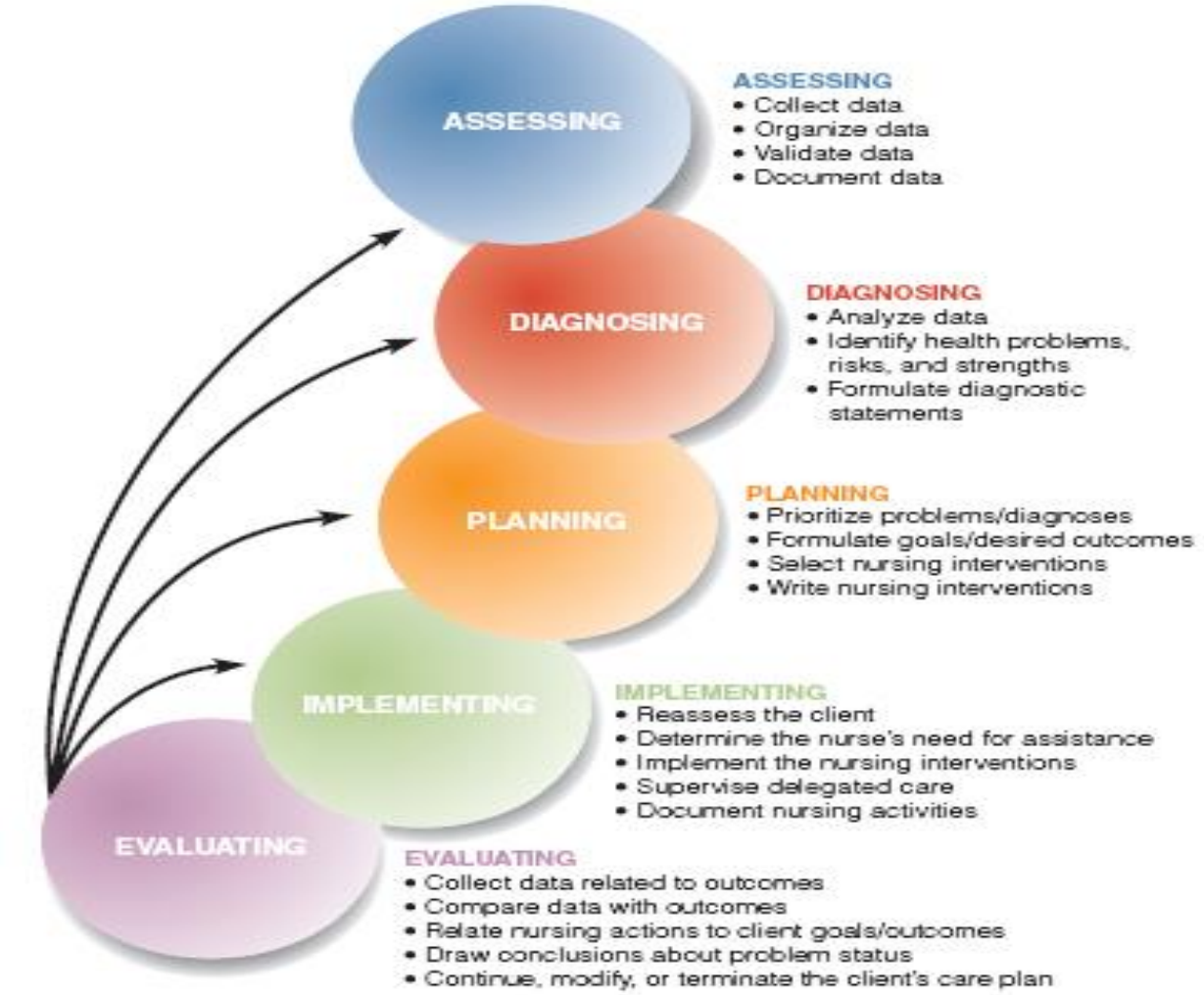


Figure- Summary of the nursing process

Self-Check -1	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. Evaluation is **(3 Points)**

A. carrying out the nursing interventions in a systematic way

B. a series of steps by which the nurse sets priorities and goals

C. assessing the patient's response to the nursing interventions

D. purposeful mental activity by which ideas are evaluated

2._____is gathering data to determine if outcomes were achieved? **(2 Points)**

A. Assessment B. Diagnosis C. Planning

D. Implementation E. Evaluation

Short Answer Questions

3. Mention the Process of Evaluating Client Responses (**5 points**)

Note: **Satisfactory rating - 10 points** **Unsatisfactory - below 10 points**

You can ask you teacher for the copy of the correct answers.

Answer Sheet 1. _____ 2. _____

3._____

Name: _____ Date: _____

Score = _____

Rating: _____

Information Sheet-2	Re-assessment whether the expected outcome are achieved or not

1.1. Re-assessment whether the expected outcome are achieved or not

Evaluation at the end of a course of treatment involves reassessment of all the plan of care to determine if the expected outcomes have been achieved. Hogston also states that evaluation is 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.” With evaluation the whole process starts again.

Self-Check -2	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. Mention the importance of re-assessment during evaluation? (**5 points**)
2. When is re-assessment is performed? **(3 Points)**

Note: **Satisfactory rating - 8 points** **Unsatisfactory - below 8 points**

You can ask you teacher for the copy of the correct answers.

Answer Sheet

1._____

2._____

Name: _____ Date: _____

Score = _____

Rating: _____

Information Sheet-3	Keeping records in nursing care plan format

1.1. Keeping records in nursing care plan format

Record-keeping is an important primary tool in the practice of nursing. Records are the who, why, how, where, what and when of patient care during hospitalization (Garba, 2018). According to Chelagat, Sum, Chebor, Kiptoo and Bundotich-Mosol (2013), since the time of Florence Nightingale, nurses viewed documentation or recording as being a very important aspect in the nursing profession. Documentation is the written and legal recording of the interventions that concern the patient and it includes a sequence of processes. Documentation is established with the personal record of the patient, which constitutes a base of information on the situation of his health. Records stand as a source of evidence of each health-care provider's accountability in the delivery of care. They also serve both as an educational tool and a method of monitoring patient status. Record-keeping is important as it also provides data useful in research and education – be it retrospective, prospective or longitudinal. Moreover, record-keeping can help with the planning and budgeting of the hospital. Record-keeping demonstrates effective patient care and the response to nursing intervention. Good record-keeping promotes continuity of care and demonstrates the quality of care delivered to the clients. Moreover, documentation provides the evidence necessary for any legal proceedings. However, poor record-keeping has a negative impact on care delivery and clinical decision-making. Record-keeping has, by far, become a low priority for busy nurses, and patient notes are now often poorly maintained. Good and quality record-keeping is linked with the improvement of patient care, while poor documentation is regarded as contributing to poor quality nursing care. Incomplete nursing records shows no evidence of care provided to the patient – like a saying in nursing that 'what is not recorded is not done' (Mutshatshi, Mothiba, Mamogobo, & Mbombi, 2018). Additionally, record-keeping demonstrates a full account of a nurse's assessment and care planned and provided to the patient, and includes all relevant information about patient condition at a given time and the measures a nurse took to respond to their needs. There are numerous documents to be recorded for patient care.

These include admission records, six-hourly observation charts, progress reports, nursing care plans, nursing clinical records and many others.

Documentation of Outcomes and Revision of the Plan Outcomes are documented concisely and objectively. Documentation should relate outcomes to the nursing diagnoses and collaborative problems, describe the patient's responses to the interventions, indicate whether the outcomes were met, and include any additional pertinent data. As noted previously, the nurse individualizes a plan of care for each patient's particular circumstances.

1.2. Problem Oriented Medical Records (POMR)

- A structured method of documentation
- Emphasizes client problems (look example)
- Based on the nursing process
- For facilitates communication of client needs
- is composed of a data-base, a numbered problem list, and progress notes referred to as Subjective data, objective data, Assessment, Plan (**SOAP)** notes

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 list. After a problem list is developed, succeeding record entries (e.g. progress notes) are coded by the problem number.

1.3. Common Record Keeping Forms

A variety of paper or electronic forms are available for the type of information nurses routinely document. The categories within a form are usually derived from institutional standards of practice or guidelines established by accrediting agencies.

1.3.1. **Admission Nursing History Forms**:-A nurse completes a nursing history form when a patient is admitted to a nursing unit. The form guides the nurse through a complete assessment to identify relevant nursing diagnoses or problems.

1.3.2. **Flow Sheets and Graphic Records**: - Flow sheets allow you to quickly and easily enter assessment data about a patient, including vital signs and routine repetitive care such as hygiene measures, ambulation, meals, weights, and safety and restraint checks.

Flow sheets help team members quickly see patient trends over time and decrease time spent on writing narrative notes. Critical and acute care units commonly use flow sheets for all types of physiological data.

1.3.3. **Patient Care Summary or Kardex**: - Kardex forms have an activity and treatment section and a nursing care plan section that organize information for quick reference. An updated Kardex eliminates the need for repeated referral to the chart for routine information throughout the day. The patient care summary or Kardex includes the following information:

- Basic demographic data (e.g., age, religion)
- Health care provider's name
- Primary medical diagnosis
- Medical and surgical history
- Current orders from health care provider (e.g. dressing changes, ambulation, glucose monitoring)
- Nursing care plan
- Nursing orders (e.g., education sessions, symptom relief measures, counseling)
- Scheduled tests and procedures
- Allergies

1.3.4. Standardized Care Plans: - Some institutions use standardized care plans. The plans, based on the institution's standards of nursing practice, are pre-printed, established guidelines used to care for patients who have similar health problems. After completing a nursing assessment, the nurse identifies the standard care plans that are appropriate for the patient and places the plans in his or her medical record. The nurse modifies the plans to individualize the therapies.

1.3.5. Progress Notes: - Progress notes made by nurses provide information about the progress a client is making toward achieving desired outcomes.

1.3.6. Discharge Summary Forms: - Discharge documentation includes

- Medications
- Diet
- Community resources
- Follow-up care

• Who to contact in case of an emergency or for questions.

1.4. Most Common Documents in Patient Record:

• Admission sheet

• Physician's order sheet

• Nurse's admission assessment

• Graphic sheet and flow sheet- vital signs, I/O chart

• Medical history and examination

• Nurses' notes

• Medication records

• Progress notes

• Results from diagnostic tests (e.g., laboratory and x-ray film results)

• consent forms

• Discharge summary

• Referral summary

Self-Check -3	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. What are Problem Oriented Medical Records (POMR?)? (**4 points**)
2. Write the most common documents in patient record at least 5 (**5 points**)?
3. Develop record Keeping format of nursing care plan. (**6 points**)

Note: **Satisfactory rating – 15 points** **Unsatisfactory - below 15 points**

You can ask your teacher for the copy of the correct answers.

Answer Sheet

1_____

2_____

3_____

Name: _____ Date: _____

Score = _____

Rating: _____

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Reference

1. Nursing Health Assessment. 2nd Edition, F.A. Davis Company Philadelphia, Pennsylvania

2. Kozier, B., Erb, G., Berman, A., Snyder, S., Abdalrahim, M., Abu-Moghli, F., Saleh M. (2012). *Fundamentals of Nursing: Concepts, Process, and Practice.* Essex, England: Pearson Education Limited.

3. Nursing Health Assessment. 2nd Edition, F.A. Davis Company Philadelphia, Pennsylvania

4. Kozier, B., Erb, G., Berman, A., Snyder, S., Abdalrahim, M., Abu Moghli, F., Saleh M. (2012). *Fundamentals of Nursing: Concepts, Process, and Practice.* Essex, England: Pearson Education Limited.

5. Basic Clinical Nursing Skills, Abraham Alano, B.Sc., M.P.H. Hawassa University November 2002,

6. Delmar's.Fundamental.&.Advanced.Nursing.Skills.3HAXAP.pdf.

7. 2018; Medical - surgical.pdf.

8. Fundamental of Nursing Procedure Manual.pdf