Essentials of nursing practice

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Learning objectives

By the end of this chapter you will be able to:

- discuss the essentials of nursing practice
- differentiate between clinical skills and clinical competencies
- demonstrate functional/clinical nursing competencies
- understand the principles of interprofessional practice.

Key terms

Clinical pathways
Competencies
Effective nursing practice
Nursing process
Skills

Introduction

This chapter follows on from the discussions about the essential competencies required for the newly registered nurse, those competencies that you have already begun developing in your undergraduate program. Throughout this book, you will find continual reference to the Australian Nursing and Midwifery Council (ANMC) competency standards, and your continued registration is dependent on you providing evidence to the registering authority (AHPRA) that you are competent to practice as a registered nurse. It might be appropriate to pause at this point and reflect on what is meant

by competencies. There have been many definitions of competency in the literature but Carraccio et al. (2002, p. 362) synthesised these defintions into 'a complex set of behaviours built on the components of knowledge, skills, attitudes and personal ability'. A later study by Calman (2006) described nurse competence from the patients' perspective as a synthesis of technical ability and nursing knowledge. The study also reported that the foundations of competence in nursing were technical skills and knowledge but that 'skill acquisition does not guarantee effective performance' (p. 721). So you can see that competency development as a registered nurse is a complex process combining what some writers describe as the 'art and science' of nursing (Siviter 2008).

Point to ponder

What competencies are you going to bring to an employer as a newly registered nurse?

WORKING IN GROUPS

In a group, discuss how you will continue to develop clinical competencies as a newly registered nurse.

1 Discuss the differences between clinical skills and competencies.
2 Which competencies would you focus on to begin with?

This chapter focuses on the practical aspects of nursing practice—it is the 'how to do' chapter. In your undergraduate program you learned the theories that support nursing practice and were given opportunities to apply these theories to the practice of nursing in the simulated environments and on clinical placement. In these situations you were supervised; however, you now need to consider possible scenarios where you could be supervising the work of others.

As a student nurse you were introduced to the nursing process, a problem-solving framework that enables the registered nurse to develop individualised care plans for patients. The nursing process helped you to develop your critical thinking and reflective skills, and competencies that are central to safe, effective nursing practice.

Point to ponder

How would you define safe nursing practice?

The nursing process

The nursing process has five elements:

- Assessment
- Nursing diagnosis
- Planning
- Implementation
- Evaluation

The nursing process is not a sequential process but rather a non-sequential one in which nurses move through all five stages while delivering care to patients. The process of assessment, for example, is a continuous one in which nurses observe and note patient responses to therapeutic interventions.

Point to ponder

How would you rate your assessment skills?

Assessment

Assessment begins the nursing process, and in Chapter 8: Essential competencies for the newly registered nurse, assessment was presented as an essential competency for registered nurses. Why do you think this is? Why is assessment important in nursing practice? Assesment is a complex process because it requires you to collect information from multiple sources, starting with the patient. A comprehensive assessment of a patient's clinical, psychological and spiritual condition leads to a nursing diagnosis, which leads to an appropriate nursing care plan. This then leads to nursing interventions that can be evaluated quantitatively (physical observations, eg. temperature, pulse, respiration, blood pressure) and qualitatively (patient responses to questions, patient mood). Assessment involves observing the patient for clinical signs and symptoms, taking baseline observations and asking questions. Clinical observations are important but what is more important are the interpretations you make of these observations that then lead to developing a nursing diagnosis and a nursing care plan. Another important aspect of assessment is asking questions and listening to patient responses, or if the patient is unable to respond then whoever is acting on their behalf. The patient's clinical appearance, provisional diagnosis and psychological demeanour should give you some direction into the type of questions you need to ask and also how you will ask these questions. This part of the assessment process should not be conducted as an interrogation but more as a professional conversation,

with you explaining why you are asking the questions and also waiting for the patient to reply. Many nurses make the mistake of answering for the patient by assuming that, because they have a provisional diagnosis, they know how the patient will respond.

Point to ponder

Remember, the ANMC competency standards do not distinguish between experienced registered nurses and newly registered nurses.

WORKING IN GROUPS

(One of you can be the patient with a specific diagnosis)

1 Work through the assessment process — where will you begin?
2 Identify some of the pitfalls to be avoided during the assessment process.
3 What indicators drive the assessment process? How do you identify these?
4 Will you be using any equipment for the assessment?
5 What documentation will you require?
6 Should relatives be present during the assessment?

An integral part of this professional conversation you have with the patient will involve you listening very carefully to the patient's responses. You should be observing for any differences between the patient's responses and their body language. Astute observation of a patient's body language: their posture; facial expressions; tone of voice, are all indicators of whether there is a connection between what is being said and what is being felt by the patient. One example of this difference between the spoken word and body language may occur when you are completing a pain assessment. Patients can either understate or overstate their level of pain and if there is a difference then you should be able to deduce this from the patient's body language or non-verbal communication.

Nursing diagnosis

Point to ponder

Is a nursing diagnosis the same as a medical diagnosis?

The nursing diagnosis results from you translating the information you collected during the assessment phase to identify the clinical problems or

issues that you as the registered nurse will develop interventions for as part of the problem-solving process. The key elements of a nursing diagnosis are:

- A clear statement of the patient's problem.
- It is a clinical or health problem.
- It is based on objective and subjective information.
- It is presented as a short concise statement.
- The nurse can prescribe nursing interventions for the clinical condition.
- The patient is able to validate the problem.
- It is outcomes-focused and evidence-based.

(Adapted from Hogston 2007, p. 13)

When developing the nursing diagnosis, remember it can be actual, that is resulting from the assessment, or predictive. A predictive nursing diagnosis is one that could result from the actual diagnosis. For example, you have admitted a patient following a cerebral episode requiring a period of bed rest prior to rehabilitation. During the assessment phase you will have to note what effect on the patient prolonged bed rest may have and so your nursing diagnosis and subsequent plan of care will include any potential consequences of prolonged bed rest, and nursing interventions that will minimise these consequences.

Nursing care planning

The nursing care plan consists of setting goals and developing nursing interventions to meet these goals. In Chapter 1 you were introduced to the SMARTTA framework for setting goals so you know that goals have to be:

S= Specific
M= Measurable
A= Achievable
R= Realistic
T= Timeframe
T= Trackable
A= Agreed

(Dwyer, Hopwood 2010, p. 261)

Point to ponder

The point of goal setting is....?

Other indicators that need to be included in the care plan are the patient's:

- age
- principal diagnosis and subsequent clinical condition

- mobility levels
- pain levels
- level of comprehension (comprehension may be affected by a number of factors including language; emotions such as fear; high pain levels; communication difficulties)
- socio-cultural background
- psychological status.

WORKING IN GROUPS

In your group discuss the effects of prolonged bed rest on a patient.

Patient 1

A young person (male) aged between 20–35 years has had a cerebral bleed following an accident during a football match and requires a period of bed rest.

1 What might this patient's nursing care plan look like?
2 What are some of the clinical indicators you would be looking for?
3 What are the potential outcomes of prolonged bed rest for this patient?

Patient 2

An older woman aged between 70–80 years is admitted following a severe cerebro-vascular accident affecting the left side. The patient's social history indicates that she lives alone and has minimal family support.

1 What might your nursing diagnosis be for this patient?
2 What might the nursing care plan look like?
3 What clinical indicators will you focus on?

In both cases what strategies will you implement to minimise the effects of prolonged bed rest?

Implementation

Point to ponder

What types of evidence do nurses use to inform their practice?

Having developed the plan of care, you will now need to implement nursing interventions that reflect the patient's goals and that will assist the patient to achieve these goals. You will plan these nursing interventions very carefully because you may not be the person implementing them and may have delegated the nursing interventions to care workers, assistants in nursing or enrolled

nurses. Therefore, nursing interventions must be written in clear, jargon-free language and be specific to the patient. The nursing actions or interventions must be realistic, evidence-based, outcomes-focused and prioritised. The majority of patients will have more than one nursing intervention and so you begin with the most significant. For example, monitoring the clinical status of the patient with the cerebral accident through taking observations of temperature, pulse, respirations, blood pressure, pupil size and levels of consciousness and, in extreme cases, responses to stimuli. All of these observations would be documented and you use your assessment skills to note changes. What you are doing is in fact translating knowledge and clinical observations into objective information that can be used for ongoing clinical management.

Point to ponder

Knowledge transfer is an important nursing competency. Would you agree?

Evaluation

In the nursing process framework, evaluation comes as the last stage but in actual fact, evaluation begins the nursing process again. Having reached the evaluation stage, you are looking to see the outcomes of the nursing process that resulted from the goals of care developed for the patient. Having achieved the goals of care, you make an assessment of the patient's response to therapeutic and nursing interventions, make a clinical judgment, and begin the nursing process all over again but with a different set of clinical parameters. The process of evaluation enables you to review and reflect on the effectiveness of the care plan you developed together with the nursing actions in achieving the appropriate health outcomes for the patient. The process of evaluation also enables you to see if your care initiatives and interventions have complied with the ANMC standards of practice, the policies and procedures of the healthcare organisation, and are evidence-based.

Point to ponder

Where else in nursing practice is evaluation used?

Your nursing care plan and interventions will also be evaluated by your peers and other members of the healthcare team during clinical handover. Clinical handover is where you comment on the effectiveness of your care planning and your peers may in fact offer suggestions on making changes if the patient goals have not been achieved. The clinical handover period is an

excellent vehicle for sharing clinical information because it is here that you will have clinicians sharing their knowledge and expertise with you and the rest of the healthcare team. A good resource for you to access at this stage is from the Australian Commission on Quality and Safety in Healthcare, *The OSSIE Guide to Clinical Handover Improvement*. This resource will provide you with information that will help you to develop your clinical handover skills so that the information you handover is relevant, accurate and reflects the patient's clinical status at a point in time.

Point to ponder

Nurses are valued members of a multidisciplinary team.

WORKING IN GROUPS

In a group, practice your clinical handover skills. You should take turns in presenting a clinical handover for the following patient.

Annie G is 19 years old and has been admitted to your unit with the following symptoms:

- Pale, sweaty
- Short, shallow respirations
- Elevated pulse rate
- Pain in the right upper quadrant of her abdomen

1 What might Annie's diagnosis be?
2 What would you say about this patient?
3 What are the likely outcomes for her?
4 Have they been seen by a doctor?
5 Is there anything specific that has to be done for her?
6 Have her relatives been informed?

Point to ponder

Clinical handover is communicating information about patients to peers and colleagues.

Observing and critically reflecting on the patient's responses to the nursing interventions is another way of evaluating the effectiveness of your care planning. This reflective process may result in you having to review the care plan with colleagues and make changes as necessary. Where possible the patient should always be included in the care planning process. The patient

is the best person to tell you of their perceived mobility limitations, their dietary preferences, their sleeping habits and preferences, and their preferred times for showering, for example. All of these points you will have noted when completing the assessment and will now incorporate into the nursing care plan. You can ask the patient whether or not they were satisfied with the nursing care plan you developed for them. Remember the Australian Charter of Healthcare Rights available at http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/0797B562EBEAF8C5CA257753001EDB6D/$File/17501-ConsumerGuide.pdf, which identifies the patient as a partner in the management of their episode of care.

It is important to remember that when using the nursing process you will be engaging your senses (sight, hearing, touch, smell) and over time, as you become more experienced and confident, you will use intuition to make clinical judgments. As you work your way through the following case study using the nursing process, think about the senses you will engage.

Case study

Mr Winters is a 70 year old man admitted to your clinical unit from the Emergency Department (ED). You are asked to admit Mr Winters and complete an assessment and a nursing care plan. Mr Winters is accompanied by his wife who is very distressed and worried about her husband's prognosis. You begin your assessment once Mr Winters has been made comfortable in bed and his wife is seated comfortably by his bedside. Mrs Winters was given the opportunity to wait in the waiting area while you completed the assessment but has chosen to remain with her husband. Mr Winters' clinical symptoms are:

- pale, sweaty
- respirations rapid and shallow
- obvious left-sided weakness
- pulse rate is thready and 100 beats/min
- blood pressure is 180/110
- hand grips stronger on the right side
- speech slurred
- pupils unequal but reacting to light
- was noted to be incontinent of urine
- agitated, restless
- not responding in an appropriate manner.

As Mr Winters is not able to respond to your questioning appropriately, you are glad that his wife is there to help you with the assessment.

Questions

- Which of your senses did you engage during the assessment process?
- What nursing goals have you developed for Mr Winters and why?
- What nursing interventions did you enter on the nursing care plan?
- Which of these interventions did you identify as priority interventions and why?
- Did you involve Mrs Winters in developing this nursing care plan for her husband?
- Did you involve anyone else in developing this nursing care plan?
- What were the key issues you stressed at the handover in relation to Mr Winters' clinical condition and why?

Organising nursing practice

Elsewhere in the book we discussed time management and how you would organise yourself to work a shift in a busy clinical environment. This section deals with how you would organise a team of nurses to care for a group of patients. There are a number of models of nursing care that you can choose from but the model of choice is of course what the nursing service in your healthcare organisation has decided to use. The models of nursing service delivery available to you are:

- team nursing
- task/functional nursing
- primary nursing
- patient allocation.

Point to ponder

Models of nursing care delivery help organise nursing practice and reflect the values, philosophy and mission of the organisation.

WORKING IN GROUPS

In your group discuss how you would manage the following scenario:
You are a new graduate registered nurse and are working in a busy surgical unit in a teaching hospital. This is your third week on the unit following orientation to the hospital and to the unit. You have arrived at 7am and found you have been allocated the following four patients:

Mr G – seventy-two years old, is waiting to go to theatre for a below-the-knee leg amputation.

Mr S – a young twenty year old who was admitted from a night club the previous evening in a diabetic coma.

Mr B – a seventy year old awaiting discharge and transfer to a rehabilitation centre following recovery from a cerebro-vascular accident, which has affected mobility on his left side.

Mr A – a thirty year old recovering from a violent assault three days ago and who is a person of interest to the police.

Some points to consider:

1 How would you organise your workload?
2 What do you need to consider for each patient?
3 Which patient would you organise first?
4 What indicators will you use to make decisions regarding these patients?
5 What will your 'cheat sheet' look like?
6 Would you consider asking for help?

Documentation

Point to ponder

Effective documentation reflects your literacy competencies.

Accurate and relevant documentation is a key responsibility of all nurses. Documentation, whether electronic or paper-based, is a form of communication about the clinical status of patients receiving nursing care from you and/or the team of staff working with you. Therefore, it is important that all nursing documentation is accurate and relevant because in current clinical environments you are communicating with health professionals from multiple disciplines who need to be able to provide continuing care using the information provided by you. Below are some guidelines for effective documentation:

- All entries should be accurate and factual.
- Make corrections as required as per hospital policies—information should not be deleted.
- All information should be timely and relevant.
- All nursing actions need to be evaluated and outcomes documented.
- All identified patient problems, nursing actions taken and patient outcomes need to be noted.
- Do not describe patient problems without including the nursing actions taken and the patient responses.
- Be objective with charting. Document within the specific clinical/psycho-social parameters for each patient.

- It is important to chart non-actions but within the context of the patient's clinical condition (why you did not do something—perhaps the patient was asleep or away for investigations).
- All entries from health professionals should have the full name and designation clearly written.
- Follow through with pertinent details of who saw the patient and what interventions were initiated. Note especially if you had to call the doctor, any interventions ordered, any nursing actions taken as a result of those orders and what was the patient response.
- Notes need to be legible and clearly reflect the clinical condition of the patient.

(Adapted from Zerwekh, Claborn 2009).

Infection control

Infection control management is a core function of all healthcare staff. You will have been introduced to the principles of infection control during your undergraduate program. Adherence to infection control measures is the responsibility of all health professionals. Registered nurses have assumed a surveillance and policing role in relation to infection control management. One reason for this is that registered nurses and other nurses are a continued presence while other health professionals are transient. The Australian Commission on Quality and Safety in Healthcare (ACQSHC) website (http://www.safetyandquality.gov.au) provides current information on infection control management in the healthcare organisations. There is also a ACQSHC website that gives you access to the National Hand Hygiene Initiative (http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-03_NHHP).

These two websites are worth accessing and reading because infection control management and practices are integral components of the registered nurse role. Most hospitals have a designated infection control nurse; this is a senior nursing position that has a surveillance role, collecting infection control data such as infection rates, sources of infection and types of infection. You will be well aware that hospital units have been closed down if the infection rates are compromising patient care. Infection control management is also part of a healthcare organisation's risk management and quality improvement strategy.

Wound management

Wound management is closely linked to infection control management. Wounds can result from surgical interventions, the introduction of invasive

catheters and monitoring devices, accidents in the home such as burns, motor vehicle accidents, pressure ulcers and venous and arterial ulcers found in the lower extremities resulting from impaired vascular circulation. Effective wound management requires you to find the best research-based evidence available to treat the wound. Some hospitals have senior registered nurses or nurse practitioners whose area of expertise is wound management. If this is an area of interest, you may find it beneficial to spend time with these nurses to develop your skills and knowledge in the area of wound management. Wound management in healthcare organisations is based on research-generated evidence, which is translated into clinical guidelines and protocols used in the clinical environment. It is your responsibility to become familiar with these clinical guidelines and protocols.

When assessing a wound you will use the nursing process to determine the best way to treat it, and if the wound is a pressure ulcer or decubitus ulcer, you will develop nursing interventions that will promote wound healing. There are a number of wound risk assessment tools that nurses can use to determine the best possible strategies to support their clinical decision-making in this area. Examples of these wound risk assessment tools include the Braden and Waterlow scales for assessing pressure ulcers. Your organisation may use other assessment tools and again, you need to find out what these may be.

Managing clinical emergencies

In your undergraduate program you will have completed basic life support training. Organisations have clinical guidelines and protocols relating to clinical emergency management and knowing these is a must for all health professionals. As a registered nurse you will have to know how to initiate emergency procedures if you are first on the scene.

Point to ponder

Emergencies, by definition, occur when least expected and so if you are in a unit where there are seriously ill patients or patients whose clinical condition is unstable, these patients need frequent observations so that the incidence of emergencies is minimised. Again, this is where good assessment and communication competencies are essential for registered nurses.

The Australian Resuscitation Council (ARC) is the peak body in Australia that provides advice, policy and guidelines for the management of emergencies in healthcare facilities. The ARC guidelines may be accessed at http://www.resus.org.au/. Your healthcare organisation will have developed emergency resuscitation procedures using these ARC guidelines.

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DISCUSSION QUESTIONS

1 What are three take-home messages for developing a plan of care?
2 Have you ever been involved in an emergency situation? What were your reactions and responses during the event?
3 How confident are you in using the nursing process for developing a nursing diagnosis?

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