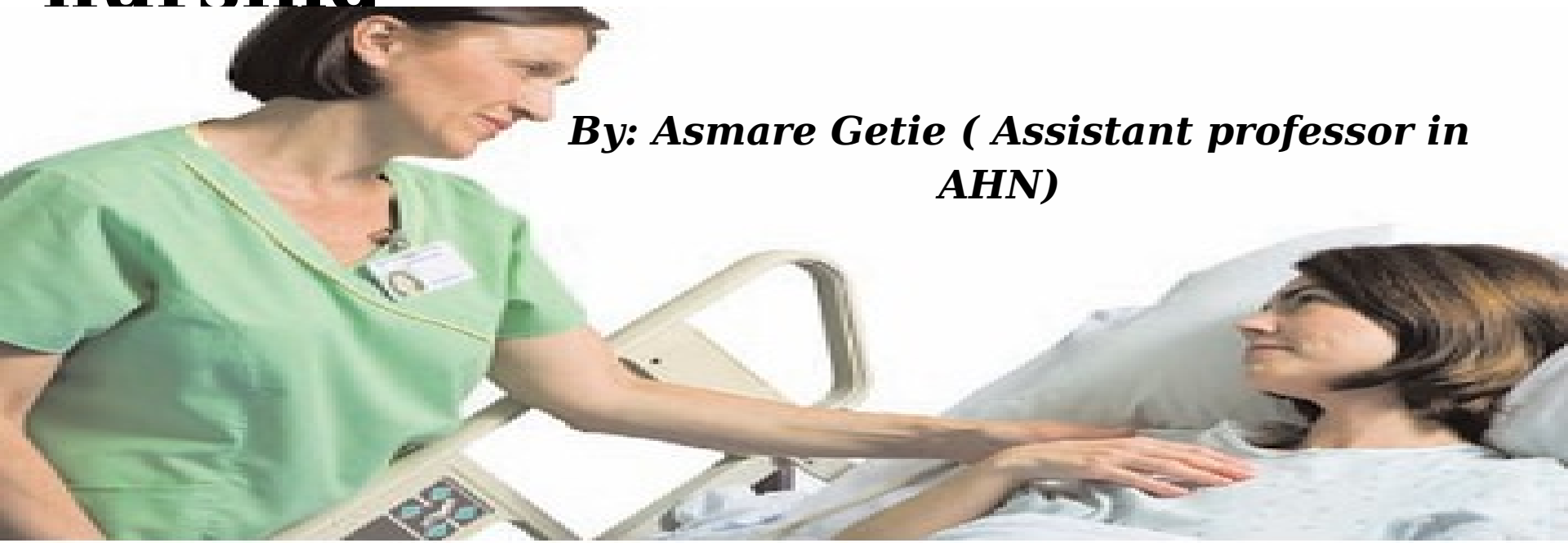
Introduction to Medical Surgical nursing



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Learning objectives

At the end of this session students will be able to

- Define Medical surgical Nursing
- Discuss the roles of medical surgical nurse
- Define health and wellness
- Describe nursing process
- State and carry out nursing process components effectively.

Definitions

Medical-surgical nursing is a nursing specialty area ***concerned with the care of adult patients*** in a broad range of settings.

- It focuses on adult patients with acute or chronic illness and ***their responses to actual or potential alterations*** in health.
- It is one of many specialties in nursing, ***yet its scope is much broader*** than such specialties as cardiovascular or orthopedic nursing.

- **Medical** refers to the study of disease and its treatment, which ***doesn't need surgical intervention***.
- **Surgical** manual and operative procedures for ***correction of deformities*** and ***defects***, repair of injuries, and diagnosis and cure certain diseases with surgical intervention.
- **Nursing is the diagnosis and treatment of human responses to health and illness**.

- The goal of the medical-surgical nursing specialty is to ***promote***, ***restore***, and ***maintain*** the client's health.

Roles and functions MSN

- Recent changes in health care reflect changes in the populations requiring nursing care and a philosophical ***shift toward health promotion*** rather than treatment of illness.

- The role of the medical-surgical nurse has broadened in response to these changes.

Medical-surgical nurses are:

- Caregivers, as always, but now they're also
- Educators,
- Advocates: a person who speaks up for or acts on behalf of the client.
- Coordinators,
- Change agents,
- Discharge planners, and researchers.

In general

- The roles of nurses in the healthcare delivery system are ***multiple*** and ***complex***.
- Nurses collect data, diagnose human responses to health problems, plan and provide care, and evaluate outcomes of care.
- In addition, they participate in ***disease prevention*** and ***health promotion activities*** for clients, families, and communities.

CONCEPTS RELATED TO HEALTH

Health and Wellness

Health

- ☑ No single definition is universally accepted.
- ☑ A common one describes health as a ***disease-free state***.
- ☑ World Health Organization (WHO) defines health as ‘‘a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity’’

wellness

Wellness describes a state of being healthy.

- It is a ***constant*** and ***intentional*** effort to stay healthy and ***achieve the highest potential for total well-being***.
- It requires ***life-style choices*** that assist individuals to strive for and maintain a balance in their physical, occupational or leisure, environmental, intellectual, spiritual, and emotional/social domains.

Illness and Disease

- Theoretically, ***illness*** refers to a state of being sick.
- Illness may be viewed as catastrophic (sudden, traumatic), acute, chronic, or terminal.
- **Disease** refers to a ***pathologic condition*** of the body that presents with ***clinical signs*** and ***symptoms*** and

Cont..

- Illness may be defined as a ***sickness*** or ***deviation from a healthy state***.
- It's considered a ***broader*** concept than disease.
- **Sickness** is a ***process of experiencing symptoms of physical illness*** such as nausea, aches and pain, dizziness, weakness, blurred vision or malaise.
- Disease commonly refers to a ***specific biological*** or ***psychological problem*** that's supported by ***clinical manifestations*** and results in a body system or organ malfunction.

Cont..

- The major difference between illness and disease is that illness is ***highly individual and personal***, whereas disease is something ***more definitive and measurable***.
- For example, a client with ***arthritis*** presents with ***distinct pathologic changes*** associated with the disease. A person, however, may or may not be ill with arthritis.
- The degrees of pain, suffering, and immobility vary with each person.

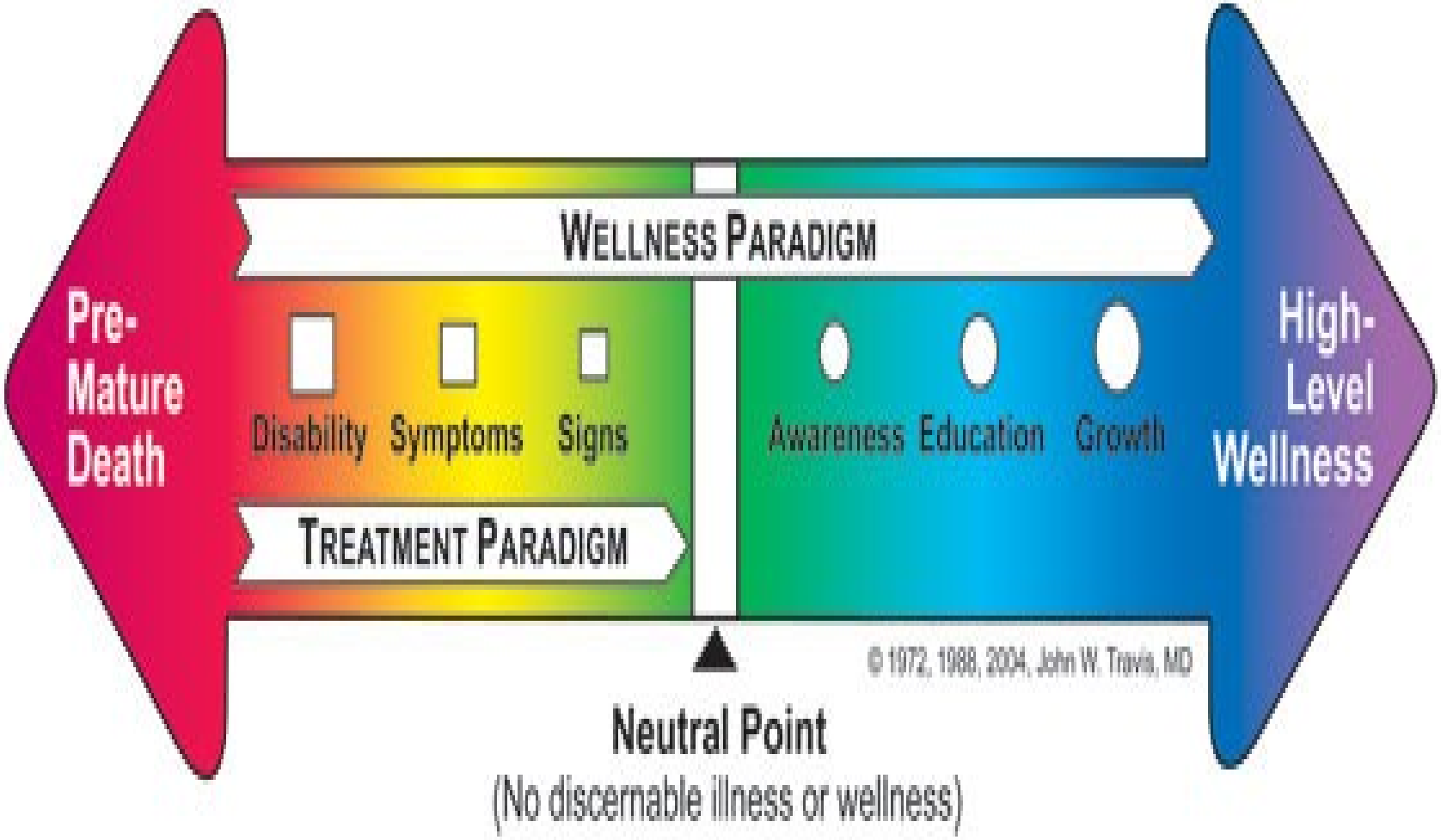
THE ILLNESS-WELLNESS CONTINUUM

- ✓ ***Wellness is a process, never a static state.***
- ✓ Most of us think of wellness in terms of illness; we assume that the absence of illness indicates wellness.
- ✓ There are actually many degrees of wellness, just as there are many degrees of illness.
- ✓ The Illness-Wellness Continuum illustrates the relationship of the treatment paradigm to the wellness paradigm

The role of nurse in IWC

- To help the client to identify their place on the health continuum.
- To assist the client to adopt some measures in order to reach a well state of health.

Illness-Wellness Continuum



IWC…con

- Movement to the **right to the arrows (toward the high level of wellness)** equals an increase in level of health and wellbeing Achieved in three steps ,
  - ✓Awareness
  - ✓Education
  - ✓Growth

IWC

- Movement to the **left to the arrows (towards premature death)** equates a progressively decreasing state of health.
- Achieved in three steps,
  - ✓Signs
  - ✓Symptoms
  - ✓Disability

- Most important is the direction the individual facing on the pathway.
  - ✓ If towards **high level of health** , a person has ***genuinely optimistic*** or ***positive out look*** despite his/ her health status.
  - ✓ If towards **premature death** , a person has a ***genuinely pessimistic*** or ***negative out look*** about his or her health status.

Nursing process

- Is a deliberate problem solving approach for meeting people's health care and nursing needs.
  - is a systematic method of providing care to clients
  - “A series of steps or acts that lead to accomplishment of some goal or purpose”
- One of the most significant advances in nursing has been the ***development and acceptance of the nursing process***.

Advantages of Nursing Process

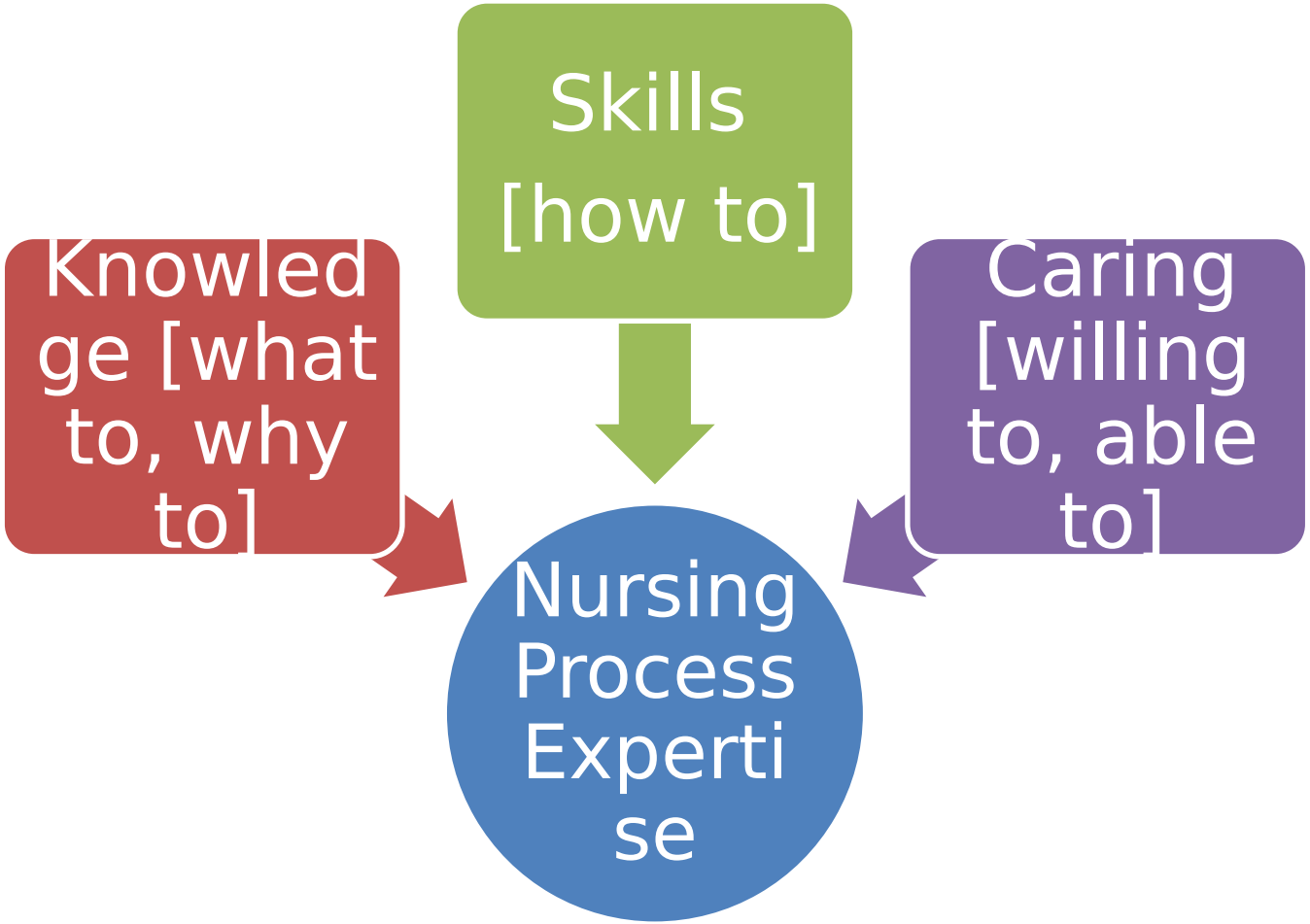
- Provides individualized care
- ***Client*** is an active participant
- Promotes ***continuity*** of care
- Provides ***more effective communication*** among nurses and healthcare professionals
- Develops a clear and efficient plan of care
- Provides ***personal satisfaction*** as you see client achieve goals
- ***Professional growth*** as you evaluate effectiveness of your interventions

Cont..

- The nursing process serves as a guide for ***professional nursing practice***.
- It has the following characteristics;
  - It is a ***framework*** for providing nursing care to individual, families, and communities.
  - It is ***orderly*** and ***systematic***.
  - It's ***interdependent***.

- It is client centered, using the client’s strength.
- It is appropriate for use throughout the lifespan.
- It can be used in all settings.
- Outcome focused (results oriented) - is being tied to what happens at the end of the process.

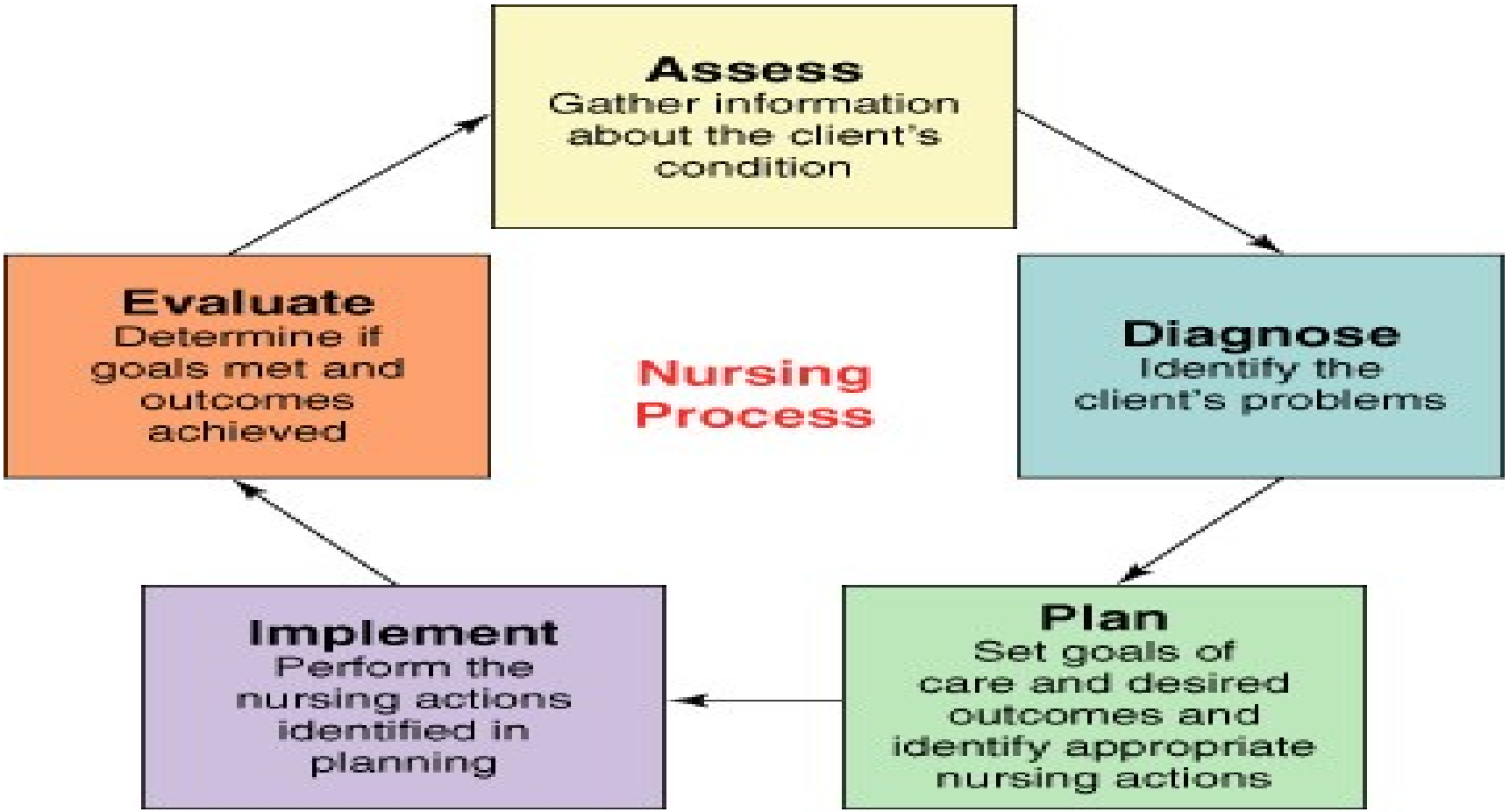
The Heart of the Nursing Process



Comparison of Nursing Process and Medical Process

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

Steps of the Nursing Process



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Assessment

- Systematic collection of data to determine the patient's health status and identify any actual or potential health problems.
- Gather Information/Collect Data
  - **Primary Source** - Client
  - **Secondary Source** - physical exam, nursing history, lab reports, diagnostic tests…..

Types of Nursing Assessment

- Data Base Assessment
  - Performed on initial contact
  - All aspects of health status
- Focus Assessment
  - Performed to gather detailed information about the status of a specific condition
- Emergency assessment
- Time-lapsed assessment

- The data can be objective and subjective
  - Objective data -observable and measurable facts **(Signs).** Blood Pressure 130/80
  - Subjective data -information that only the client feels and can describe **(Symptoms).**
    - "I have a headache"

Reasons for doing assessment:-

- To establish baseline information on the client
- To determine the client's normal function
- To determine the client's risk for dysfunction
- To determine the client's strengths
- To provide data for the diagnosis phase

APPROACH OF HEALTH ASSESSMENT IN NURSING

- There are three commonly used formats for assessment data including
  1. Body system approach
  2. Functional health pattern approach

- **Body system approach**:

  - Is the ***traditional approach*** in which the nurse observe and recorded data about each of the body system
  - This format ***does not usually permit the nurse to collect*** all of the information needed to perform a holistic nursing assessment
  - It is difficult to perform nursing diagnose

STRUCTURES OF MEDICAL APPROACH

- ✓ Biography
- ✓ Chief compliant
- ✓ History of present illness
- ✓ History of past illness
- ✓ Systemic review
- ✓ Physical examinations
- ✓ Medical diagnose
- ✓ Deferential diagnose
- ✓ Diagnostic test
- ✓ Treatment

STRUCTURE (GORDON'S AND MEDICAL APPROACH)

❖ Structure of Gordon's approach

- This Gordon model assesses functional and dysfunctional pattern.
- Dysfunctional health patterns result in:
  - ✓ nursing diagnosis, and
  - ✓ identify risk conditions for problems.
- It assess the following area

Structure of Gordon's approach….

1. Health perception and health management pattern
2. Nutritional & metabolic pattern
3. Elimination pattern
4. Activity-exercise pattern
5. Sleep-rest patterns
6. Self perception and self concept pattern
7. Cognitive and perceptual pattern
8. Role relation ship pattern
9. Sexuality-reproductive pattern
10. Coping-stress tolerance pattern
11. Value belief pattern

Nursing Diagnosis

- The second step in the nursing process involves further **analysis** (breaking the whole down into parts that can be examined) and **synthesis** (putting data together in a new way) of the data that have been collected.

- According to the North American Nursing Diagnosis Association (NANDA)
  - a **nursing diagnosis** is a ***clinical judgment*** about individual, family, or community responses to actual or potential health problems/life processes.
  - Nursing diagnosis is ***unique*** in that it focuses on a client's response to a health problem, rather than on the problem itself.

COMPONENTS OF A NURSING DIAGNOSIS

☞The first component is a problem statement or **diagnostic label**.

- Is the name of the nursing diagnosis as approved by NANDA International
- Describes the essence of a patient's response to health conditions in as few words as possible.

Eg.

- ✓Impaired skin integrity
- ✓Fluid volume deficit
- ✓Risk for infection
- ✓Enhanced self-care

☞The diagnostic label and etiology(second component) are linked by the term related to (RT).

- Always within the domain of nursing practice
- Condition that responds to nursing interventions.

❖ **For example**

- ✓ Disturbed Body Image RT loss of left lower extremity.
- ✓ Activity Intolerance RT decreased oxygen-carrying capacity of cells.
- ✓ Acute pain RT breast cancer.
- ✓ Acute pain related to impaired skin integrity

Descriptive words or terms may be added to clarify specific nursing diagnoses.

- These descriptive words are called ***qualifiers*** and include Acute, Chronic, Decreased, Deficient, Depleted, Disturbed, Dysfunctional, Enhanced, Excessive, Impaired, Increased, Ineffective, Intermittent, Potential for, and Risk.
- These terms specify a degree of qualification for the identified nursing diagnosis and are placed (used) before the problem statement.

☞The third component is **defining characteristics** (collected data that are also known as signs and symptoms, subjective and objective data, or clinical manifestations).

☞The third part is joined to the first two components with the connecting phrase “as evidenced by” (AEB).

✓ Ineffective airway clearance RT fatigue AEB dyspnea at rest

✓ Deficient knowledge RT misinterpretation of information AEB inaccurate return demonstration of self injection

✓ FVD related to fluid loss as manifested by **dry oral mucosa**

✓ Acute pain related to impaired skin integrity as evidenced by **patient verbalization**

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

- Myocardial infarction (heart attack) is a medical diagnosis.
- Examples of nursing diagnoses for a person with myocardial infarction include:
- Fear, Altered Health Maintenance, Knowledge Deficit, Pain, and Altered Tissue Perfusion.

By: Asmare G

Types of nursing diagnosis

- Actual nursing diagnosis
- Risk/potential nursing diagnosis
- Possible nursing diagnosis
- Wellness nursing diagnosis

❖ **Actual Nursing Diagnoses**

- Describe a human response to a health problem that is being manifested.
- They are written as three- part statements: diagnostic label, related factors, defining characteristics.
- **e.g.** Acute pain RT surgical trauma and inflammation, AEB grimacing and verbal reports of pain.
- Impaired skin integrity RT prolonged pressure on bony prominence AEB stage II pressure ulcer over

❖ Risk nursing diagnosis

- As defined by NANDA, ’’describes human responses to health conditions that may develop in a vulnerable individual, family, or community.
- It is supported by risk factors that contribute to increased vulnerability’’.

- Risk nursing diagnoses are two – part statements because they do not include defining characteristics (diagnostic label, risk factors).
- **Example –**
  - Risk for infection related to surgery and immunosuppression.
  - Risk for Impaired Skin Integrity related to inability to turn self from side to side in bed.

- **Wellness nursing diagnosis**
- Is a diagnostic statement that describe the human response to levels of wellness in an individual, family, or community that have a **potential for enhancement to a higher state.**
- Wellness nursing diagnosis are one part statement includes diagnostic label.
- **Example**
  - Readiness for enhanced spiritual well being
  - Readiness for Enhanced Self-Esteem.

Avoiding Errors When Writing Diagnostic Statements

- Don’t write the diagnostic statement in such a way that it may be **legally incriminating**

Example

Wrong:

- High risk for injury related to lack of side rails on bed

Correct

- High risk for injury related to disorientation

Avoiding Errors……

- Don’t state the nursing diagnosis using **medical terminology**
- Focus on the **person’s response** to the medical problems Example

Wrong:

- Dehydration related to vomiting

Correct

- FVD related to fluid loss secondary to vomiting

Avoiding Errors

- Don’t state the nursing diagnosis based on a **value judgment**
- Example
- Incorrect
- Spiritual Distress related to atheism as evidenced by statements that she has never believed in God
- Don’t state **two problems** at the same time.
- Example
- Incorrect
- ✓ Pain and Fear related to diagnostic procedures

Nursing Planning

- This is when the nurse organizes a nursing care plan based on the nursing diagnoses.
- Nurse and client formulate goals to help the client with their problems
- Expected outcomes are identified
- Interventions (nursing orders) are selected to aid the client reach these goals.

The four critical elements of planning include:

- Establishing priorities
- Setting goals and developing expected outcomes (outcome identification)
- Planning nursing interventions (with collaboration and consultation as needed)
- Documenting

Establishing Priorities

- The establishment of priorities is the first element of planning.
- In establishing priorities, the nurse examines the client's nursing diagnoses and ***ranks them in order of physiological or psychological importance***.
- determining which nursing diagnosis will be addressed initially.

Planning…con

- **Setting Priorities**
- To set priorities, look at the identified problems and
- ask some key questions:

✓ What problems need immediate attention (ex. Life threatening problems, pain, discomfort)?

✓ What problems have simple solutions?

✓ What problems must be referred?

- Fundamental Principles of Setting Priorities (Maslow, 1943,)

Priority 1

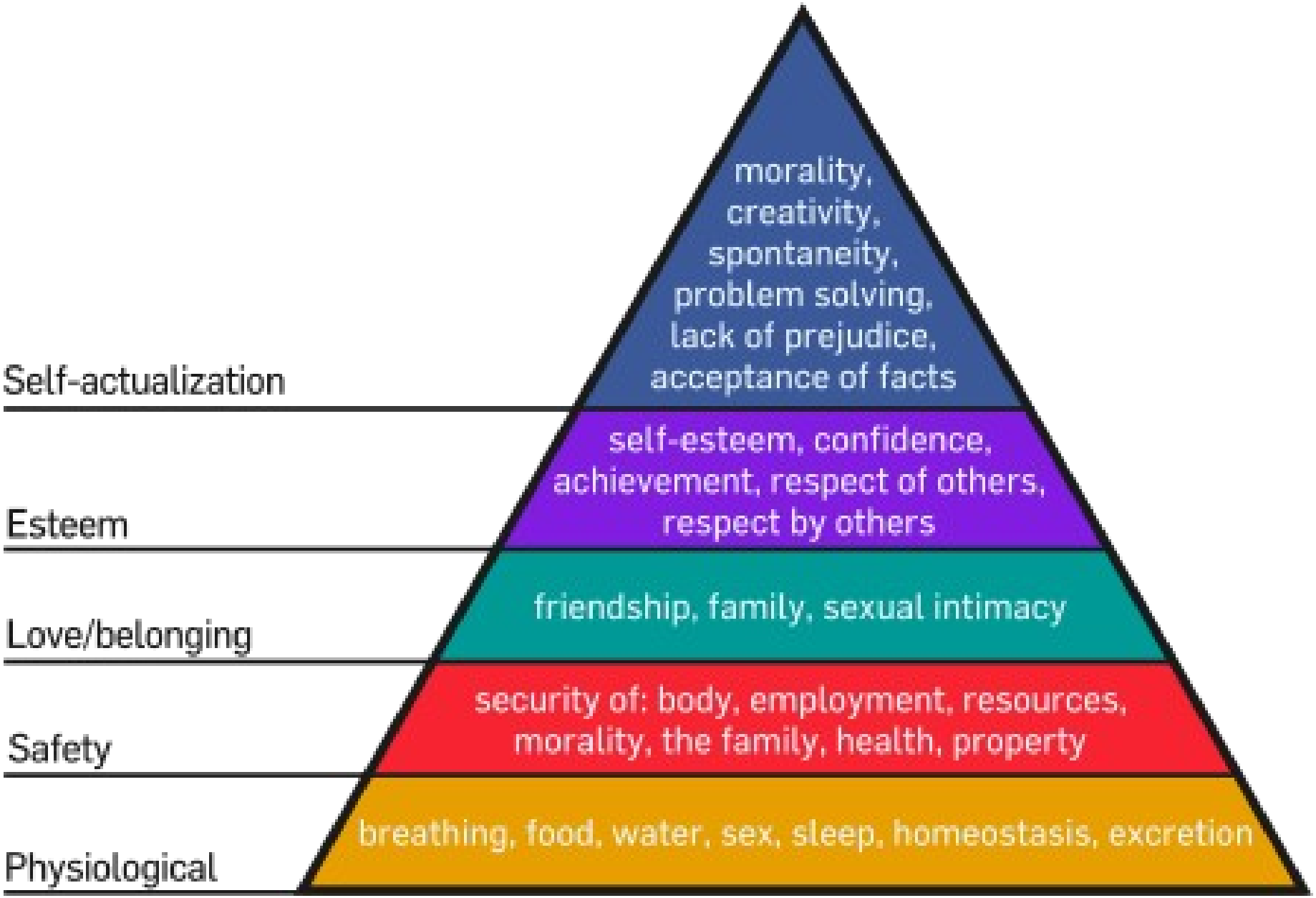
- ✓ Life threatening problems and those interfering with physiological needs.
- ✓ Examples: Problems with respiration, circulation, nutrition, hydration, elimination, temperature regulation, physical comfort

Priority 2

- ✓ Problems interfering with safety and security.
- ✓ Examples: Environmental hazards and fear.

Setting Priorities …con

- **Priority 3**
- Problems interfering with love and belonging.
- Examples: Isolation or loss of a loved one.
- **Priority 4**
- Problems interfering with self esteem.
- Examples: Inability to wash hair, perform normal activities.
- **Priority 5**
- Problems interfering with the ability to achieve personal goals.


morality, creativity, spontaneity, problem solving, lack of prejudice, acceptance of facts
Self-actualization
self-esteem, confidence, achievement, respect of others, respect by others
Esteem
friendship, family, sexual intimacy
Love/belonging
security of: body, employment, resources, morality, the family, health, property
Safety
breathing, food, water, sex, sleep, homeostasis, excretion
Physiological

Establishing Goals and Expected Outcomes

- **A goal** is a broad or globally written statement describing the ***intended or desired change*** in the client's behavior, response, or outcome.
- **An expected outcome** is a detailed, specific statement that describes the methods through which the goal will be achieved.
- GOAL has the following characters tics:

"SMART"

Example

- ***NURSING DIAGNOSIS:*** Disturbed Sleep Pattern

Goal: Client will sleep uninterrupted for 6 hours.

EXPECTED OUTCOMES

- Client will request back massage for relaxation.
- Client will set limits to family and significant other visits.

- ***NURSING DIAGNOSIS:*** Ineffective Tissue Perfusion:

Goal: Client will have palpable peripheral pulses in 1 week.

EXPECTED OUTCOMES

- Client will identify three factors to improve peripheral circulation.
- Client's feet will be warm to touch.

Plan Nursing Interventions

- ✓ Once the goals have been mutually agreed on by the nurse and client, the nurse should use a decision-making process to select appropriate nursing interventions.
- ✓ The nurse uses clinical judgment and professional knowledge to select appropriate interventions that will aid the client in reaching their goal.

Interventions – 3 types

- **Independent (Nurse initiated)**- any action the nurse can initiate without direct supervision
- **Dependent (Physician initiated)**- nursing actions requiring MD orders
- **Collaborative**- nursing actions performed jointly with other health care team members

Writing a client plan of care

Two important concepts guide a client plan of care:

1- The plan of care is client centered.

2- The plan of care is a step – by step process.

- At least one goal must be stated for each nursing diagnosis
- Outcome criteria must be identified for each goal

- Nursing interventions must be specifically designed to meet the identified goal.
- Each intervention should be supported by a scientific rationale.
- Evaluation must address whether each goal was completely met, partially met, or completely unmet.

Making Nursing intervention /actions Specific

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

IMPLEMENTATION

- This is the “Doing” step
- Carrying out nursing interventions (orders) selected during the planning step.
- This includes monitoring, teaching, further assessing, reviewing NCP, incorporating physicians orders and monitoring cost effectiveness of interventions.

- To implement the care plan successfully, nurses need ***cognitive***, ***interpersonal***, and ***technical*** skills.

Process of Implementing

- ✓ Reassessing the client
- ✓ Determining the nurse’s need for assistance
- ✓ Implementing the nursing interventions
- ✓ Supervising the delegated care
- ✓ Documenting nursing activities

Evaluation

- **Final step** of the Nursing Process but also done concurrently throughout client care
- A comparison of client behavior and/or response to the established outcome criteria
- Continuous review of the nursing care plan
- Examines if nursing interventions are working
- Determines changes needed to help client reach stated goals.

Evaluation

- Outcome criteria met? Problem resolved!
- Outcome criteria not fully met? Continue plan of care- ongoing.
- Outcome criteria unobtainable- review each previous step of NCP and determine if modification of the NCP is needed.

Evaluation

- Factors that impede goal attainment:
  - Incomplete database
  - Unrealistic client outcomes
  - Nonspecific interventions
  - Inadequate time for clients to achieve outcomes.

Chart 3-5 • *Steps of the Nursing Process*

Assessment

1. Conduct the health history.
2. Perform the physical assessment.
3. Interview the patient's family or significant others.
4. Study the health record.
5. Organize, analyze, synthesize, and summarize the collected data.

Diagnosis

Nursing Diagnosis

1. Identify the patient's nursing problems.
2. Identify the defining characteristics of the nursing problems.
3. Identify the etiology of the nursing problems.
4. State nursing diagnoses concisely and precisely.

Collaborative Problems

1. Identify potential problems or complications that require collaborative interventions.
2. Identify health team members with whom collaboration is essential.

Planning

1. Assign priority to the nursing diagnoses.
2. Specify the goals.
   a. Develop immediate, intermediate, and long-term goals.
   b. State the goals in realistic and measurable terms.
3. Identify nursing interventions appropriate for goal attainment.
4. Establish expected outcomes.
   a. Make sure that the outcomes are realistic and measurable.
   b. Identify critical times for the attainment of outcomes.
5. Develop the written plan of nursing care.
   a. Include nursing diagnoses, goals, nursing interventions, expected outcomes, and critical times.
   b. Write all entries precisely, concisely, and systematically.
   c. Keep the plan current and flexible to meet the patient's changing problems and needs.
6. Involve the patient, family or significant others, nursing team members, and other health team members in all aspects of planning.

Implementation

1. Put the plan of nursing care into action.
2. Coordinate the activities of the patient, family or significant others, nursing team members, and other health team members.
3. Record the patient's responses to the nursing actions.

Evaluation

1. Collect data.
2. Compare the patient's actual outcomes with the expected outcomes. Determine the extent to which the expected outcomes were achieved.
3. Include the patient, family or significant others, nursing team members, and other health care team members in the evaluation.
4. Identify alterations that need to be made in the nursing diagnoses, collaborative problems, goals, nursing interventions, and expected outcomes.
5. Continue all steps of the nursing process: assessment, diagnosis, planning, implementation, and evaluation.

Summary

- Definitions of medical surgical
- Roles of medical surgical nursing
- Concept relate to health
- The illness-wellness continuum
- Nursing process


THANK YOU