Performe Basic Nursing Care Procedures and Techniques

NTQF Level III

Learning Guide # 28

Unit of Competence: **Performe Basic Nursing Care Procedures and Techniques**

Module Title: **Performing Basic Nursing Care Procedures and Techniques**

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LO 2: Performe Basic Nursing Care Procedures and Techniques

Instruction Sheet	Learning Guide #26

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

2. Manage patient safety and comfort

2.1. Patient assessment

2.1.1. History taking

2.1.2. Physical examination

2.2. General principles of patient bed making

2.3. Bed making based on patient condition/need

2.4. Patient safety and comfort device

2.4.1. purpose and indications of patient safety and comfort

2.5. Documentation

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 –

- Assess patient history and perform physical examination
- Describe general principles of patient bed making
- Performe Bed making based on patient condition/need
- Identify Patient safety and comfort device
- Documentation

Learning Instructions:

1. Read the specific objectives of this Learning Guide.
2. Follow the instructions.
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. .

6. Submit your accomplished Self-check. This will form part of your training portfolio.

Information Sheet	Manage patient safety and comfort

2. Manage patient safety and comfort

2.1. **Patient Assessment**

Introduction

Assessment is the first step in determining the condition of the patient's health and their immediate and long-term needs. The nursing assessment of patients on admission to hospital or on attendance at clinics is key to clinical decision-making and to planning patient care that takes account of the individual patients' needs and circumstances. Nurses have responsibility for carrying out the initial and ongoing patient assessments, for initiating interventions that take patients' needs into consideration and for evaluating the effectiveness of these interventions. The nursing assessment is one component within a larger, multidisciplinary team assessment during which the patient is assessed by different healthcare professionals as part of the care pathway and patient referral process. A multifactorial assessment of the older person for falls, for example, can involve the nurse, doctor, physiotherapist, occupational therapist, optician and other healthcare professionals working in specialist areas of practice such as cardiac assessment. As a member of the multidisciplinary team, the nurse often plays a key role in coordinating the patient assessment and ensuring that appropriate referrals are made and followed up. At ward or unit level, more specific assessment procedures may apply; for example, cerebrovascular or stroke units may include an assessment of swallowing and mood as part of the assessment of a patient newly diagnosed with a cerebrovascular accident – a stroke.

The purpose of nursing assessment

Assessment is the first stage in the nursing process and is key to developing a care plan that is tailored to a patient's individual needs. The purpose of assessment is to achieve the following:

- **Obtain baseline data and track changes**. On admission to hospital or on a first visit to the clinic, it is important to carry out a comprehensive assessment of the patient to establish a set of baseline data against which subsequent assessments can be

compared or tracked. and any changes indicating a deterioration improvement in the patient's condition

- **Early recognition of the critically ill or deteriorating patient**. Identifying patients who are 'at risk' is key to initiating a rapid response from the medical emergency or rapid response team. 'Track and Trigger' (e.g. Alert® and other early warning systems) incorporate objective physiological and subjective criteria that can be used to support the nurse's decision about when to call the medical team for help and avert more serious patient emergencies. If a Track and Trigger system has not been set up in the hospital, a nurse who is concerned about a patient should take urgent action and notify the medical team.
- **Risk assessment**. Assessment is the first step in preventing complications, the aim being to identify patients who are 'at risk' of developing complications associated with their healthcare problem, hospitalization and reduced mobility. Key areas for risk assessment include pressure ulcers, infection, falls and constipation. Local hospital policy may include risk assessment tools as part of the admission procedure, for example the Braden, Waterlow and Norton scores to identify patients at risk of pressure ulcers and to activate an action plan and interventions to prevent pressure ulcers developing.
- **Screening for health problems**. Nursing assessment provides an ideal opportunity for health promotion and for screening patients for risk factors associated with obesity, cancer, cardiovascular disease, diabetes mellitus and other major problems. It also provides the opportunity to screen for specific problems such as emotional distress or organisms important in infection control

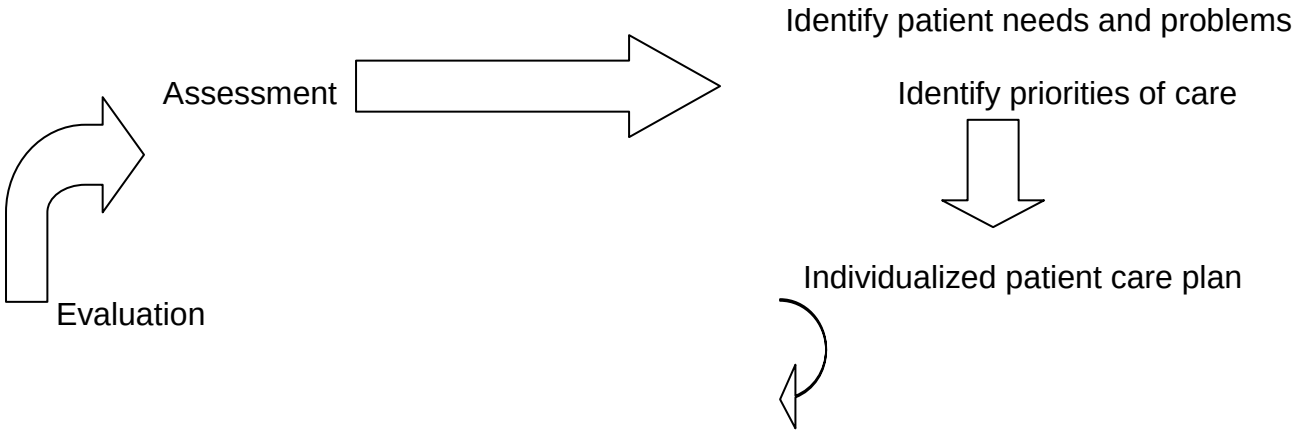

Figure 1. Assessment – the first stage in the process of planning patient care.

- **Identify actual and potential problems and prioritize care**. The patient's current problems (actual problems) and problems that could develop in the future (potential problems) need to be identified so that the care plan can be tailored to individual patient needs. Importantly, once the range of patient problems has been identified, care can be prioritized so that major problems are dealt with first.
- **Care planning, tailored to individual patient needs**. The purpose of assessment is not only to determine and document the patient's current condition, but also to provide evidence for the planning and provision of nursing care. Although standardized care plans are available in some units or hospitals, the nursing actions that are required to meet a patient's needs and problems should be tailored to take account of individual patient needs.
- **Discharge planning**. Patient assessment also includes the early identification of patients' needs for forward planning and organizing the supports and community services necessary to facilitate a timely discharge from hospital. Recent trends indicate that patients' stay in hospital is shortening, the use of day surgery is increasing, and policies on early discharge and discharge planning are setting the standards for healthcare practice. Although the reasons for a delay in discharging the patient home from hospital are multifactorial, patient assessment that includes information about the patient's home and social circumstances, family and community supports will help prevent problems arising from a poor knowledge of a patient's home situation or the support available, and will avert delays related to non-medical reasons.

2.1.1. History taking

Assessment frameworks

An important principle underpinning the nursing approach to patient assessment is that it is systematic, comprehensive and person-centred. Many of the assessment frameworks used in clinical practice are linked to nursing theories such as the activities of living (Roper et al. 2000) or the self-care deficit theory of nursing (Orem 2001), or to other theory including Maslow's (1999) hierarchy of needs.

Nursing models and theories serve as a guide for clinical practice and provide for a structured approach insofar as they map out what areas to include in a patient assessment.

The number of new or modified assessment frameworks for nursing practice is ever increasing, but a common feature across different nursing assessments is the inclusion of the core aspects of physical, psychosocial and spiritual assessment within the context of family, community and environment (Figure 2).

The decision of which assessment framework to use is made by healthcare organizations and nursing management, who then oversee its implementation in their admission procedures and nursing documentation. This is important because it provides a way of assuring a standardized approach to nursing assessment and quality patient care.

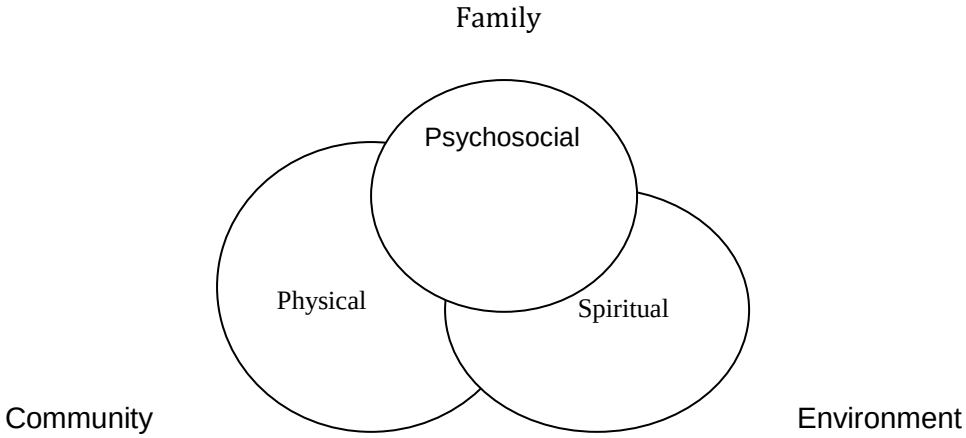

Figure .2. Key aspects to include in a patient assessment.

In terms of how this translates into practice and what information is gathered during the nursing assessment, the broad areas to consider include biographical and health data, a systematic review of patient systems and functions, and a social assessment:

- **Biographical and health data**. Obtaining information about the patient's health history is vital for putting the current problem or illness into context
- **Patient assessment**. This involves a 'head-to-toe' systematic review of the patient. A review of systems and functions enables the nurse to elicit information about problems and provide vital clues to support a clinical diagnosis or uncover a problem of which the patient is

unaware. The depth of the patient assessment will depend on the patient's condition and the urgency of the clinical situation.

- **Social assessment.** Taking a social history enables an early identification of patients' needs and problems that might delay discharge from hospital. Social history-taking is not always considered a priority in acute healthcare services, but it helps nurses to identify the patient's needs so that appropriate referrals can be made to the health and social services and service delivery is coordinated.

Methods of assessment

The methods of assessment that are used to gather the information for clinical decision-making include interviewing the patient and obtaining a health history, carrying out a physical examination, making clinical observations and using risk assessment tools.

- ✓ **Interviewing and obtaining a health history**

Taking a patient history is an essential part of assessment as an accurate history can provide over 80% of the information required for diagnosis. Obtaining an accurate history is not just about asking a list of questions, but also requires establishing an effective patient–nurse relationship in which the patient feels that the nurse is interested in understanding their healthcare problems.

This involves putting patients at their ease, providing as much privacy as possible, ensuring the nurse is familiar with any information already gathered, being sensitive to cultural differences and inviting patients to tell their story. Once the introductions have been completed, obtaining a health history begins with inviting the patient to tell their story and using an open question such as, '*Can you tell me what has brought you here today?'*

After an explanation has been given, the nurse moves to asking key and targeted questions to build up a comprehensive picture of the patient's problem:

'How has it affected you? Have you noticed what makes it worse or what helps? Have you noticed any changes in . . . ? How does this compare with previous times you have had this problem?'

More targeted questions are used to focus on eliciting whether there are any associated symptoms so the nurse needs to be familiar with the patterns associated with specific health problems. Investing in the end of the interview and considering the closing questions is vital to ensuring ongoing continuity in the patient–nurse relationship in future consultations.

Ending the interview involves summarizing, framing information using the patient's perspective and providing opportunity for the patient to add further information. *A closing question such as 'Is there anything else we haven't covered that you would like to discuss?'* enables patients to provide additional information.

During the first nurse–patient encounter, some patients may find it difficult to disclose problems and may be unwilling to do so until they know and have established a trusting relationship with the nurse. One helpful way in which the nurse can let the patient know there will be further opportunities to discuss issues is by saying, for example, 'If you think of anything else later on, let me know and we can have a chat then.'

- ✓ **Physical examination**

Physical examination provides objective data and is used to corroborate evidence gathered from the patient interview and clinical observation. Examination involves measurement of the 'vital signs', including temperature, heart rate, respiratory rate and blood pressure. The patient's weight is recorded and, if indicated, the patient's body mass index may also be calculated to determine whether the patient has a normal weight or is under- or overweight. Urinalysis using a dipstick reagent strip and a clean sample of fresh urine from the patient is used to screen for abnormal substances such as glucose or protein. Any abnormalities detected in the urinalysis should be followed up by more specific laboratory tests to investigate the cause and perhaps detect a previously undiagnosed condition such as diabetes mellitus. The patient's skin condition is examined; in addition to carrying out a pressure ulcer risk assessment, any abnormalities such as the presence of bruises, rashes and peripheral edema are noted.

- ✓ **Clinical observation**

Observation is an integral part of patient assessment as it provides an additional layer of information gathered during the patient–nurse interaction, physical examination and routine ward-based tests. Observation provides a means of gathering vital indicators about the patient's condition and well-being, and this information contributes to the overall evidence supporting clinical decision-making. During the interaction with the patient, the nurse takes note of non-verbal cues. Indicators of patient anxiety or distress can prompt the nurse to investigate further using gentle questioning or to return for a follow-up visit if the patient is unwilling or not ready to discuss their problems at that time. Observing patients as they walk around the ward, move from chair to bed, get dressed and close buttons or zips can provide important information

about their mobility, balance and dexterity. Observing the patient's general appearance includes noting the colour of the face and body and any abnormal signs such as nasal flaring, which can indicate respiratory distress. Abnormal smells or odors such as the odor of ketones on the patient's breath may indicate fasting or diabetic ketoacidosis. Observing the patient's behavior noting inappropriate responses and actions can indicate neurological, metabolic, endocrine or mental health problems. Information gathered from observing the patient is used along with that assimilated from the patient interview and physical examination to make sense of the patient's health problem and to support clinical decision-making.

- ✓ **Assessment tools**

Nurses can make use of a range of assessment tools and rating scales as part of their assessment of the patient. These provide a standardized approach to assessing specific aspects of the patient's condition that can otherwise be difficult to measure.

E.g. The Glasgow Coma Scale, for example, provides a means of assessing a patient who is becoming increasingly drowsy and unresponsive and, importantly, enables nurses to communicate the findings in a way that other healthcare professionals will understand.

Using the Glasgow Coma Scale, the patient is assessed on three specific items of

1. best eye-opening,
2. best verbal response, and
3. best motor response.

The patient's response on each of these items is converted into a numerical score, with the total score used to determine the level of consciousness.

- ✓ **Health History**

The health history is a series of questions used to provide an overview of the current health status of the patient. When obtaining the health history, attention is focused on the impact of psychosocial, ethnic, and cultural background on a person's health, illness, and health promotion behaviors. The interpersonal and physical environments, as well as the person's lifestyle and activities of daily living, are explored in depth. Many nurses are responsible for obtaining a detailed history of the person's current health problems, past medical history, and family history and a review of the person's functional status. This results in a total health profile that focuses on health as well as illness.

The format of the health history traditionally combines the medical history and the nursing assessment, although formats based on nursing frameworks, such as functional health patterns, have also become standard. Both the review of systems and the patient profile are expanded to include individual and family relationships, lifestyle patterns, health practices, and coping strategies. These components of the health history are the basis of nursing assessment and can be easily adapted to address the needs of any patient population in any setting, institution, or agency. Combining the information obtained by the physician and the nurse into one health history prevents duplication of information and minimizes efforts on the part of the patient to provide this information repeatedly.

The Informant

The informant, or the person providing the health history, may not always be the patient, as in the case of a developmentally delayed, mentally impaired, disoriented, confused, unconscious, or comatose patient. The interviewer assesses the reliability of the informant and the usefulness of the information provided. For example, a disoriented patient is often unable to provide reliable information; people who use alcohol and illicit drugs often deny using these substances. The interviewer must make a clinical judgment about the reliability of the information (based on the context of the entire interview) and include this assessment in the record.

Component of the Health history

When a patient is seen for the first time by a member of the health care team, the first requirement is that baseline information be obtained (except in emergency situations). The sequence and format of obtaining data about a patient may vary, but the content, regardless of format, usually addresses the same general topics. A traditional approach includes the following: biographical data, chief complaint, present health concern (or present illness), past history, family history, review of systems, and patient profile.

- ✓ **Biographical Data**

Biographical information puts the patient's health history into context. This information includes the person's name, address, age, gender, marital status, occupation, and ethnic origins. Some interviewers prefer to ask more personal questions at this part of the interview, whereas others wait until more trust and confidence have been established or until a patient's immediate or urgent needs are first addressed. A patient who is in severe pain or has another urgent problem

is unlikely to have a great deal of patience for an interviewer who is more concerned about marital or occupational status than with quickly addressing the problem at hand.

- ✓ **Chief Complaint**

The chief complaint is the issue that brings a person to the attention of the health care provider. Questions such as, "*Why have you come to the health center today?" or "Why were you admitted to the hospital?"* usually elicit the chief complaint. In the home setting, the initial question might be, *"What is bothering you most today?"* When a problem is identified, the person's exact words are usually recorded in quotation marks. However, a statement such as, "My doctor sent me," should be followed up with a question that identifies the probable reason why the person is seeking health care; this reason is then identified as the chief complaint

- ✓ **Present Health Concern or Illness**

The history of the present health concern or illness is the single most important factor in helping the health care team arrive at a diagnosis or determine the patient's needs. The physical examination is helpful but often only validates the information obtained from the history. A careful history assists in correct selection of appropriate diagnostic tests. Although diagnostic test results can be helpful, they often support rather than establish the diagnosis.

The history of the present illness or problem includes such information as the date and manner (sudden or gradual) in which the problem occurred, the setting in which the problem occurred (at home, at work, after an argument, after exercise), manifestations of the problem, and the course of the illness or problem. This includes self-treatment (including complementary and alternative therapies), medical interventions, progress and effects of treatment, and the patient's perceptions of the cause or meaning of the problem.

- ✓ **Past Health History**

A detailed summary of a person's past health is an important part of the health history. After determining the general health status, the interviewer should inquire about immunization status according to the recommendations of the adult immunization schedule and record the dates of immunization (if known). The interviewer should also inquire about any known allergies to medications or other substances, along with the type of allergy and adverse reactions. Other relevant material includes information, if known, about the patient's last physical examination, chest x-ray, electrocardiogram, eye examination, hearing test, dental checkup.

The interviewer then discusses previous illnesses and records negative as well as positive responses to a list of specific diseases. Dates of illness, or the age of the patient at the time, as well as the names of the primary health care provider and hospital, the diagnosis, and the treatment are noted.

The interviewer elicits a history of the following areas:

- Childhood illnesses—rubeola, rubella, polio, whooping cough, mumps, measles, chickenpox, scarlet fever, rheumatic fever, strep throat
- Adult illnesses
- Psychiatric illnesses
- Injuries—burns, fractures, head injuries
- Hospitalizations
- Surgical and diagnostic procedures
- Current medications—prescription, home remedies, complementary and alternative therapies
- Use of alcohol and other drugs

✓ **Family History**

To identify diseases that may be genetic, communicable, or possibly environmental in origin, the interviewer asks about the age and health status, or the age and cause of death, of first-order relatives (parents, siblings, spouse, children) and second-order relatives (grandparents, cousins). In general, the following conditions are included: cancer, hypertension, heart disease, diabetes, epilepsy, mental illness, tuberculosis, kidney disease, arthritis, allergies, asthma, alcoholism, and obesity. One of the easiest methods of recording such data is by using the family tree, genogram, or pedigree

✓ **Review of Systems**

The review of systems includes an overview of general health as well as symptoms related to each body system. Questions are asked about each of the major body systems for information about past and present symptoms. Reviewing each body system helps reveal relevant data. Negative as well as positive answers are recorded. If a patient responds positively to questions about a particular system, the information is analyzed carefully. If any illnesses were previously mentioned or recorded, it is not necessary to repeat them in this part of the history. Instead, reference is made to the appropriate place in the health history where the information can be found.

A review of systems can be organized in a formal checklist, which becomes a part of the health history. One advantage of a checklist is that it can be easily audited and is less subject to error than a system that relies heavily on the interviewer's

- ✓ **Patient Profile**

In the patient profile, more biographical information is gathered. A complete composite, or profile, of the patient is critical to analysis of the chief complaint and of the person's ability to deal with the problem.

At this point in the interview, the information elicited is highly personal and subjective. People are encouraged to express feelings honestly and to discuss personal experiences. It is best to begin with general, open-ended questions and to move to direct questioning when specific facts are needed.

Interviews that progress from information that is less personal (birthplace, occupation, education) to information that is more personal (sexuality, body image, coping abilities) often reduce anxiety.

A general patient profile consists of the following content areas: past life events related to health, education and occupation, environment (physical, spiritual, cultural), lifestyle (patterns and habits), presence of a physical or mental disability, self-concept, sexuality, risk for abuse, and stress and coping response.

- ○ **Past Life Events Related to Health**

The patient profile begins with a brief life history. Questions about place of birth and past places of residence help focus attention on the earlier years of life. Personal experiences during childhood or adolescence that have special significance may be elicited by asking a question such as, "Was there anything that you experienced as a child or adolescent that would be helpful for me to know about?" The interviewer's intent is to encourage the patient to make a quick review of his or her earlier life, highlighting information of particular significance. Although many patients may not recall anything significant, others may share information such as a personal achievement, a failure, a developmental crisis, or an instance of physical, emotional, or sexual abuse. The life history should include a brief medication history as appropriate for the patient.

- ○ **Education and Occupation**

Inquiring about current occupation can reveal much about a person's economic status and educational preparation. A statement such as, "Tell me about your job," often elicits information about role, job tasks, and satisfaction with the position. Direct questions about past employment and career goals may be asked if the person does not provide this information.

It is important to learn about a person's educational background. Asking a person what kind of educational requirements were necessary to attain his or her present job is a more sensitive approach than asking whether he or she graduated from high school. Information about the patient's general financial status may be obtained by questions such as, "Do you have any financial concerns at this time?" or "Sometimes there just doesn't seem to be enough money to make ends meet. Are you finding this true?" Inquiries about the person's insurance coverage and plans for health care payment are also appropriate.

- **Environment**

The concept of environment includes a person's physical environment and its potential hazards, spiritual awareness, cultural background, interpersonal relationships, and support system.

- ✓ **Physical Environment.**

Information is elicited about the type of housing (apartment, duplex, single-family) in which the person lives, its location, the level of safety and comfort within the home and neighborhood, and the presence of environmental hazards (eg, isolation, potential fire risks, inadequate sanitation). If the patient is homeless or living in a homeless shelter or has a disability, the patient's environment assumes special importance.

- ✓ **Spiritual Environment.**

The term spiritual environment refers to the degree to which a person thinks about or contemplates his or her existence, accepts challenges in life, and seeks and finds answers to personal questions. Spirituality may be expressed through identification with a particular religion. Spiritual values and beliefs often direct a person's behavior and approach to health problems and can influence responses to sickness. Illness may create a spiritual crisis and can place considerable stress on a person's internal resources and beliefs.

Inquiring about spirituality can identify possible support systems as well as beliefs and customs that need to be considered in planning care. Information is gathered about the extent to which religion is a part of the person's life as well as religious beliefs and practices related to health and illness. A spiritual assessment may involve asking the following questions:

- Is religion or God important to you?
- If yes, in what way?
- If no, what is the most important thing in your life?
- Are there any religious practices that are important to you?
- Do you have any spiritual concerns because of your present health problem?

✓ **Cultural Environment.**

When obtaining the health history, the person's cultural and religious backgrounds are taken into account. Cultural attitudes and beliefs about health, illness, health care, hospitalization, the use of medications, and use of complementary and alternative therapies, which are derived from personal experiences, vary according to ethnic, cultural, and religious background. A person from another culture may have different views of personal health practices from those of the health care practitioner.

The beliefs and practices that have been shared from generation to generation are known as cultural or ethnic patterns. They are expressed through language, dress, dietary choices, and role behaviors; in perceptions of health and illness; and in health-related behaviors.

The influence of these beliefs and customs on how a person reacts to health problems and interacts with health care providers cannot be underestimated. The following questions may assist in obtaining relevant information:

- Where did your parents or ancestors come from? When?
- What language do you speak at home?
- Are there certain customs or values that are important to you?
- Is there anything special you do to keep in good health?
- Do you have any specific practices for treating illness?

o **Family Relationships and Support System.**

An assessment of family structure (members, ages, and roles), patterns of communication, and the presence or absence of a support system is an integral part of the patient profile. Although the traditional family is recognized as a mother, a father, and children, many different types of living arrangements exist within our society. "Family" may mean two or more people bound by

emotional ties or commitments. Live-in companions, roommates, and close friends can all play a significant role in a person's support system

- **Lifestyle**

The lifestyle section of the patient profile provides information about health-related behaviors. These behaviors include patterns of sleep, exercise, nutrition, and recreation, as well as personal habits such as smoking and the use of illicit drugs, alcohol, and caffeine. Although most people readily describe their exercise patterns or recreational activities, many are unwilling to report their smoking, alcohol use, and illicit drug use, and many deny or understate the degree to which they use such substances. Questions such as, *"What kind of alcohol do you enjoy drinking at a party?"* may elicit more accurate information than, *"Do you drink?"* The specific type of alcohol (eg, wine, liquor, beer) and the amount ingested per day or per week (eg, 1 pint of whiskey daily for 2 years) should be described.

- **Disability**

The general patient profile needs to contain questions about any hearing, vision, or other type of physical disability. Mental, sensory, or cognitive disabilities need to be inquired about as well. The presence of an obvious physical limitation (eg, using crutches to walk or using a wheelchair to get around) necessitates further investigation. The etiology of the disability should be elicited, and the length of time the patient has had the disability, the impact on function, and health access are important to assess.

- **Self-Concept**

Self-concept refers to a person's view of himself or herself, an image that has developed over many years. To assess self-concept, the interviewer might ask how a person views life, using a question such as, "How do you feel about your life in general?" A person's self-concept can be threatened very easily by changes in physical function or appearance or other threats to health. The impact of certain medical conditions or surgical interventions, such as a colostomy or a mastectomy, can threaten body image. The question, "Do you have any particular concerns about your body?" may elicit useful information about self-image.

- **Sexuality**

No area of assessment is more personal than the sexual history. Interviewers are frequently uncomfortable with such questions and ignore this area of the patient profile or conduct a very cursory interview about this subject. Lack of knowledge about sexuality, preconceived notions

(eg, assuming all people are heterosexual), and anxiety about one's own sexuality may hamper the interviewer's effectiveness in dealing with this subject (Neville & Henrickson, 2006). Sexual assessment can be approached at the end of the interview, at the time interpersonal or lifestyle factors are assessed, or it may be easier to discuss sexuality as a part of the genitourinary history within the review of systems. In female patients, a discussion of sexuality would follow questions about menstruation. In male patients, a similar discussion would follow questions about the urinary system.

Obtaining the sexual history provides an opportunity to discuss sexual matters openly and gives the person permission to express sexual concerns to an informed professional. The interviewer must be nonjudgmental and must use language appropriate to the patient's age and background. The assessment begins with an orienting sentence such as, "Next, I would like to ask about your sexual health and practices." Such an opening may lead to a discussion of concerns related to sexual expression or the quality of a relationship, or to questions about contraception, risky sexual behaviors, and safer sex practices.

Examples of other questions are, "Do you have one or more sexual partners?" and "Are you satisfied with your sexual relationships?"

Determining whether a person is sexually active should precede any attempts to explore issues related to sexuality and sexual function.

Care should be taken to initiate conversations about sexuality with elderly patients and patients with disabilities and not to treat them as asexual people.

Questions are worded in such a way that the person feels free to discuss his or her sexuality regardless of marital status or sexual preference. Direct questions are usually less threatening when prefaced with such statements as, "Most people feel that . . ." or "Many people worry about . . . ." This suggests the normalcy of such feelings or behavior and encourages the person to share information that might otherwise be omitted because of fear of seeming "different."

- **Risk for Abuse**

Physical, sexual, and psychological abuse is a topic of growing importance in today's society. Such abuse occurs to people of both genders, of all ages, and from all socioeconomic, ethnic, and cultural groups. Patients rarely discuss this topic unless specifically asked about it. In fact, research shows that the majority of women currently in an abusive relationship have never told a health care provider. Therefore, it is important to ask direct questions, such as:

- Is anyone physically hurting you or forcing you to have sexual activities?

- Has anyone ever hurt you physically or threatened to do so?
- Are you ever afraid of anyone close to you (your partner, caregiver, or other family members)?

Patients who are elderly or have disabilities are at increased risk for abuse and should be asked about it as a routine part of assessment. However, when elderly patients are questioned directly, they rarely admit to abuse. Health care professionals should assess for risk factors, such as high levels of stress or alcoholism in caregivers, evidence of violence, and emotional outbursts, as well as financial, emotional, or physical dependency.

- **Stress and Coping Responses**

Each person handles stress differently. How well people adapt depends on their ability to cope. During a health history, past coping patterns and perceptions of current stresses and anticipated outcomes are explored to identify the person's overall ability to handle stress. It is especially important to identify expectations that a person may have of family, friends, and caregivers in providing financial, emotional, or physical support.

2.1.2. Physical assessment

Physical assessment, or the physical examination, is an integral part of nursing assessment. The basic techniques and tools used in performing a physical examination are described in general in this chapter. The examinations of specific systems, including special maneuvers, are described in the appropriate chapters throughout the book.

- **Examination consideration**

The physical examination is usually performed after the health history is obtained. It is carried out in a well-lighted, warm area.

The patient is asked to (or helped to) undress and is draped appropriately so that only the area to be examined is exposed.

The person's physical and psychological comfort are considered at all times. It is necessary to describe procedures to the patient and explain what sensations to expect before each part of the examination.

The examiner's hands are washed before and immediately after the examination. Fingernails are kept short to avoid injuring the patient. If there is a possibility of coming into contact with blood or other body secretions during the physical examination, gloves should be worn.

An organized and systematic examination is the key to obtaining appropriate data in the shortest time. Such an approach encourages cooperation and trust on the part of the patient.

The person's health history provides the examiner with a health profile that guides all aspects of the physical examination

A "complete" physical examination is not routine. Many of the body systems are selectively assessed on the basis of the presenting problem. For example, if a healthy 20-yearold college student requires an examination to study abroad and reports no history of neurologic abnormality, the neurologic assessment is brief. Conversely, a history of transient numbness and diplopia (double vision) usually necessitates a complete neurologic investigation.

Similarly, a patient with chest pain receives a much more intensive examination of the chest and heart than one with an earache. In general, the health history guides the examiner in obtaining additional data for a complete picture of the patient's health.

The process of learning to perform a physical examination requires repetition and reinforcement in a clinical setting. Only after basic physical assessment techniques are mastered can the examiner tailor the routine screening examination to include thorough assessments of particular systems, including special maneuvers

- **Components of Physical Examination**

The components of a physical examination include general observations and then a more focused assessment of the pertinent body systems. The tools of the physical examination are the human senses of vision, hearing, touch, and smell.

These may be augmented by special tools (eg, stethoscope, ophthalmoscope, reflex hammer) that are extensions of the human senses; they are simple tools that anyone can learn to use well. Expertise comes with practice, and sophistication comes with the interpretation of what is seen and heard..

- ✓ **Initial Observations**

General inspection begins with the first contact with the patient. Introducing oneself and shaking hands provide opportunities for making initial observations: Is the person old or young? How old? How young? Does the person appear to be his or her stated age? Is the person thin or

obese? Does the person appear anxious or depressed? Is the person's body structure normal or abnormal? In what way, and how different from normal? It is essential to pay attention to the details in observation. Vague, general statements are not a substitute for specific descriptions based on careful observation

These important specific observations are documented in the patient's chart or health record. Among general observations that should be noted in the initial examination of the patient are posture and stature, body movements, nutritional status, speech pattern, and vital signs.

- **Posture**

The posture that a person assumes often provides valuable information. Patients who have breathing difficulties (dyspnea) secondary to cardiac disease prefer to sit and may report feeling short of breath when lying flat for even a brief time. Patients with abdominal pain due to peritonitis prefer to lie perfectly still; even slight jarring of the bed causes agonizing pain. In contrast, patients with abdominal pain due to renal or biliary colic are often restless and may pace the room.

- **Body Movements**

Abnormalities of body movement are of two kinds: generalized disruption of voluntary or involuntary movement and asymmetry of movement. The first category includes tremors of a wide variety; some tremors may occur at rest (Parkinson's disease), whereas others occur only on voluntary movement (cerebellar ataxia). Other tremors may exist during both rest and activity (alcohol withdrawal syndrome, thyrotoxicosis).

Some voluntary or involuntary movements are fine, and others are quite coarse. At the extreme are the convulsive movements of epilepsy or tetanus and the choreiform (involuntary and irregular) movements of patients with rheumatic fever or Huntington disease.

Asymmetry of movement, in which only one side of the body is affected, may occur with disorders of the central nervous system (CNS), primarily in those patients who have had a cerebrovascular accident (stroke). Patients may have drooping of one side of the face, weakness or paralysis of the extremities on one side of the body, and a foot-dragging gait. Spasticity (increased muscle tone) may also be present, particularly in patients with multiple sclerosis.

- **Nutritional Status**

Nutritional status is important to note. Obesity may be generalized as a result of excessive intake of calories, or it may be specifically localized to the trunk in patients who have an

endocrine disorder (Cushing's disease) or who have been taking corticosteroids for long periods. Loss of weight may be generalized as a result of inadequate caloric intake, or it may be seen in loss of muscle mass with disorders that affect protein synthesis.

- **Speech Pattern**

Speech may be slurred because of CNS disease or because of damage to cranial nerves. Recurrent damage to the laryngeal nerve results in hoarseness, as do disorders that produce edema or swelling of the vocal cords. Speech may be halting, slurred, or interrupted in flow in patients with some CNS disorders (eg, multiple sclerosis, stroke).

- **Vital Signs**

The recording of vital signs is a part of every physical examination (Bickley, 2007). Blood pressure, pulse rate, respiratory rate, and body temperature measurements are obtained and recorded. Acute changes and trends over time are documented, and unexpected changes and values that deviate significantly from a patient's normal values are brought to the attention of the patient's primary health care provider. The "fifth vital sign," pain, is also assessed and documented, if indicated

- ✓ **Focused Assessment**

Following the general inspection, a more focused assessment is conducted. Although the sequence of physical examination depends on the circumstances and on the patient's reason for seeking health care, the complete examination usually proceeds as follows:

- Skin
- Head and neck
- Thorax and lungs
- Breasts
- Cardiovascular system
- Abdomen
- Rectum
- Genitalia
- Neurologic system
- Musculoskeletal system

In clinical practice, all relevant body systems are tested throughout the physical examination, not necessarily in the sequence described. For example, when the face is examined, it is appropriate to check for facial asymmetry and, thus, for the integrity of the fifth and seventh cranial nerves; the examiner does not need to repeat this as part of a neurologic examination.

When systems are combined in this manner, the patient does not need to change positions repeatedly, which can be exhausting and time-consuming.

The traditional sequence in the focused portion of the examination is inspection, palpation, percussion, and then auscultation, except in the case of an abdominal examination.

- **Inspection**

The first fundamental technique is inspection or observation of each relevant body system in more detail as indicated from the health history or the general inspection. Characteristics such as skin color, presence and size of lesions, edema, erythema, symmetry, and pulsations are noted. Specific body movements that are noted on inspection include spasticity, muscle spasms, and an abnormal gait.

- **Palpation**

Palpation is a vital part of the physical examination. Many structures of the body, although not visible, may be assessed through the techniques of light and deep palpation

- **Percussion**

The technique of percussion translates the application of physical force into sound. It is a skill requiring practice that yields much information about disease processes in the chest and abdomen.

The principle is to set the chest wall or abdominal wall into vibration by striking it with a firm object. The sound produced reflects the density of the underlying structure. Certain densities produce sounds as percussion notes.

These sounds, listed in a sequence that proceeds from the least to the most dense, are tympany, hyper resonance, resonance, dullness, and flatness. Tympany is the drum like sound produced by percussing the air-filled stomach. Hyper resonance is audible when one percusses over inflated lung tissue in a person with emphysema. Resonance is the sound elicited over air-filled lungs. Percussion of the liver produces a dull sound, whereas percussion of the thigh produces a flat sound.

- **Auscultation**

Auscultation is the skill of listening to sounds produced within the body created by the movement of air or fluid. Examples include breath sounds, the spoken voice, bowel sounds, heart sounds, and cardiac murmurs. Physiologic sounds may be normal (eg, first and second heart sounds) or pathologic (eg, heart murmurs in diastole, crackles in the lung). Some normal sounds may be distorted by abnormalities of structures through which the sound must travel (eg, changes in the character of breath sounds as they travel through the consolidated lung of a patient with lobar pneumonia).

Sound produced within the body, if of sufficient amplitude, may be detected with the stethoscope, which functions as an extension of the human ear and channels sound. The nurse must avoid touching the tubing or rubbing other surfaces (hair, clothing) during auscultation to minimize extraneous noises.

Sound produced by the body, like any other sound, is characterized by intensity, frequency, and quality. The intensity, or loudness, associated with physiologic sound is low; therefore, the use of the stethoscope is needed. The frequency, or pitch, of physiologic sound is in reality “noise,” in that most sounds consist of a frequency spectrum, as opposed to the single-frequency sounds that we associate with music or a tuning fork. The frequency spectrum may be quite low, yielding a rumbling noise, or comparatively high, producing a harsh or blowing sound. Quality of sound relates to overtones that allow one to distinguish among various sounds. Sound quality enables the examiner to distinguish between the musical quality of high-pitched wheezing and the low-pitched rumbling of a diastolic murmur.

- **Nursing Diagnosis Basics**

Healthcare is delivered by various types of healthcare professionals, including nurses, physicians, and physical therapists, to name just a few. This is true in hospitals as well as other settings across the continuum of care (e.g., clinics, home care, long-term care, churches, prisons).

Each healthcare discipline brings its unique body of knowledge to the care of the client. In fact, a unique body of knowledge is often cited as a defining characteristic of a profession.

Collaboration, and at times overlap, occurs between professionals in providing care. For example, a physician in a hospital setting may write an order for the client to walk twice per day. Physical therapy focuses on core muscles and movements necessary for walking.

Nursing has a holistic view of the patient, including balance and muscle strength related to walking, as well as confidence and motivation. Social work may have involvement with insurance coverage for necessary equipment.

Nurses deal with responses to health conditions/life responses among individuals, families, groups, and communities. Such responses are the central concern of nursing care and fill the circle ascribed to nursing. A nursing diagnosis can be problem-focused, or a state of health promotion or potential risk.

- ✓ **Problem-focused diagnosis** – a clinical judgment concerning an undesirable human response to a health condition/life process that exists in an individual, family, group, or community
- ✓ **Risk diagnosis** – a clinical judgment concerning the vulnerability of an individual, family, group or community for developing an undesirable human response to health conditions/life processes
- ✓ **Health promotion diagnosis** – a clinical judgment concerning motivation and desire to increase well-being and to actualize human health potential. These responses are expressed by a readiness to enhance specific health behaviors, and can be used in any heath state. Health promotion responses may exist in an individual, family, group, or community.

- **How Does a Nurse (or Nursing Student) Diagnose?**

The nursing process includes assessment, nursing diagnosis, planning, outcome setting, intervention, and evaluation.

Nurses use assessment and clinical judgment to formulate hypotheses, or explanations, about presenting actual or potential problems, risks, and/or health promotion opportunities. All of these steps require knowledge of underlying concepts of nursing science before patterns can be identified in clinical data or accurate diagnoses can be made.

- ✓ **Assessment**

Assessment involves the collection of subjective and objective information (e.g., vital signs, patient/family interview, physical exam) and review of historical information in the patient chart.

Nurses also collect information on strengths (to identify health promotion opportunities) and risks (areas that nurses can prevent or potential problems they can postpone). Assessments can be based on a particular nursing theory such as one developed by Sister Callista Roy, Wanda Horta, or Dorothea Orem, or on a standardized assessment framework such as Marjory Gordon's Functional Health Patterns.

- ✓ **Nursing Diagnosis**

A nursing diagnosis is a clinical judgment concerning a human response to health conditions/life processes, or vulnerability for that response, by an individual, family, group, or community. A nursing diagnosis typically contains two parts: 1) descriptor or modifier, and 2) focus of the diagnosis, or the key concept of the diagnosis.

- ✓ **Planning/Intervention**

Once diagnoses are identified, prioritizing of selected nursing diagnoses must occur to determine care priorities. High-priority nursing diagnoses need to be identified (i.e., urgent need, diagnoses with a high level of congruence with defining characteristics, related factors, or risk factors) so that care can be directed to resolve these problems, or lessen the severity or risk of occurrence (in the case of risk diagnoses).

- ✓ **Evaluation**

A nursing diagnosis "provides the basis for selection of nursing interventions to achieve outcomes for which nursing has accountability". The nursing process is often described as a stepwise process, but in reality a nurse will go back and forth between steps in the process. Nurses will move between assessment and nursing diagnosis, for example, as additional data is collected and clustered into meaningful patterns, and the accuracy of nursing diagnoses is evaluated. Similarly, the effectiveness of interventions and achievement of identified outcomes is continuously evaluated as the client status is assessed.

Evaluation should ultimately occur at each step in the nursing process, as well as once the plan of care has been implemented. Several questions to consider include: "What data might I have missed? Am I making an inappropriate judgment? How confident am I in this diagnosis? Do I need to consult with someone with more experience? Have I confirmed the diagnosis with the patient/family/group/community? Are the outcomes established appropriate for this patient in this setting, given the reality of the client's condition and resources available? Are the interventions based on research evidence or tradition (e.g., "what we always do")?

2.2. General principles of patient bed making

- **Introduction:**

  Bed making is an art. It is a way of preparing the appropriate bed based on the condition of the patient which adopts scientific principles of nursing. Skillful bed making promotes comfort for the patient. Nurses need to be able to prepare hospital beds in different ways for specific purposes. In most instances, bed are made after a client receives certain care and when beds are unoccupied. At times, nurses need to make an occupied bed or prepare a bed for a client who is having surgery can anesthetic post operative, or surgical bed.

- **What is Bed Making in Nursing?**

Bed making is one of the important nursing techniques to prepare various types of bed for patients or clients to ensure comfort and useful position for a particular condition.

The bed is especially important for patients who are sick. The nurse plays inevitable role to ensure comfort and cleanliness for ill patient. It should be adaptable to various positions as per patient's need because they spend varying amount of the day in bed.

- **Types of Bed:**

  Bed is of two types.

Simple Beds	Special Beds.
1. Closed Bed.	1. Operation Bed.
2. Open Bed.	2. Cardiac Bed
3. Occupied Bed.:	3. Blanket Bed.
	4. Amputation Bed.
	5. Fracture Bed

- **Purpose of Bed Making in Hospital:**

Bed-making is a nursing art. The purpose of the bed-making should be patients or clients-centered. The main purposes of bed-making are to prevent complications by ensuring comfort and security to patient.

1. To provide rest and sleep.
2. To provide physical and psychological comfort and security to the patient.

3. To give the unit neat appearance.
4. To establish an effective nurse patients relationship.
5. To provide active and passive exercise to the patient.
6. To promote fresh and cleanliness.
7. To develop skill in the posture/body alignment of the nurse in bed-making.
8. To observe, identify and prevent patient's complications.
9. To accommodate the patient's needs.
10. To reduce patient's exertion by bed-making.
11. To eliminate irritants to skin from patient's body.
12. To dispose soiled and dirty linen properly.
13. Another purpose of bed-making is to save time, effort and material properly

- **General Principals of Bedmaking**

Skillful bed making contributes patients comfort.

1. It is important to learn that how to make a bed in such a way where least amount of energy and time is required.
2. During bed-making, use good body mechanics and make each step purposeful.
3. Keep everything ready on bed side before starting bed-making.
4. Change bed linen frequently to assure cleanliness.
5. To ensure the patient need by providing a safe and comfortable bed.
6. It should have a finished appearance.
7. To make bed tight and free from wrinkles, place all linen straight line on the bed.
8. Prevent complications of prolonged bed ridden patient such as pressure sore.
9. Soiled linen or linen whether clean or dirty should not be thrown on the floor, but it is should be kept in a dirty linen box.

10. After cleaning bed, dump soap water and disinfectant properly.
11. Try to prevent cross infection of microorganism during bed-making.
12. Ensure all bed-making in a nursing unit alike for uniformity of appearance.
13. Make all beds in a nursing unit alike for uniformity of appearance. A well-made bed is neat, comfortable, free of wrinkles, and readily adaptable to the specific needs of an individual patient.
14. Provide clean blankets for each new hospital patient. Use cotton blankets for safety and economy of laundering.
15. Following Army Medical Department policy, use plastic protective cover on all mattresses and pillows. (Add a rubber or laminated cotton draw sheet to protect the bottom or foundation sheet as necessary.)
16. When standard cotton bedspreads are not available, use a top sheet as a blanket cover.

2.3. Bed making based on patient condition/need

Some clients are so ill that they are totally or partially confined to bed. A bed should provide comfort and correct posture for the client, as well as proper height and accessibility for caregivers. The ideal bed is durable, lightweight, easy to move, and easy to clean.

The most commonly used bed in healthcare facilities adjusts to different positions. (This is called a Gatch bed.) This bed is equipped with an electric mechanism that lowers the entire bed so that the client can get in and out easily and raises the bed for easy care giving. The mechanism can lower and raise the head and foot of the bed as well. Often both the client and caregivers can use controls to position the bed as desired. Usually, the controls for the TV, reading light, and the nurse call are incorporated into the bed controls.

(In some areas, the Gatch adjustments may be operated using a hand crank.) The controls on a hospital bed can be locked so the client cannot adjust the bed. This may be necessary in the event of a delicate suture line or unset fracture. In these cases, adjusting the bed could cause client discomfort and could be dangerous to the client.

Bed Making

The purpose of bed making is to help clients feel comfortable and to decrease pathogens in the client's environment. Clean, dry, and wrinkle-free linens also help to reduce the potential for skin breakdown and they are important to help control odor.

Necessary supplies for bed making include clean linens, a tight bottom sheet to prevent wrinkles that might cause skin irritation, and upper bed clothing that does not weigh on the client's body or restrict movements, but still covers his or her shoulders. Adjustments in basic bed making may be necessary for comfort and to suit individual client conditions.

Schedules for changing beds vary among healthcare agencies. Usually you remake the bed after the client's bath or morning care. Make exceptions if the linen becomes soiled or if changing the bed may prove harmful to the client.

For example, a client may be bleeding, receiving a special treatment, or feeling too weak or exhausted to be disturbed. Change stained sheets immediately. In some cases, beds are not changed every day or are partially changed. Even if you do not change the bed, tuck in sheets and blankets, to get rid of wrinkles, and fluff the pillows.

Key Concept Every client needs a smooth, clean bed for comfort and to prevent complications. Wrinkles or crumbs can make the client uncomfortable and cause skin breakdown. It is very important to change linens that are soiled. One or more incontinence pads are added to the linens on the bed if the client is bleeding, incontinent, or vomiting.

Key Concept The client with an orthopedic disorder often requires a head-to-toe linen change, sometimes more than once a day This client must be moved very carefully particularly if he or she has an un stabilized fracture.

Making an Occupied Bed

Some clients are unable to get out of bed as a result of their specific condition or generalized weakness. Changing bed linens with the client in the bed is known as making an occupied bed. Work quickly and disturb the client as little as possible. This task of bed making may be done by one nurse; however, if the client is large or his or her medical condition is unstable, ask a coworker to assist you.

In Practice: Nursing Procedure 49-2 gives the steps in making an occupied bed. If done efficiently, this procedure requires minimum exertion for both you and the client. Some clients need extra blankets for additional warmth, and some may have fractures or injuries that necessitate turning or moving them in a special way.

Opening a Bed for a Client

The open bed has the linens folded down, making it easier for the client to get into bed. Open a bed for a new client or leave it open when the client is out of bed for a short time. Follow these steps:

Making a Postoperative Bed

When a client is to return from the operating room or from another procedure that requires transfer into bed from a stretcher and sometimes from a wheelchair, a postoperative bed is prepared. The postoperative bed is made in such a way as to make it easy to transfer the client from a stretcher to the bed.

Special Beds And Mattresses

Special types of mattress surfaces are used for clients on prolonged bed rest or for those with poor skin integrity. Examples include the egg crate mattress, which is foam rubber with a surface shaped like an egg carton, and the flotation mattress or pad (usually used in a specific area of the body). The flotation mattress or pad contains a special gel-type material, which supports the body or body part in such a way as to avoid creating pressure points. Although egg crate mattresses and flotation pads provide client comfort, they do not necessarily prevent skin breakdown.

Therapeutic beds are used to treat clients with severe joint contractures, prolonged immobility, or skin wounds such as pressure ulcers or severe burns. These beds reduce or relieve the effects of pressure against the skin through various mechanisms.

The surface of such beds often feels like a waterbed. These beds are more comfortable for clients who have severe contractures because their bodies float as if suspended in midair. Severe skin wounds are more likely to heal when the effects of pressure are reduced. Some special beds are pictured in Figure 49-7. Many special beds also are available in sizes that accommodate very large or heavy clients.

Special orthopedic beds and frames support clients who must remain immobilized. Although largely replaced by other computerized beds and overlay mattresses, the circle bed (Circ-O-Lectric bed) is still used in special situations. It functions to turn the client as a unit, keeping the body straight.

Key Concept Bariatric beds are also available for very large clients. These beds are larger than regular hospital beds and of heavier construction. Usually three people are required to move a bariatric bed.

Throughout nursing career, a nurse will work with clients who need therapeutic beds, many of which are complex to use. Be sure to read carefully the instructions for use, paying particular attention to safety features. You are responsible for the safe and effective use of these therapeutic beds, as well as the safety and well-being of your clients.

2.4. Patient safety and comfort device

- **Definition of Patient Safety**

Patient safety was defined by the IOM as "the prevention of harm to patients." Emphasis is placed on the system of care delivery that (1) prevents errors; (2) learns from the errors that do occur; and (3) is built on a culture of safety that involves health care professionals, organizations, and patients. Patient safety is about maximizing the things that go right and minimizing the things that go wrong for people experiencing healthcare.

- **Fundamentals in Patient Safety**

What is Patient Safety? Patients can be harmed from health care, resulting in permanent injury, increased lengths of stay in hospital and even death. Over the past years, we have learned that adverse events occur not because people intentionally hurt patients, but rather due to the complexity of health-care systems, where treatment and care depend on many factors, in addition to the competence of health-care providers.

When so many and varied types of health-care providers, such as dentists, dieticians, doctors, midwives, nurses, surgeons, pharmacists, social workers, and others are involved, it can be difficult to ensure safe care, unless the system is designed to facilitate the delivery of quality and safe services.

- **The burden of unsafe care**

Health care is one of the most unsafe industries. Studies show that about 10% of hospital patients suffer an adverse event (AE) and the incidence of AE in developing countries is higher than 10%.

Health care associated infection (HCAI)	○ Hundreds of millions of patients are affected by HCAI worldwide each year, leading to significant mortality and financial losses for health systems and patients ○ Of every 100 hospitalized patients at any given time, 7 in developed and 10 in developing countries will acquire at least one HCAI ○ 5-15% of hospitalized patients acquire HCAI - about 40% in ICUs - mortality from HCAI is 12%-80% (WHO) ○ 5 million HCAI estimated to occur in hospitals in Europe/year (WHO)
Medication errors	○ leading cause of injuries in developing countries ○ 1.5 million harmed and thousands killed in USA/year (2006) ○ In some countries, 70% of patients' medication histories contain errors
Unsafe surgery	○ 234 million surgical procedures/year worldwide (more than childbirths) ○ 7 million complications, 1 million deaths worldwide each year (WHO)
Clinical handovers	○ Communication between units/health-care team/hospital facilities/community ○ 15% handovers result in adverse events
Injection safety	○ Over 70% of injections in primary health-care are unnecessary ○ Unsafe injections account for 33% of new HBV infections, 42% of HCV and 2% of all new HIV infections worldwide

- ✓ “Adverse events,” include missed and delayed diagnoses, mistakes during treatment, medication mistakes, delayed reporting of results, miscommunications during transfers and transitions in care, inadequate postoperative care, mistaken identity and others.
- ✓ Patient safety is an issue in all countries that deliver health services, whether these services are privately commissioned or funded by the government.

- ✓ In developing countries, the poor state of infrastructure and equipment, unreliable supply and quality of drugs, shortcomings in infection control and waste management, poor performance of personnel, low motivation or insufficient skills and severe under-financing of the health services makes the probability of adverse events much higher.
- ✓ Many of the features of patient safety program do not require financial resources, but rather the commitment of individuals to practice safely.
- ✓ Health-care providers can improve patient safety by engaging with patients, checking procedures, learning from errors and communicating effectively within the health-care team.
- ✓ Such simple activities can help minimize costs, while minimizing the harm caused to patients too.
- ✓ Reporting and analysis of errors can help identify the contributing factors. Understanding the factors that lead to errors is essential in order to develop changes that will prevent future errors.

- **Challenges related to unsafe care can be categorized into:**
  - Unsafe medical care, e.g.: unsafe medication, injection practices, unsafe blood practices, health care-associated infection, unsafe care related to mothers and neonates or the elderly, patient falls.
  - Structural factors contributing to unsafe care, such as no regulation or accreditation, no culture of safety, poor training and education of health-care workers (HCW), environment pressures.
  - Poor processes contributing to unsafe care, such as misdiagnosis, poor test follow-up, counterfeit drugs, poor involvement of patients in their care.

- **A model for patient safety**

Leaders in patient safety have defined patient safety as: “A discipline in the health-care sector that applies safety science methods towards the goal of achieving a trustworthy system of health-care delivery. Patient safety is also an attribute of health-care systems; it minimizes the incidence and impact of, and maximizes recovery from adverse events.”

- **How to apply patient safety thinking to all health-care activities**

✓ **Develop relationships with patients**: Every health-care provider should relate with patients as unique human beings with their own experience of their disease. The application of knowledge and skills alone will not necessarily result in the best outcomes for patients. Safe and effective care depends on patients disclosing their experiences of their illnesses, their circumstances, their attitudes to the risks involved, and their values and preferences on how they wish to be treated.

✓ **Understand the multiple factors involved in failures**: There are many factors associated with an adverse event. Consider errors from a systems perspective. Questions about the underlying factors and causes of errors should be asked: 'what happened?' rather than 'who was involved?'. The "whys" (why something happened when given an answer) is a method used to investigate the causes focused on the system rather than the health-care provider involved.

✓ **Avoid blaming when an error occurs:** Health-care providers must support each other when they are involved in an adverse event. Unless they are open about errors, there will be little opportunity to learn from them. Conduct meetings or peer-review forums, such as morbidity and mortality meetings, to review such events.

✓ **Practice evidence-based care**: Health-care providers should learn how to apply evidence-based practices and be aware of the role of protocols/guidelines and how important it is to follow them.

✓ **Maintain continuity of care for patients**: The health-care system is made up of many parts that interrelate to produce a continuum of care. Understanding the journey that patients make through this system is necessary in understanding how failures arise. Important information can be missed, outdated or be incorrect, leading to inadequate care or errors.

✓ **Be aware of the importance of self-care**: Health-care providers should be responsible for their own well-being and that of their colleagues. Act ethically every day: Health-care providers should be aware of their legal and ethical obligations to put the interests of their patients first.

- ✓ **The delivery of safe health care** The success of a patient's care depends on understanding the entire health system available to that particular patient. An understanding of systems will help the health-care providers appreciate how different parts of the health system are connected and how continuity of care for the patient is dependent on all parts of the system communicating in an effective and timely manner.

- **Comfort Devices**

- ✓ **Comfort**- The state of freedom from pain, discomfort, tension. The absence of irritating stimuli that distract one's attention from the task at hand. COMFORT - DEFINITION & Comfort- Is a sense of mental and physical well being.
- ✓ **Comfort devices** are invented articles which would add comfort to the patient when used in appropriate manner. Comfort devices are the mechanical devices planned to provide optimal comfort to an individual.
- ✓ **LIST OF COMFORT DEVICES**…

1. Pillows	2. Back Rest	3. Bed Cradle
4. Cardiac Table	5. Mattresses	6. Trapeze Bar
7. Footboard	8.Trochanter Rolls	9.Sandbags
10.Side Rails	11. Wedge/ Abductor Pillow	12.Knee Rest
13.Bed Blocks	14. Splints & Braces	15. Air Cushion
16. Rubber & Cotton Rings	17. Hand Roll	

Table 2: shows Factors Promoting And Inhibiting Comfort:

Factors promoting	**Factors inhibiting**

Normal temperature	Too high or too low temperature
Normal humidity	Dry or too humid
environment Safe, clean, quite and comfortable environment	Unsafe, unpleasant and stressful environment
Comfortable positions	Uncomfortable position
Neat and clean bed and linen	Dirty and soiled bed and linen
Good ventilation	Poor ventilation
Normal lighting	Glaring or too dim lighting
Pleasant odours	Unpleasant odours
No fear	Fear
No stress and worry	Stress and worry

- ✓ MECHANICAL DEVICES FOR COMFORT MEASURES
  1. PILLOWS :- Used under head , arms , legs Used for support to maintain correct body alignment & along spine or abdomen to provide comfort.
  2. BACK REST:- Used for pts suffering with cardiac
     - ¬ Arms of patient are well supported.
     - ¬ Extra pillows are needed.
     - ¬ Can be adjusted to desired angle.
     - ¬ Support patient's back at an angle , so that he may maintain a sitting position
  3. BED CRADLE :- is a frame used to hold the bed linen from touching the pt.
     - Cradle is a semicircular / rectangular frame of metal.
     - May be made of wood or bamboo.
  4. CARDIAC TABLE :- Bed table placed in front with a pillow on it, patient can lean forward & take rest.
     - able without pillow is used for writing & meals.

- Used for pts with cardiac conditions & Helps to take meals
- Patient can rest over the table with the help of pillow.

5. AIR MATTRESS water mattress :- Used for very thin and very obese patients and those who are prone to pressure sores.
6. TRAPEZE BAR:- Bar is suspended from an overhead frame to head of bed - -- Patient can grasp the bar to raise the trunk off the bed surface or to move up in bed.
7. FOOTBOARD:-
    - Device that is placed towards the foot of pts bed to serve as support for his feet
    - Usually made up of wood/plastic/heavy canvas
    - Used to prevent foot drop & to support patients feet
8. SANDBAGS:-
    - They are sand filled plastic bags that can be shaped to body contours
    - Can be used in place of or in addition to trochanter rolls
    - Provide support & shape to body
    - Immobilize extremities & maintain specific body alignment
9. SIDE RAILS
    - Side rails are the bars positioned along the sides of the length of the bed
    - Ensure patient's safety & are useful for increasing mobility
    - Provide assistance in rolling from side to side or sitting up in bed
10. BED BLOCKS :- These are used to raise the foot end or head end of the bed

2.4.1. purpose and indications of patient safety and comfort

The development and integration of a framework of interprofessional patient safety competencies is a critical achievement that will accelerate the development of local patient safety curricula. The integration of safety theories and the how-to's of system improvement at all levels of education and continuing professional development is needed across the spectrum of care

A culture of patient safety arises from attitudes, activities and enduring ethical values that are conducive to the safe delivery of patient care. More specifically, it refers to the commitment of

health care practitioners and their institutions and organizations to minimize patient harm, promote the well-being of patients and health care providers, reduce the likelihood of adverse events, and communicate safety concerns – while at the same time learning from close calls and other events.

Health care professionals who commit to patient and provider safety through safe, competent, high-quality daily practice:

- Are able to articulate their role as individuals, as professionals, and as health care system employees in providing safe patient care
- Act as role models and champion patient-safety behaviours
- Recognize personal limitations and ask for assistance when required
- Demonstrate knowledge of policies and procedures as they relate to patient and provider safety, including disclosure
- Report unsafe processes within the health care system
- Participate actively in event and close call reporting, event analyses and process improvement initiatives
- Exchange feedback with colleagues on safety issues on an ongoing basis in an open manner
- Integrate safety practices into daily activities (e.g., hand hygiene)
- Recognize clinical situations that may be unsafe and support the empowerment of all staff to resolve unsafe situations
- Demonstrate a commitment to a just culture, promoting fair approaches to dealing with adverse events
- Advocate for improvements in system processes to support professional practice standards and the best patient care

2.5. Documentation

- ✓ “Nurses ensure that documentation present an accurate, clear, and comprehensive picture of the clients need, the nurse intervention and client outcomes
- ✓ Documentation should be a complete record of nursing care – assessment, planning, intervention and evaluation
- ✓ Document objective and subjective data
- ✓ Ensure plan of care is clear, current, relevant and individualized to meet the client’s needs and wishes
- ✓ Minimize duplication of information in the health record
- ✓ Ensure that relevant client care information kept in temporary hard copy documents (such as kardex, shift reports or communication books) is captured in the permanent health record
- ✓ Provide full signature or initials, and professional designation
- ✓ If handwritten – make sure it is legible and in permanent ink
- ✓ Use abbreviations and symbols appropriately
- ✓ Document informed consent
- ✓ “Nurses are accountable for ensuring their documentation of client care is accurate, timely and complete
- ✓ Complete documentation during or as soon as possible after the care or event
- ✓ Document date and time that care was provided and when recorded
- ✓ Document chronologically
- ✓ Clearly indicate if the entry is late
- ✓ Do not leave empty space for others to add information later
- ✓ Correct errors and make sure original information is visible or retrievable

- ✓ Do not delete, alter or modify another person's documentation
- ✓ Document if information for a specific time frame has been lost or cannot be recalled
- ✓ Ensure that documentation is completed by the individual who performed the action or observed the event
- ✓ Clearly identify the individual performing the assessment and/or intervention when documenting
- ✓ Ensure that relevant client care information is captured in a permanent record
- ✓ Maintain confidentiality of client health information, including passwords or information required to access the client record
- ✓ Understand and adhere to policies, standards and legislation related to confidentiality

Self check	**written test**

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.

1. Which of the followings is not method of physical examination
   a. Papation b. percussion c. Auscultation d. inspection E. none
2. Identify which is part of nursing process
   a. Assessment b. Nsg. Diagnoses c. intervention d. evalution e. all
3.

Score = _____

Rating: _____

Answer Sheet

Name: _____ Date: _____

1.

2.

3.

List of Reference materials

1. Best Practices in Patient Safety 2nd Global Ministerial Summit on Patient Safety(WHO)
2. Global action on patient safety, 12 December (WHO)
3. Brunner & Sudderth's text book of Medical Surgical Nursing Vol.1, 12th edition.