Introduction to Professional Nursing and Ethics

By DESTA S.

CHAPTER ONE

FOUNDATION OF MODERN NRSING

Definition of nursing

Early Definitions of Nursing

- The word nursing come from Latin word **”nutricus”** which means something that nourishes, foster and protect. - a person who is prepared to care for the sick, injured, and aged.
- The word “nurse” has also referred to a woman who suckled or nourishes or to take care of a child or children.

“Nurse”

N- neatness

U- unselfish

R -realistic

S- sensitive

E- enthusiastic, energetic, eager

Definition of nursing cont…

Different people and associations have defined nursing differently.

- **Florence Nightingale**
- **Virginia Henderson**
- **Martha Rogers**
- **Canadian Nurses Association (CNA)**
- **American Nurses Association (ANA)…**

Definition of nursing cont…

Florence Nightingale (1860).

- “The act of utilizing the environment of the patient to assist him in his recovery"

- Nightingale considered a clean, well-ventilated, warmth , no odor and quite environment are essential for recovery.

Definition of nursing cont…

Virginia Henderson(1966)

- "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death)“ that he would perform unaided if he had the necessary strength, will, or knowledge.

- **Virginia Henderson**



Virginia Henderson
1897-1996

Definition of nursing cont…

Martha Rogers

- “Nursing is a learned profession, a science and an art
- The science of nursing is an organized body of abstract knowledge, a synthesis of facts and ideas
- The art of nursing refers to use of this knowledge in the delivery of nursing care for human betterment(The science of Unitary Man, 1970)

Definition of nursing cont…

Canadian Nurses Association (CNA)

- Described nursing practice as a **dynamic, caring, helping** relationship in which the nurse **assists** the client to achieve and obtain optimal health.

Definition of nursing cont…

American Nurses Association (ANA)

- "Nursing is the diagnosis and treatment of human responses to actual or potential health problems".(ANA, 1980)
- In 2003, the (ANA) changed this definition of nursing to " Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering though the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities and populations"

Definition of nursing cont…

INTERNATIONAL COUNCIL OF NURSES (ICN)

- Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings.
- Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people.

Definition of nursing cont…

N.B. Despite the multitude of definition of nursing, **Certain themes are common to many of these definitions**

- Nursing is an art.
- Nursing is a science
- Nursing is caring.
- Nursing is client centered
- Nursing is holistic
- Nursing is a helping profession.

History and Development of Nursing

- It is difficult to trace the exact origin of the nursing profession. However, moral action is the historical basis for the creation, evolution and practice of nursing.
- By learning from historical role models, nurses can enhance their abilities to create positive change in the present and set a course for the future.

History and Development of Nursing cont…

Nursing in ancient civilization

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

History and Development of Nursing cont…

Nursing in ancient civilization cont…

- In the Babylonian civilization, there were references to tasks and practices traditionally provided by nurses.
- Nurses are mentioned occasionally in old Evidence as women who provide care for infant, for the sick and dying and as midwives who assisted during pregnancy and delivery.

History and Development of Nursing cont…

Nursing in ancient civilization cont…

- The ancient Greeks believed in Apollo, the Greek god of healing and prayed to him for magic cures for their illness.
- In 460 BC Hippocrates born and credited with being the Father of medicine.
- He proved that illness had natural cause and not to be of a religious or magical cause.

History and Development of Nursing cont…

Nursing in ancient civilization cont…

- In ancient India, male nurses staffed early Hospitals and women served as midwives and nursed ill family members.

History and Development of Nursing cont…

Nursing in the Middle Ages

- During this time, monasticism and other religious groups offered the only opportunities for men and women to pursue careers in nursing.
- It was the Christian value of **"love the neighbor as the self"** that had a significant impact on the development of western nursing.

History and Development of Nursing cont…

Dark Age of Nursing

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

The development of modern Nursing

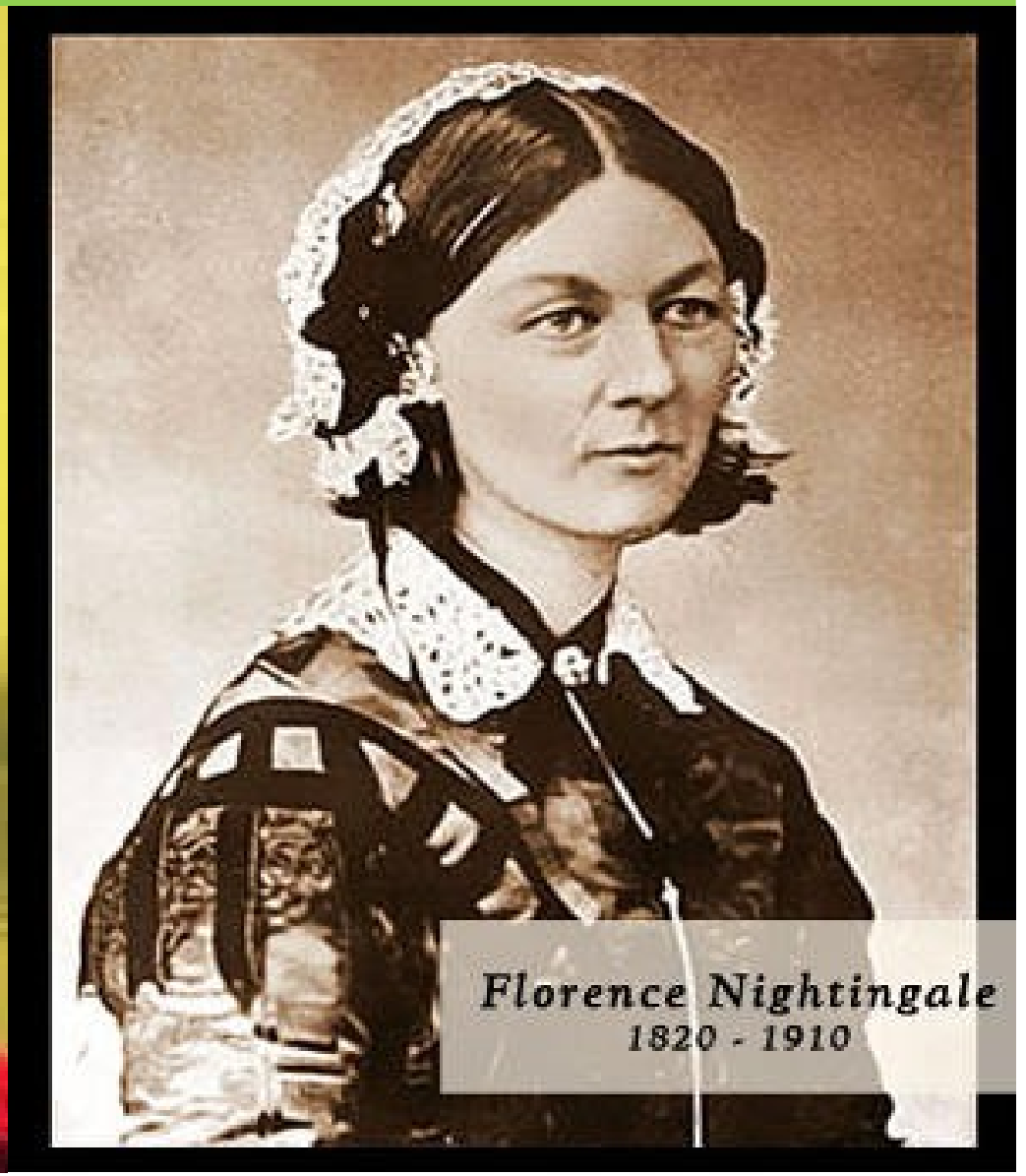
- Until the 1800s, nursing had been closely connected with church related organizations and hospitals. In particular with the **Catholics and the Protestants.**
- Nursing was not organized into a professiond
- By the middle of 18th century and the beginning of 19th century, nursing services started to be delivered by civil nurses
- In the latter half of the 19th C, as a respected field.

Florence Nightingale (1820-1910)



FLORENCE NIGHTINGALE





The development of modern Nursing cont…

Florence Nightingale

- Florence Nightingale is considered the founder of modern nursing. **(Mother of modern nursing).**
- She was born on **12 May 1820**. She had rich parents.
- She grew up in a wealthy upper-class family in England during the mid-1800s.

The development of modern Nursing cont…

Florence Nightingale…

- By the age of 17 she had mastered several languages and mathematics and was extremely well read.
- She believed she was **"called" by God** to help others/sick and to improve the wellbeing of mankind.
- Florence announced her decision to enter nursing in **1844,** despite the intense anger and distress of her mother and sister.

The development of modern Nursing cont…

Florence Nightingale cont…

- After completing the **3-month course** of study at **Kaiserwerth Institute**, Germany, which is the **1st formally established school of nursing in the world**, and then continued her studies with the Sisters of charity of St. Vincent de Paul in Paris.

The development of modern Nursing cont…

Florence Nightingale cont…

- Her goal was to change the social view of nurses from the low to that of **well - educated care givers**.
- Nightingale worked to free nursing from the bonds of the church.
- She saw nursing as a separate profession from the church.

The development of modern Nursing cont…

Florence Nightingale cont…

- During the Crimean war, A public out cry over the danger of the British soldier caused the British government to seek resolution of this problem.
- The secretary of the war, **Sir Sidney Herbert**, contacted miss Nightingale and requested her to give care to the wounded soldiers.
- On 21 October 1854, she and a staff of 38 women volunteer nurses, trained by Nightingale ,were sent.

The development of modern Nursing cont…

Florence Nightingale cont…

- She insisted that soldiers be **bathed,** their wounds **dressed**, and **unspoiled/unchanged food be fed** to the sick.
- A **pure water** supply was established.
- As a result of Nightingale's efforts, the mortality rate declined to approximately **2%.**
- Florence Nightingale's most famous contribution came during this time.



Florence became known as the ‘lady with the lamp’. She walked around the hospital carrying her lamp.

The development of modern Nursing cont…

Florence Nightingale cont…

- The implementation of her principles in the areas of nursing practice and environmental modifications resulted in **reduced** morbidity and mortality rates during the war.
- The achievements of Florence nightingale in the war were so outstanding that she was recognized by the queen of England who awarded her the Order of Merit.



Development of modern Nursing cont…

Florence Nightingale cont…

- When she returned to England She established the Nightingale Training School of Nurses at **St. Thomas' Hospital** in London, the school served as a model for other training school.
- This was the first school for nurses that provided both **theory-based** knowledge and **clinical skill** building.

Development of modern Nursing cont…

Florence Nightingale cont…

- St. Thomas' Hospital in London.



Development of modern Nursing cont…

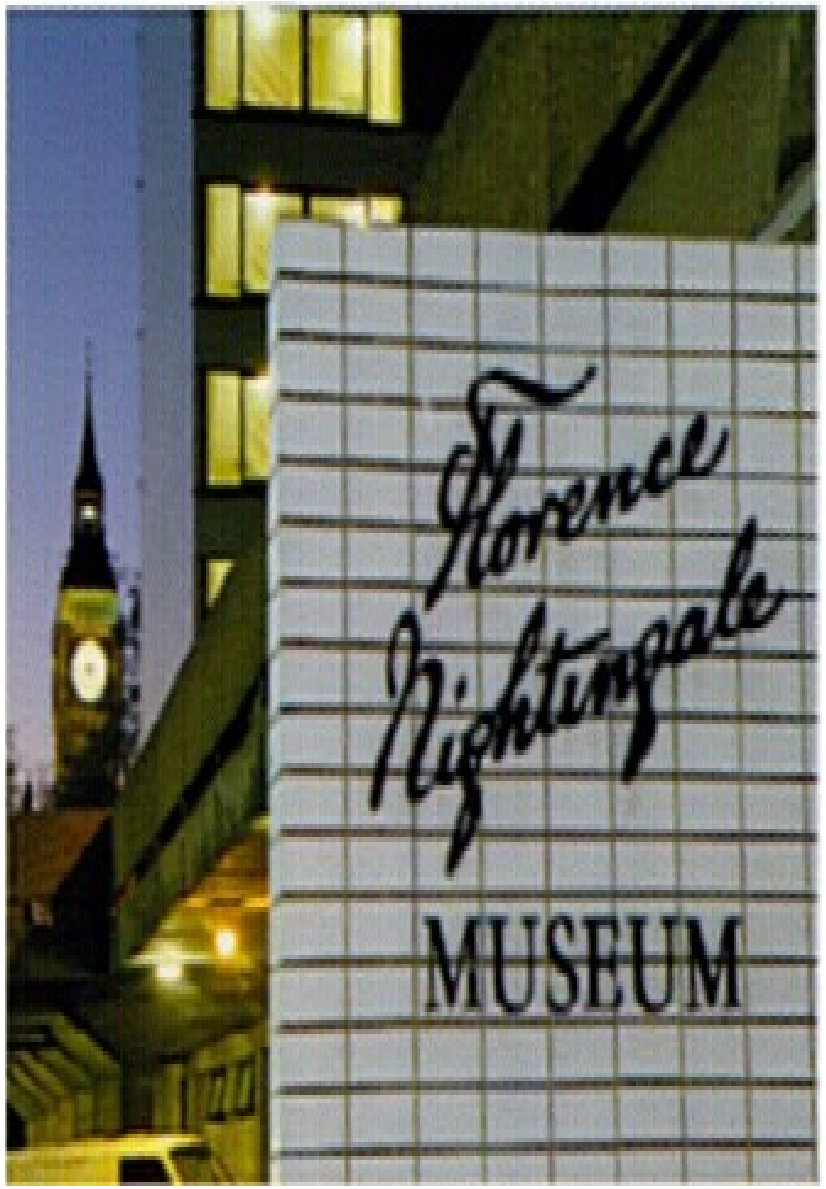
Florence Nightingale cont…



- Florence died at home on August 13, 1910. She was 90 years old.

Development of modern Nursing cont…

- **Florence Nightingale**
  - She changed hospitals all over the world.
  - Nursing became a respected profession because of her.
  - There is a museum in London which celebrates her life and work



History of Nursing in Ethiopia

- In ancient Ethiopia **illness** was considered to be **punishment from sins or magic.**
- Most tribes and people had a medicine man or women called **"Hakims" or wegasha"** who performed rituals, using various **plants and herbs** to heal the sick.
- The religious people were also providing care for the sick or injured in the **monks‘ hospital in Debrelibanos.**

History of Nursing in Ethiopia cont…

- In late 19th century before nurses training started, **foreign nurses** were practicing in the health care delivery system of Ethiopia.
- In 1917 **Sister Karin Holmer** came as trained nurse to Ethiopia.
- In **1908, Emperor Menelik II** established the **1st Governmental p/health**
- In **1909**, the first **hospital Menelik II** was built in Ethiopia.

History of Nursing in Ethiopia cont…

- **Dejasmatch Balcha Hospital** was established in **1948.**
- The **Princes Tsehay memorial Hospital (Army Hospital)** was opened in **1951.**

History of Nursing in Ethiopia cont…

- **Princess Tsehai** was the first graduated national nurse from **Ormond street hospital** London.
- Sister Mahret Paulos is probably the second Ethiopian nurse graduate in Jerusalem in 1942.
- Sister Sambatu Gabru graduated from Beirut in 1949 is the third Ethiopian trained nurse.
- In 1949 the first School of Nursing (The Ethiopian Red Cross) was opened in private Hospital Bet- Saida which later changed to Haleslassie I Hospital. Then during the Derg regime, this hospital is changed its name to Yekatit 12 hospital, which still exists.

History of Nursing in Ethiopia cont…

- In **1950**, the school of nursing was established at **Empress Zewditu memorial hospital** for **male and female nurses.**
- In **1951**, two school of Nursing was established: **princess Tsehai memorial** only for female nurses and in **Nekemt at the Teferie Mekonnen Hospital.**
- In March 1953, the first **eight** nurses from **Ethiopian Red Cross of nursing** and **nine** from **Empress Zewditu** memorial hospital were graduated.

History of Nursing in Ethiopia cont…

- In **1954 the Gondar Health College** and training center(The current Gondar College of Medicine and Health Sciences) opened and gave training to **community nurses.**
- In **1958 Fifteen community nurses** graduated from this center.
- Those community nurses graduated from Gondar were basically working in the **community while the other schools train bed side nurses who work mainly in hospital settings.**

History of Nursing in Ethiopia cont…

- The **Baccalaureate degree Program was** started in Jimma university in1993.
- Later on the Program continued in Dilla (Now Hawassa University), Alemaya(Now Haramaya University) and Gondar(University of Gondar).
- The master's Program has been proposed in September, 2005 in Ethiopia in Addis Ababa University and University of Gondar us also launched the master program in nursing in September 2011.

Nursing as a profession

- **A profession** is a learned vocation or occupation that requires advanced training in specialized field, and that involves intensive academic preparation Such as engineering, medicine, teaching, and nursing .
- It needs widely varying levels of training or education, skills and variable knowledge base.
- **Occupation:** is a job by which somebody obtain money in return for labor or services and performed with minimum requirements.
- All professions are occupations but not all occupations are professions

Nursing as a profession cont…

Criteria of a profession

- A clearly defined, highly developed, specialized, and theoretical knowledge base
- Preparation for the profession includes an extensive period of training to apply that knowledge in an institution (professional school or university campus), and internship.
- The body of specialized knowledge is continually developed and Evaluated through research.

Nursing as a profession cont…

Criteria of a profession cont…

- Provides a specific service and demonstrates a commitment to public service and receives compensation through limited fees rather than direct profits.
- The members are self organized and collectively assume the responsibility of establishing standards for education and practice.

Comparison between Profession and occupation

Occupation	Profession
Training may occur on job	Education takes place in College and university
Length of training varies	Education is definite and prolonged
Largely manual work	Mental creativity
Values, beliefs & ethics not part of preparation	Values, beliefs & ethics integral part of preparation
Commitment may vary	Strong commitment
Works are Supervised	Works are Autonomous
People Often change jobs	People Unlikely to change professions

International and national nursing association

- Associations are organizations of persons with common interests.
- As the number of nurses increased the activities and problem in connection with work also increased.
- A professional association is an association of practitioners who judge one another as professionally competent and who banded together to perform social function’s which they can not perform in their separate capacities as individual.

International and national nursing association cont...

Functions of Nursing Associations

- Defining and regulating the profession through setting and enforcing standard of education and practice for generalist and specialist.
- Developing the knowledge base for practice in its broadest and narrowest components.
- Communicating and advocating the value and contribution of field to several publics and populations.

International and national nursing association cont…

Functions of Nursing Associations cont…

- **Transmitting values, norms, knowledge, and skill to** nursing students, new graduates and members of the profession for application in practice.
- Professional associations give their member **social and moral support** to perform their roles as professionals and cope with professional problems.

International and national nursing association cont...

International Council of Nurses(ICN)

- ICN was established in **1899.**
- Nurses from Great Britain, the United States, and Canada were among the founding members.
- **In 1993, 111 national Nurses Associations** representing 1.4 Million Nurses worldwide were affiliated with the ICN.
- The ICN provides an organization through which member of national Nursing Association can work

International and national nursing association cont…

Ethiopian Nurses Association

- Was established 6th may, **1952,** in Addis Ababa by the Ethiopian government.
- **Princess Tenagnework Hailesilassie** was the patron of the association.
- There were **15** member when 1st constituted.
- The Ethiopian Nurses Association becomes a member of ICN in May 1957.

International and national nursing association cont…

Ethiopian Nurses Association cont…

- **The aim of the Ethiopian Nurses Association was**:
  - Discuss and solve problems affecting nurses.
  - Setting higher standards in nursing

Role of the professional nurse

- Care provider/Caregiver
- Communicator / Helper
- Teacher/educator
- Counselor
- Client advocator
- Change agent
- Leader
- Manager
- Researcher

Role of the professional nurse cont…

- **Care provider:**
  - Caring involve knowledge and sensitivity to what matter and what is important to the client.
- **Communicator / helper:**
  - Effective **communication** is an essential element of all helping profession, including nursing.
  - It helps the client to explain the internal feeling.
  - Nurses communicate with the client, support persons, other health professionals, and people in the community

Role of the professional nurse cont…

- **Teacher/educator:**
  - the nurse helps clients learn about their health and the health care procedures they need to perform to restore or maintain their health.
- **Counselor:**
  - Counseling is a process of helping a client to recognized and cope with **stressful psychological or social problems.**
  - It involves providing emotional, intellectual, and

Role of the professional nurse cont…

- **Client advocator:**
  - In this role the nurse may **represent the client's need** and wishes to other health professional.
- **Change agent:**
  - A change agent is a person or group who initiates changes or who assists others in making modification in them selves or in the system.

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Role of the professional nurse cont…

- **Leader:**
  - Influences others to work together to accomplish a specific goal. The leader role can be employed at different levels: individual client, family, groups of clients, colleagues, or the community.
- **Manager:**
  - Management defines manager as who plans, gives direction, monitoring operations, giving rewards fairly and representing both staff member and administration as needed

Role of the professional nurse cont…

- **Researcher::**
  - Nurses often use research to improve client care. In a clinical area, <u>nurses need to:</u>

    Awareness of the process and language of research.

    Be sensitive to rights of human subjects.

    Identification of significant researchable problems.

WE ALL ARE PROUD OF BEING A NURSE !!!!!!!!!!!!!!!!!!





UNIT TWO

Individual Assignment(10%)

1. Write about Nursing Theories

2. Write and explain about Types of Nursing Theories

UNIT THREE

HEALTH, ILLNESS AND HEALTH CARE SYSTEM

Learning objectives

At the end of this unit, each student will be able to

- Define health and illness
- Mention the limitation of WHO definition of health
- Differentiate the concepts disease, illness and sickness
- Explain the importance of health models to the profession of nursing
- Discuss the commonly used health models in nursing

Concepts of Health and Illness

- Health and illness are relative concepts which are perceived differently by different individuals.
- **Health:** is a goal shared by a number of health professionals, emerged as a central goal in nursing in the writings of nightingale in the mid of 1800’s.
- Health is accepted as more than the absence of disease and that concept is becoming more emphasized in nursing.

Definitions of health

- According to World Health Organization (WHO), 1948, health is defined as **“ a state of complete physical, mental and social well-being, not merely the absence of disease and infirmity.”**

- Health in its abstract form refers to a person’s physical, mental and spiritual state. It can be positive (as being in a good health) or can be negative (as being in poor health).
- The state of Positive Health implies the notion of **“perfect function of the body and mind (the hardware and the software in computer science).”**

- Is a person healthy if free from disease?
- What about people who are clinically disease free but are continues compliant by feelings of depression or even specific aches and pains? Are this people well?
- What of the person who may clinically has some disease such as cancer that has not yet presented symptoms and has not yet been clinically diagnosed? He feels good, produces well and perceives him self as healthy, is this person well?

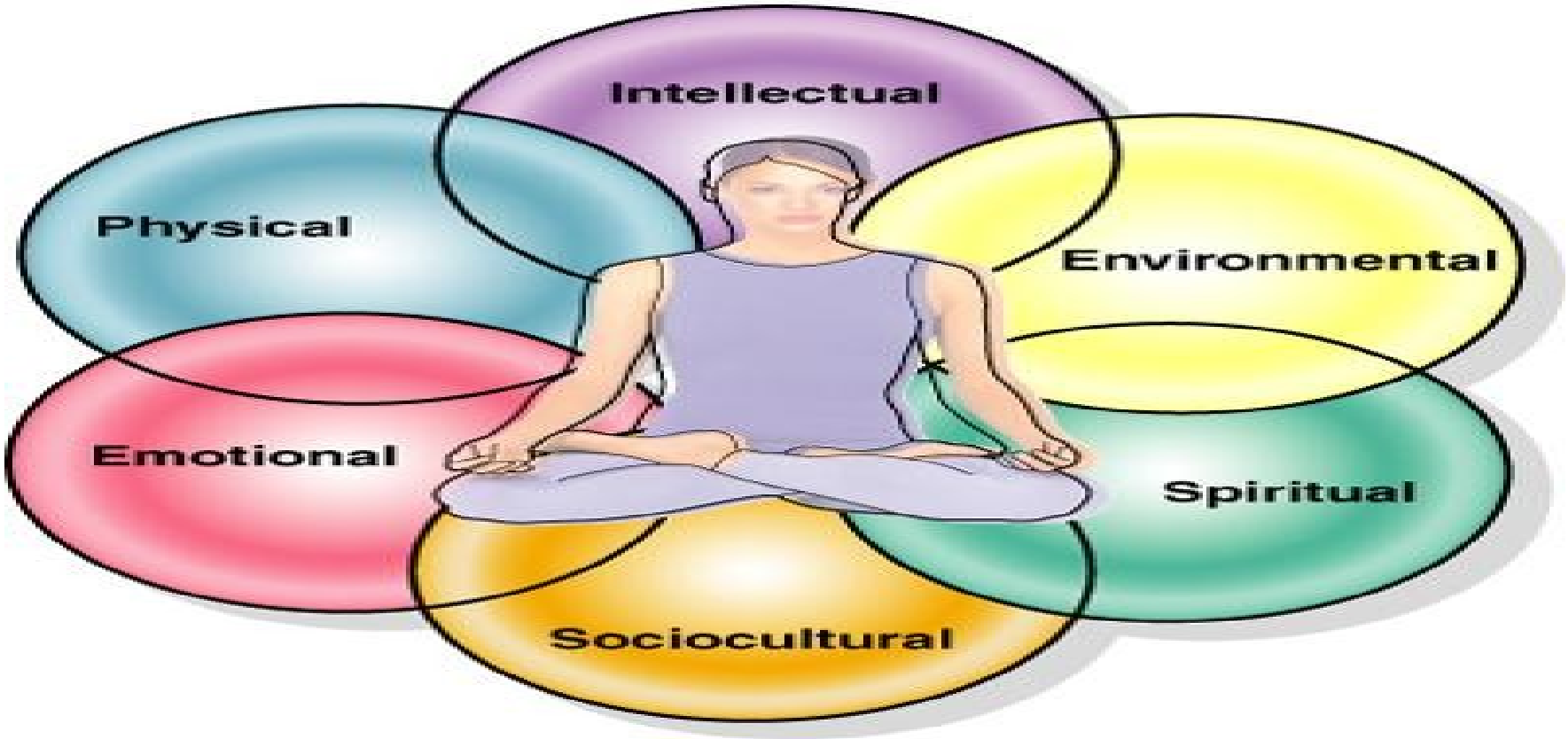
The limitations of the WHO definition of health

- Such a definition of health does not allow for any variation in the degrees of wellness or illness.
- The limitations of the WHO definition of health are clear in relation to chronic illness and disability.
- A chronically ill person cannot meet the standards of health as established by the WHO definition.

Human Dimensions of Health

- **Physical health**: concerned with anatomical integrity & physiological functioning of body
- **Mental health**: the ability to learn & think clearly and coherently
- **Social health**: the ability to make & maintain acceptable interaction with other people
- **Spiritual health**: relate health with religion. It has to do with personal value, belief, principles & ways of achieving mental satisfaction
- **Emotional health**: the ability of expressing emotions with the appropriate way. E.g.. Fear, tension, anger

The Human Dimensions Composing the Whole Person



According to Illis, 1975, health is defined as:

- Health describes the ability to adapt to changing environments to growing up & to aging, to healing when damaged, to suffering & to peaceful expectation of death.

According to Brody and Sobel, 1981, health is defined as:

- The ability of a system (e.g. cell, organism, family, society) to respond adaptively to a wide variety of environmental change.

According to Florence Nightingale health is defined as:

- Health is the ability to use well every power one has.

Cont…

- Each person has a personal definition of health.
- Some people describe their state of health as “good,” even though they may actually have one or more diagnosed illness.
- That is because each person defines health in relation to personal expectations and values

Cont…

Wellness

- A state of being healthy
- Is freedom from sickness or illness, freedom from disease state

Illness

- A state of being sick
- Illness is a highly personal state in which the person feels unhealthy.
- It is highly subjective; only the individual person can say he or she is ill

Cont…

disease

- Indicates a change in the structure or function of a person's body or mind.
- Disease is a medical term, meaning that there is a pathologic change in the structure or function or the body or mind.
- Conditions that impairs the normal body function

sickness

- Is loss of social role function due to disease or illness,

Models of Health and Illness

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

1. The Agent – Host - Environment Model

- It also called **Ecologic Model.** This model helps to identify the cause of an illness.

In this model:

- **Host:** Refers to the person (or group) who may be at risk for or susceptible to an illness.
- **Agent:** is any factor (internal or external) that can lead to illness by its presence.
- **Environment:** refers to those factors (physical, social, economic, emotional, spiritual) that may create the likelihood or the predisposition for the person to develop disease.

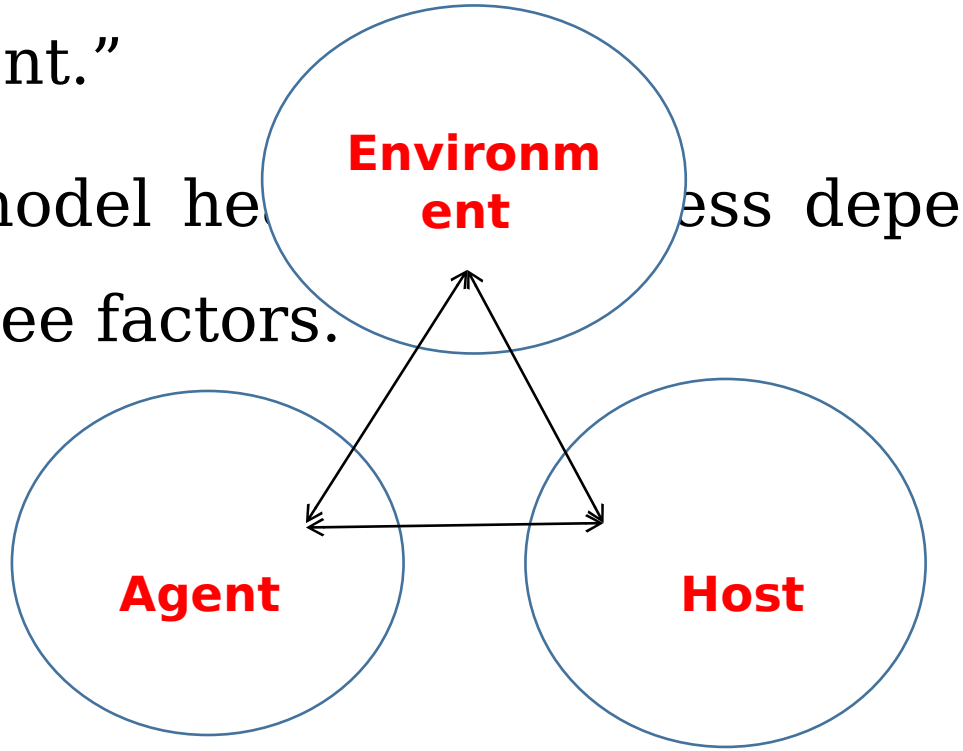
1. The Agent – Host - Environment Model…

- According to this model health is an ever (always) changing state and illness depends on interaction of the **host, agent** and **environmental factor**.
- When the agent, host and environment variable are in equilibrium health is maintained.
- On the other hand when the balance is disrupted disease occurs.

1. The Agent – Host - Environment Model…

Agent-Host-Environment concept defines health as “a state in which the host remained resistant to pathogenic agents in the environment” and disease as “state resulting from the susceptibility of the host to pathogenic agents in the environment.”

- In this model he ess depends on the interaction of these three factors.



1. The Agent – Host - Environment Model…

- To prevent the disease it should be sufficient to modify one (but preferably more than one) of the factors on the corners of the triangle.
  - To immunize the host
  - To develop a protective environment
  - To remove the agent

1. The Agent – Host - Environment Model…

Note that this model is also helpful in thinking about non-communicable disease.

- An occupational injury is more likely when there is a dangerous agent (chemical, biological or physical hazard), a susceptible host (a worker who is inadequately protected) and a hazardous working environment (poor supervision, inadequate culture of safety,…)

2. The Health Illness Continuum Model

- It Measures a person's perceived level of health.
- According to this model, health is a constantly changing state with high – level wellness and death being on opposite ends of a graduated scale, or continuum.
- The Nurse must be aware that a client with a chronic illness may place himself at different points on the continuum at any given time depending on how will he believes himself to be functioning for his

3. High-Level Wellness Model (Dunn, 1961)

This model describes high level wellness as functioning to one's maximum potential while maintaining balance, and purposeful direction in the environment.

The concept of high – level wellness can be applied to the individual, family, community, environment and society.

Dunn differentiates **"Wellness"** from **"good health"** believing that good health is a passive state wherein the person is not ill. **Wellness**, on the other hand, is a more

3. High-Level Wellness Model (Dunn, 1961)…

Dunn’s model is holistic, allowing the nurse to care for the total person with regard for all dimensional factors affecting the person’s state of being as he or she strives to reach maximum potential.

4. Health Belief Model

- It is based on what people perceive, or believe, to be true about themselves in relation to health.

❖This model is based on three components:

1. Perceived susceptibility to a disease

- Is an individual's belief that he/she either will or will not contracting a disease? Perceived susceptibility may range from being **very afraid of contracting a disease** to **complete denial that certain behaviors will result in illness**.

For example; the person smoking may believe smoking will pose no serious threat and will continue to smoke.

2. Perceived seriousness of a disease

Involves two factors:

- Seriousness of the disease and
- Its perceived effect on the person's life style.

This component is based on **how much the person known about the disease and can result in a change in health behavior.**

If the person who smokes believes the lung cancer could lead to physical disability or death and would affect his ability to work and care for his family, he is more likely to stop smoking.

3. Perceived value of action

- Is concerned with how effective the individual believes preventive measures in preventing illness.
- It is influenced by **two** factors:
  - Conviction that carrying out a recommended action will prevent or modify the disease and the person's perception of the cost and
  - Unpleasant effects of performing the health behavior (as compared to taking no action at all).

Based on this components, the person may believe that stopping smoking will prevent altered respiratory function and that the initial withdrawal symptoms can be overcome, and therefore will stops smoking.

- The health belief model enable nurses to understand **why people practice health behavior and also to predict some of the circumstances under which people's health behavior will change.**

5. Clinical Model (Dunn, 1961)

- In this model, health is interpreted as the absence of signs and symptoms of disease or injury; thus the opposite of health is disease. Dunn defined, in this model,
- **“health as a relatively passive state of freedom from illness, and a condition of relative homeostasis.” Illness is therefore, something that happens to a person.**

Factors affecting Health and illness

1. **Physical dimension-** genetic make up, age, developmental level, race and sex

2. **Emotional dimension-** how the mind and body interact to affect to body function and to respond to body conditions also influences health. E.g. long term stress affects the body systems, anxiety affects health habits.

3. **Intellectual dimension-** encompasses cognitive abilities, educational background and past experiences.

4. Environmental dimensions- the environment has many influences on health and illness. Housing sanitation, climate, pollution of air, food and water

5. Sociocultural dimensions- health practices are strongly influenced by a person's economic level, life style, family and culture.

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

Nursing care as preventive care

Level of preventive care

The focus of health care today is on preventive care.

- **Primary level preventive care-** is directed toward health promotion and specific protection against illness. Activities at this level may focus on individuals or groups. Example: immunizations, FP services, & health teaching.
- **Secondary level preventive care –** focuses on health maintenance for clients' experiencing health problems or on prevention of complications of disabilities. Example: skin care, giving medications,…

Nursing care as preventive care…

- **Tertiary level of preventive care –** it focuses on restoration, blocking further damage and rehabilitation of injured people. E.g. teaching a diabetic client how to recognize and prevent complications.

THANK YOU!!!

UNIT FOUR

Ethico-legal aspects to nursing

Objectives

At the end of this lesson the students will be able to:

- Define the term ethics and morality
- Discuss the common ethical theories
- Identify major ethical principles
- Recognize the ethical dilemma and ethical decision making in nursing
- Describe general legal issues as they apply in Nursing
- Describe the purpose and essential element informed consent.
- Describe ways standards of care affecting nursing practice
- Identify nursing code of ethics at the International and the national level
- Recognize the importance of record keeping
- List information that needs to be included report

Ethics and Morality

- Ethics is derived from the Greek word ethos, which means **custom or culture**, **a manner of acting** or **constant mode of behavior .**
- It can be defined as the branch of philosophy dealing with standards of conduct and moral judgment.

Ethics and Morality…

- **Ethics** refers to the **practices** or **beliefs of a certain group** (i.e. Nursing ethics, medical ethics).
- **Ethics** is concerned **what ought to be**, **what is right, or wrong, good or bad.**
- It is professionally and publicly stated.
- Ethics in nursing practices concerns with **nurses conduct** in to different things i.e. truth or false, right or wrong.
- It is the science that allows to make decisions about what is right or wrong.

Ethics and Morality…

- **Morality**
  - Derived from the Latin “mores”, means custom or habit.
  - Morality usually refers to an individual’s personal standards of what is right and wrong in conduct, character, and attitude.
  - It is private or personal.

Nursing Ethics -: is part f the broader called bioethics which consists of a system of principles concerning the actions of the nurse in his/her relationships with patients, patients’ family members, other health care providers, policy makers, and society as a whole.

Types of ethics

- **Descriptive:**
- **Normative**:
- **Analytical:**

Types of ethics …

- **Descriptive:**
  - It is the **description of the values and beliefs** of various cultural, religious or social **groups** about health and illness.

    What do people think is right?
- **Normative:**
  - **attempt to identify human actions that are right or wrong and good and bad qualities.**
  - **How should people act?**

Types of ethics …

- **Analytical:**
  - Analyzes the meaning of moral terms.
  - It seeks the reasons
    - **Why these action or attitudes are either wrong or right?**
    - **How do we take moral knowledge and put it into practice?**

Common Ethical theories

- Deontology
- Teleology
- Intuitionism
- The ethics of caring
  - Ethical theories may be compared to lenses that help us to view an ethical problem.

Common Ethical theories

1. Deontology/(Duty or rule-Based theory)-: This theory proposes that the rightness or wrongness of an action depends on the nature of the act rather than its consequences.

- This theory holds that you are acting rightly when you act according to duties and rights.
- The theory denotes that duties and rights are the correct measuring rods for evaluating action. E.g. informed consent, respect of patient.

2. Teleology/ (utilitarian or end based theory)

- This theory looks to the consequences of an action in judging whether that action is right or wrong.
- According to the utilitarian school of thought right action is that which has greatest utility or usefulness.
- Utilitarian hold that no action in itself is good or bad, the only factors that make actions good or bad are the outcomes, or end results that are derived from them.
- The morality required or ethical action is based on best outcomes.

3. Intuitions

- The notion that people inherently know what is right or wrong: determining what is right or wrong is not a matter of rational thought or learning.
- **For example:** nurse inherently known it is wrong to strike a client, this does not need to be taught or reasoned out.

4. The ethic of caring (case based theory)

- Unlike the preceding theories which are based on the concept of fairness (justice) an ethical caring is based on relationships.
- It stresses courage, generosity, commitment, and responsibility.
- Caring is a force for protecting and enhancing client

Which of the following principles applies to utilitarian action guiding theory?

A. The rightness or wrongness of an action depends on the consequences the action produces.

B. An action is right or wrong independent of the consequences it produces.

C. An action is right or wrong depending on the nature of the act rather than its consequences.

D. The rightness or wrongness of an action is not depending on the nature of the act rather than its consequences.

Ethical Principles

- Principles are basic ideas that are starting points for understanding and working through a problem.
- Ethical principles presuppose that nurses should respect the value and uniqueness of persons and consider others to be worthy of high regard.

Ethical Principles…

- **The major principles of nursing ethics are:**
  - **Autonomy-** self **–** government
  - **Beneficence –** Doing good
  - **Nonmaleficence-** Avoiding harm
  - **Justice-** fairness
  - **Veracity –** Truth telling
  - **Confidentiality-** Respecting privileged information
  - **Fidelity-** Keeping promise

Ethical Principles…

- **Autonomy**
  - Agreement to respect another's right to self-determine a course of action
  - Support of independent decision making.
  - **The nurse respects a client's right to make decisions even when those choices seem to the nurse not to be in the client's best interest.**

Ethical Principles…

- **Beneficence –** Doing good
  - Taking positive action to help others
  - Nurses are obligated to do good, that is, to implement actions that benefit clients and their support persons.
  - However, doing good can also pose a risk of doing harm.
  - **example, a nurse may advise a client about a persistent exercise program to improve**

Ethical Principles…

- **Beneficence…**
- Nurses need to assist clients in meeting all their needs, i.e.

✓Biological

✓Psychological

✓Social

✓Spiritual

Ethical Principles…

- **Nonmaleficence-** Avoiding harm
- Harm can mean **intentionally** causing harm, placing someone at risk of harm, and **unintentionally** causing harm.
- In nursing, intentional harm is never acceptable.
- A client may be at risk of harm as a known consequence of a nursing intervention that is intended to be helpful. For example, **a client may react adversely to a medication.**

Ethical Principles…

Nonmaleficence…

- Unintentional harm occurs when the risk could not have been anticipated.
- For example, while catching a client who is falling, the nurse grips the client tightly enough to cause bruises to the client's arm.
  - This principle requires nurses to protect individuals who are unable to protect themselves.

Ethical Principles…

- **Justice**
- Justice is often referred to as **fairness**.
- Is the obligation to be fair to all people. the concept is often expanded to what is called distributive justice.
- Distributive justice-specifically states that individuals have the right to be treated equally regardless of race, sex, marital status, medical

Ethical Principles…

- **Veracity: Truth telling**
  - Health care providers obliged to be honest with clients.
  - Truth telling and truthfulness is widely accepted as a universal virtue.
  - Should a nurse tell the truth when it is known that it will cause harm???
  - Does a nurse tell a lie when it is known that the lie will relieve anxiety and fear???

Ethical Principles…

- **Confidentiality**
  - Is a set of rules or a promise that limits access or places restrictions on certain types of information.
  - Patients need to trust their health care providers, and nurses have long been listed as c **most trusted among all professions.**



Ethical Principles…

Confidentiality

- The only times this principle may be violated are:

1. If clients may indicate harm to themselves or others

2. If the client gives permission for the information to be shared

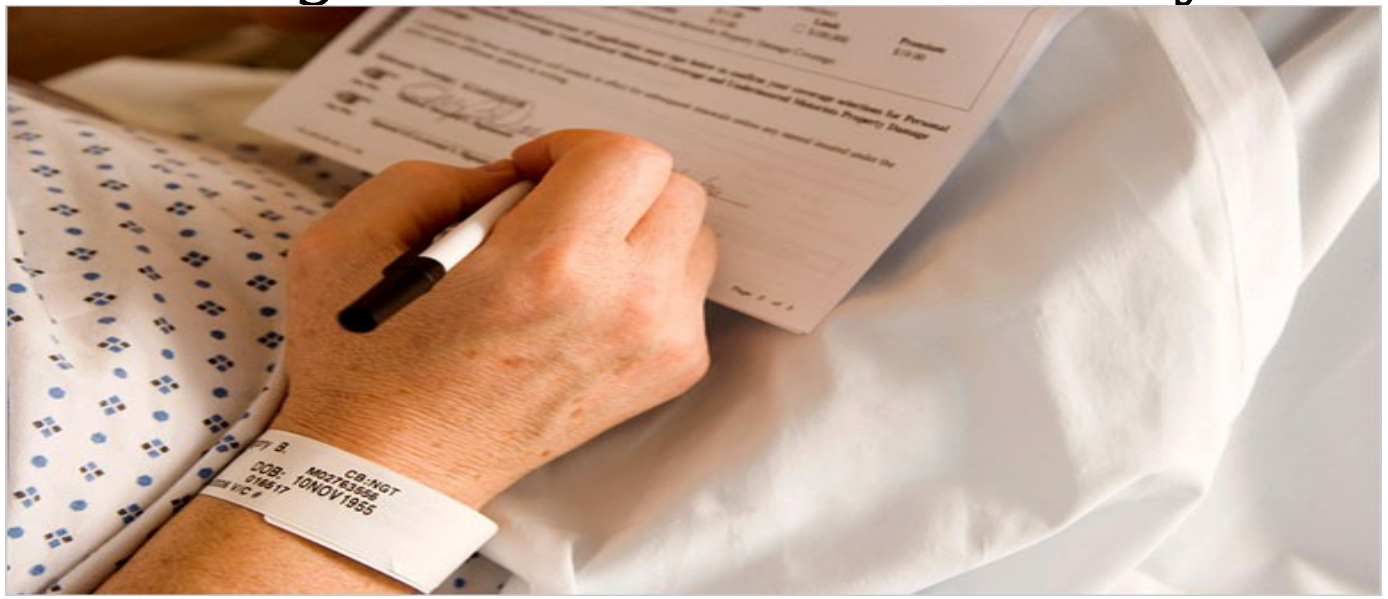
Ethical Principles...

- **Fidelity-** Keeping promise
  - Fidelity means to be **faithful** to agreements and promises.
  - By of their standing as professional caregivers, nurses have responsibilities to clients, employers, government, and society, as well as to themselves.
  - Nurses often make promises such as "I'll be right back with your pain medication" or "I'll find out for you."

Ethical Principles…

Informed consent:

- Is a process by which patients are informed of the possible outcomes, alternatives and risks of treatments and are required to give their consent freely.



Informed consent:

- A signed informed consent is needed :-
  - On admission for routine treatment
  - For each specialized diagnostic procedure
  - For experimentation involving clients

Informed consent:

- **Importance**
  - Promote the clients wellbeing
  - Respect for the client’s self determination
  - Protects against lawsuits.

Informed consent:

- **The consent must**
  - Be written
  - Be signed by the client or person legally responsible for the client
  - Before the procedure performed

Informed consent:

- **A signed consent is not needed in an emergency if :-**
  - There is an immediate threat to life or health
  - Experts agree that it is an emergency
  - The client is unable to consent and the legally authorized person can not be reached
- The client should sign except who is physically unable to sign, legally incompetent or juvenile

Informed consent…

- Infants, young children, mentally handicapped or incapacitated people, or comatose patient do not have the capacity to participate in decision making about their health care.
- If the client becomes unable to make decisions for him/ herself, this “surrogate decision maker” would act on the client's behalf.

Information About Informed Consent in the Medical Record

- Summary of information given to the patient
- Statement dictating that all the patient's questions were answered
- Any response by the patient acknowledging his/her understanding of the information provided

Information Which Should be Disclosed in Informed Consent

1. Name of person or persons providing treatment or procedure
2. Diagnosis or suspected diagnosis of the patient
3. Conflicts of interest
4 .Nature and purpose of the proposed treatment or procedure
5. Material risks, complications, side effects, and consequences of the proposed treatment or procedure
6. Benefits and anticipated outcome of the proposed treatment
7. Available benefits, if any
8. Consequences if the proposed treatment or procedure is refused.

Ethical Dilemmas and Decision making

- **A dilemma** is a situation in which **two or more choices are available** and **its difficult to determine which choice is best.**
- The alternatives in a dilemma may have **favorable and unfavorable features.**
- Ethical dilemmas in health care involve issues surrounding professional actions and client care decisions.
- **They can lead to discomfort and conflict among the members of the health care team or between the providers and the client and family.**

Decision making process

- **Step 1. Collect, analyze and interpret the data**
  - Important to know the patient's wishes , family's wishes, and the extent of the physical or emotional problems causing the dilemma
  - Understand how mentally competent the patient is to make the decision, what the patient's desire are , what the family thinks about the situation.

Decision making process…

- **Step 2: State the dilemma**
  - Reduce the dilemma into a statement
- **Step 3: Consider the choices of action**
  - List all course of action that can resolve the dilemma with out considering their consequences.
- **Step 4:Analyze the advantages and disadvantages of each course of action**
- **Step 5: Make the decision**

Legal Concepts And Implications In Nursing

To avoid legal conflicts Nurses should:

- Know the law and incorporate it into their practice
- Maintain good nurse – client relationships
- Incorporate the right of clients into their health care
- Practice within the bounds of their competence

Laws

- Laws are the body of rules and regulations that governs people’s behavior and their relationships with the society.
- Rules of social conduct made by humans to protect society and based on concerns about fairness and justice.
- Laws are intended chiefly to protect the right of the public.

The law serves a number of functions in nursing:

1. It provides a framework for establishing which nursing actions in the care of client are legal.
2. It differentiates the nurse's responsibilities from those of other health professionals.
3. It helps establish the boundaries of independent nursing action.
4. It assists in maintaining a standard of nursing practice by making nurses accountable under the law.

Types of law

- Law governs the relationship of private individuals with government and with each other.
- There are 2 types of law: Public Law and Private Law

1. **Public law:** it is a law in which the government is directly involved.

- It regulates the relationships between individuals and the government.
- An important segment of public law is criminal law

Types of law…

- **Criminal law:** crimes committed against an individual or society, innocent until proven guilty beyond a reasonable doubt. Consequences range from fine to jail to death penalty

Types of law…

2. Private law: also called civil law, is the body of law that deals with relationships, between individuals.

- It is categorized as **contract law** and **tort law**.

Private law includes:

A. **Contract Law:** involves the enforcement of agreements among private individuals or the payment of compensation for failure to fulfill the agreements.

B. **Tort Law:** tort means 'wrong " or "bad" in Latin.

- It defines and enforces duties and rights among private individuals that are not based on contractual agreements.
- Example of Tort law applicable to nursing

1. Negligence and malpractice

2. Invasion of privacy and assault.

Sources of laws

There are four sources of law existing at both federal and state (or regional) level

1. **Constitutions:** Federal and state constitutions indicate how governments are created and given authority and state the principles and provisions for establish specific laws.

- The constitution guarantees individuals certain fundamental freedoms.

Sources of laws…

2. Statutes: enacted by a legislative body; statutory law must be in keeping with the federal constitution and with the constitution of the state as well.

- Nurse practice acts are an example of statutory laws passed by the legislatures to define and regulate the practice of nursing within each state.

3. Administrative law: Executive officers such as the president of a county, prime Minister of state/ regional / governors administer various agencies for law enforcement.

- These agencies have power to make administrative rules and regulations, in conformity with enacted law.
- Boards /council/ of nursing are administrative agencies to develop and enforce regulation concerning nursing practice.

4. Common law: The government provides for a judiciary system, which is responsible for reconciling controversies.

- Common law is thus court made law. When decision is made in a court of law; that decision becomes the rule to be followed when other cases involving similar circumstances and facts arise.

Legal issues in Nursing

Nursing Practice Act:

- Regulates the practice of nursing.
- Nursing Practice Act is legally defined and describes the scope of nursing practice, which the law seeks to regulate, thereby protecting the public as well.
- Each country may have different acts but they all have common purpose: to protect the public.

Standard of Practice

- Defines the activities of nurses that are specific and unique to Nursing.
- Allow nurses to carry out professional roles, serving as protection for the nurse, the client and the institution where health care is given.
- Attempts to ensure that its practitioners are competent and safe to practice through the establishment of standard practice
- **Establishing and implementing standards of practice are major functions of a professional organization.**

- The profession's responsibilities in establishing and implementing standards of practice include:

1. To establish, maintain, and improve standards

2. To hold members accountable for using standards

3. To educate the public to appreciate the standard

4. To protect the public from individual who have not attended the standards or will fully do not follow them,

5. To safeguard individual members of the profession.

Standard of Nursing Practice require:

- helping relationship be the nature of client nurse interaction
- Nurse to fulfill professional responsibilities
- Effective use of nursing process
- Standards of nursing practice are to describe the responsibilities for which nurses are accountable.
- When implemented, they serve for the measurements used in licensure, certification, accreditations, quality

Credentialing: refers to ways in which professional competence is ensured and maintained.

Credentials include; Accreditation, Licensure, Certification, and Registration.

- **Accreditation:** is the process by which an educational program is evaluated and then recognized as having meets certain predetermined standards of education.
- **Licensure:** is the process by which a state determines that a candidate meets certain minimum requirements to practice in the profession of his or her choice and grants a license to do so.

- **Certification:** a person who has met certain criteria established by a government or nongovernmental association is granted recognition.
- **Registration:** listing of an individual's name and other information on the official roster of a governmental agency.
- **Licensure or Registration Revocation/Cancelation :** the state boards of nurse examiners may suspend a nurse’s license/

Nursing Code of Ethics

- A code of ethics is a set of ethical principles that is shared by members of the group, reflects their moral judgments over time and serves as a standard for their professional actions.
- Is formal statement of a group’s ideas and values that serve as a standards and guidelines for the groups’ professional actions and informs the public of its commitment.

Purposes of code of ethics

Nursing code of ethics has the following purposes:

- To inform the public about the minimum standards of the profession
- To provide a sign of the profession's commitments to the public
- To outline the major ethical considerations of the profession.
- To provide general guidelines for professional

ICN Code of Ethics

- An international code of ethics for nurses was first adopted by the International Council of Nurses (ICN) in 1953.
- It has been revised and reaffirmed at various times since, most recently with this review and revision completed in 2006.
- Nursing care is respectful of and unrestricted by considerations of nationality, race, creed, color, age, sex, politics or social status.

ICN Code of Ethics considerations

The ICN- Code of Ethics for Nurses (2006)

- Nurses have four fundamental responsibilities:
  - To promote health
  - To prevent illness
  - To restore health
  - To alleviate suffering

- The ICN Code of Ethics for Nurses has four principal elements that outline the standards of ethical conduct

A. Nurses and people

- The nurse, in producing care, promotes an environment in which the values, customs and spiritual beliefs of the individual are respected.

B. Nurses and Practice:

- The Nurse Caries responsibility for nursing practice, and maintaining competence by continual learning.

C. Nurse and Co-workers

- The nurse sustains a cooperative relationship with coworkers in nursing and other fields.

D. Nurse and the Profession

- The nurse plays the major role in determining and implementing desirable standards of nursing practice and nursing education. The nurse is active in developing a core of professional knowledge.

Nursing Code of Ethics in Ethiopia

- ENA code of ethics for registered nurses comprises key elements of the code.
- It includes values, responsibility statements, and levels of guidance or actions.

ENA Code of Ethics considerations

1. Accountability and responsibility

- The fundamental responsibility of the nurse is fourfold: to promote health, prevent illness, restore health and to

- Nurses advocate practice environment conducive to safe, Competent and ethical care
- Nurses work in accordance with dependent, interdependent and collaborative functions of nursing
- Nurses carefully handle nursing practice on specific ethical issue and resolve the ethical problems systematically.
- Nurses are accountable for their professional

2. Respect right and dignity

- The nurse in providing care, unrestricted by consideration of nationality, race, creed, color, age, sex, politics, religion or social statues.
- The nurse respects the value, customs and spiritual beliefs of individual.

3. Confidentiality

- Nurses safeguard the trust of the clients information

4. Advocacy

- Nurses sustain a cooperative relation ship with other health workers in the team work.
- The Nurse respects acceptance or refusal right of the patient during therapeutic and diagnostic procedures or research and learning situation up on clients.

5. Professional development

- The nurse plays the major role in determining and implementing desirable Standards of nursing practice and nursing education.

Responsibilities of nurses for specific ethical issues

Patient’s bill of rights

- Statement on a patient’s bill of rights was approved by the House of Delegates in February 6, 1973.
- The American Hospital association presents a patient’s bill of rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patients, and the hospital organization.

The patient’s rights are as follows:

1. The patient has a right to considerate and respect full care.

2. The patient has a right to obtain from his physician complete current information concerning his diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand.

3. The patient has the right to receive information from his physician which is necessary to give informed consent

4. The patient has the right to refuse treatment to the extent permitted by Law and to be informed of the medical consequences of his action.

5. The patient has the right to every consideration of his privacy concerning his own medical care program.

6. The patent has the right to expect that all

7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for their services.

8. The patient has a right to obtain information as to any relationship of his hospital to other health care and educational institutions as far as his care is concerned.

9. The patient has the right to be advised if the hospital proposes to engage in or perform human

10. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where.

11. The patient has the right to examine and receive an explanation of his bill regardless of the source of payment.

12. The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

Ethical issues related to patients rights

1. Right to truth

- The right of patients to know the truth about their condition, prognosis, and treatment .

2. Right to refuse treatment

- For reasons that are sometimes known only to themselves patient may refuse treatment even though lack of treatment may result in their death. The question of refusal of treatment may have to be decided in court.
- Many times, the courts rule that patients cannot be forced to accept treatment. In the case of minor child, however, the courts are likely to rule that parents cannot withhold treatment from a child for any reason. The child is usually made a temporary ward of the court and treatment is allowed to begin.

3. Informed consent

- The issue of informed consent applies to many health care institutions in both legal and ethical ways. Every person is granted freedom from bodily contact by another unless consent has been granted.
- Patients have the right to be given accurate and sufficient information about procedures, both major and minor, so that their consent to undergo those procedures is based on realistic expectations.

Informed consent …Cont’d

- In hospitals and other health care settings a signed informed consent form is needed:

(1) On admission (for routine treatment,

(2) For each specialized diagnostic procedure or medical or surgical treatment, and

(3) For experimentation involving clients.

Informed consent Cont'd

- The nurse signs the consent form as a witness to having seen the client sign the form, not to having obtained the consent.
- A signed consent is not needed in an emergency if ;

(1) there is an immediate threat to life or health,

(2) experts agrees that it is an emergency, and

(3) the client is unable to consent and the legally authorized person cannot be reached

Informed consent…

- **The consent must**
- (1) Be written,
- (2) Be signed by the client or person legally responsible for the client, and
- (3) Be in accordance with the procedure performed
- The client signs the consent whenever able. Exception includes a client who is physically unable to sign, legally incompetent, or a young.

Informed consent

...

- A client refusal to sign consent should be documented and the client should be informed of the possible consequences of the refusal.
- The client should sign a release form indicating his refusal to consent and releasing the nurse ,physician, and the hospital from responsibility for outcomes of this act. This statement should be witnessed.

4. Human experimentation

- Research and human experimentation are primarily concerns of the scientific and medical professionals. However, if nursing care is required for the subjects involved for such experimental projects, then nurses became involved.
- In these cases, nurses’ responsibilities and ethical decisions are related to making sure that informed consent is given for participation in the research experiments and that the safety of their patients is protected.

Health related Legal issues in Ethiopia

Along with the patients‟ bill of rights, below are certain health related issues commonly seen in Ethiopia

1. Abortion:

- The nurse shall assist the physician if she/he is sure that an abortion is performed for the purpose of saving the endangered life or health of women (legally permitted).

- It is mandatory for the nurse to treat a patient who is suffering from the effect of a criminal abortion induced by another provided there is no physician in the health institution.
- The nurse shall report to the concerned authorities of criminal abortion in the absence of physician.
- The nurse has all the right not to participate in all procedures of criminal abortion

2. Euthanasia

- Euthanasia (Gr. “eus”, good + “thanatos”, death). It is commonly referred as “mercy killing”
- Euthanasia is the act or practice of killing somebody who has an incurable illness , or assisting that person to die.

Euthanasia…

- Euthanasia is illegal in many countries.
- The nurse shall never assist; collaborate in taking life as an act of mercy even at the direct request of the patient or patient's relatives.

3. Death

- The nurse shall note the exact cessation of vital signs and notify the attending physician to pronounce death.
- The nurse shall give due respect to the dead taking in to consideration religion and cultural aspects.
- A nurse shall participate in or assist a medical team in taking out organ from a cadaver provided

4. Suicide

- A nurse who is taking care of a patient with a suicidal tendency shall remove all items that facilitate suicide

5. Organ Transplantation

- The nurse shall involve in any organ transplantation procedure provided that the donor and recipient have clear written agreement.
- The nurse shall advocate the declaration of human rights in the organ transplantation procedure.

6. Fertility Matter

- The nurse shall respect autonomy of the client for contraception and other fertility matter including artificial fertilization
- The nurse shall have responsibility to give information about the case.
- The nurse shall have moral and professional right to make ethical decision in a situation of dilemma for the fertility matter.

Areas of potential liabilities in nursing

Liability means legal responsibility

- A nurse is legally responsible for actions that fail to meet the standard care or for failing to act and thereby causing harm.

Areas of potential liabilities in nursing…

Crimes and Torts

Crime

- Crime is wrong committed against a person or his property in violation of public law and punishable by a fine and/ or imprisonment

Classification of Crimes

1. Felonies: are a crime of a serious nature such as murder, armed robbery, and second degree murder.

- A felony is punishable by imprisonment in a state or federal prison for more than one year.
- **E.g. a nurse who accidentally administering an additional and lethal dose of a narcotic to relieve discomfort can accused second degree murder.**

Classification of Crimes…

2. A misdemeanor: is an offense of a less serious nature and is usually punished by a fine or short term jail sentence or both for less than one year.

- **For example; a nurse who slaps a client's face could be charged with a misdemeanor**.

Tort

- A tort is a civil wrong committed against a person or a person’s property.
- Torts are usually litigated in court by civil action between individuals.
- In most instances, the court in a civil case will settle damages with money but rarely by imprisonment.

Tort

- Tort may be classified as **intentional or unintentional:**

1. **Intentional tort:** A person committing an intentional tort is considered to have knowledge of the permitted legal limits of his words or acts.

- Violating these limits is grounds for prosecution

Tort…

- **Intentional tort** includes Assault, Battery, Invasion of Privacy, Defamation of Character and False Imprisonment.

- **Fraud:** it is willful and purposeful false/misrepresentation that could causes or has caused, loss or harm to a person or property.
- In nursing, person fraudulently misrepresenting themselves to obtain a license to practice may be prosecuted under nurse practice acts.

Assault and Battery

- **Assault** Attempt or threat to touch another person unjustifiably.
- **E.g. a nurse who threatens someone with an injection after the client refuses to take oral medication**.

- **Battery** is an assault that is carried out and includes every deliberate, angry, and violent or negligent touching of another's person or clothes or anything attached to or held by that person.
- Is the touching of another person without the person‟s consent
- **For example; forcibly removing a client's clothing, pushing a client into a chair and giving injection without clients**

False imprisonment: is unlawful restraints or detentions of another person against his or her wishes.

- It is restraining an individual or restricting an individual's freedom.
- **False imprisonment accompanied by forceful restraint or threat of restraint is battery.**
- **Example: Keeping patient hospitalized against his/her will.**

- **Defamation:** is an intentional tort in which one party makes an offensive remarks about another that could be orally or written, diminishing the other party's reputation.
- Slander-Defamation by spoken word
- Libel -Defamation by means of print, writing, or pictures

- **Examples: Reporting a pt has an infectious disease to a government agencies when lab results are inaccurate**

- **Invasion of Privacy:** Unnecessary exposure of individual or revealing personal information without consent.

- **Examples: Improper draping or covering of a pt during a procedure that allows other pts. or personnel to see the pt. exposed, publishing photos without consent and disclosing confidential information**

2. Unintentional Torts

- An unintended ,wrongful act against another person producing injury or harm.

e.g. Negligence, malpractice

- **Negligence** is defined as performing an act that a reasonably careful person under similar circumstances would not do.
- It is misconduct or practice that is below the standard expected of an ordinary, reasonable, and prudent practitioner.

2. Unintentional Torts

- **Malpractice:** The failure of the professional to exercise the degree of skill and learning commonly applied by the average prudent reputable member of the profession.

Common Negligent Acts

- The areas in which health care providers run the greatest risks of being negligent include:

  (1) Foreign objects left in clients

  (2) Burns,

  (3) Falls,

  (4) Failure to observe and take appropriate action,

  (5) Medication errors

  (6) Loss of client’s property

- Negligence that occurred while the person was performing as a professional.
- It applies to physicians, dentists, lawyers, and generally includes nurses.
- **Duty** – refers to an obligation to use due care (what a reasonably prudent / careful/ nurse would do) and is defined by the standard of care appropriate for the nurse client relationship

- **Breach of duty-** is the failure to meet the standard of care
- **Causation-** the most difficult element of liability to prove, refers to the failure to meet the standard of care (breach) , which actually causes the injury
- **Damages-** are the actual harm or injury resulting to the client

Measures to prevent the above Malpractice situations

- A nurse always needs to check and recheck medications very carefully before administering a drug.
- The surgical team should count correctly before the surgeon closes the incision

Reporting crimes, torts and unsafe practice

- A nurse may need to report nursing colleagues or other health professionals for practices that endanger the health and safety of a client.

- **For example, Alcohol and drug use theft from a client or agency, and unsafe nursing practice.**

Guidelines for reporting a crime, tort or unsafe practices are:

- Write a clear description of a situation you believe you should report.
- Make sure that your statements are accurate
- Make sure you are credible (trustworthy)
- Obtain support from at least one trust worth person before filing the report
- Report the matter starting at the lowest possible level

Avoid Understaffing

- Understaffing is a problem that results, in reduced quality of nursing care and may jeopardize client safety.
- Temporary management solutions to understaffing, such as “floating” nurses from one unit to another or asking nurses to work overtime or “doubles”.

Record Keeping

Reporting and Documenting

- **Reporting**: it is oral or written account of patient status; between members of health care team. Report should be clear, concise, and comprehensive.
- **Documenting**: patient record/chart provides written documentation of patient's status and treatment

Record Keeping…

Purpose:

- Continuity of care, legal document, research, statistics, education, audits
- Characteristics of documentation: brief, concise, comprehensive, factual, descriptive, objective, relevant/appropriate, legally prudent.

What to document:

- Assessment
- plan of care
- Nursing interventions (care, teaching, safety measures)
- Outcome of care
- Change in status
- Health care team communication,

Record keeping

- Health records are the means by which information is communicated about clients and means of ensuring continuity of care.
- The clients’ medical record is legal document and can be produced in a court as evidence.

Record keeping…

- Used as risk management tools & for research purpose.
- Often the record is used to remind a witness of events surrounding a lawsuit.
- The effectiveness of record depends up on accuracy and completeness of the record.
- Nurses need to keep accurate and complete records of nursing care provided to clients.

Insufficient or Inaccurate documentation

- Can constitute negligence and be the basis for tort liability.
- Hinder proper diagnosis and treatment and result injury to the client.

Accurate Record keeping

- Routine nursing assessment and intervention should be documented properly.
- Use pen rather than pencil during documentation.
- When making correction do not erase the previous draw one line on an old and add correction so the previous remained legible because correction is not for changing.

Accurate Record keeping

- Write legibly.
- Document all information.
- Add time, date, name and other important information.
- Document all medically related conditions.

The incident report

- Incidents / accident means un expected and usually unpleasant things that happens or take place.
- Is an agency record of an accident or incident.
- An incidental report may be written for situations involving a patient, visitors, or employee.

The incident report used

- To make all the facts about an accident available to personnel
- To contribute to statistical data about accidents or incidents
- To help health personnel to prevent future accidents.
- **The reports should be completed as soon as possible i.e., Within 24 hours of the incident**

Information to be included in incident report:

- Identify the client by name and hospitals
- Give date and time of the incident. Avoid any conclusions or blame.
- Describe the incident as you saw it even if your impressions differ from those of others
- Identify all witnesses to incident
- Document any circumstance surrounding the incident. For example, that another client is experiencing cardiac arrest.

UNIT FIVE

COMMUNICATION PROCESS

Learning objectives

Upon completion of this unit, each student will be able to:

- Define communication
- List the purpose and levels of communication
- Discuss the types of communication
- Describe the component of communication
- Discuss the relationship of language and experience to the communication process.
- State the basic characteristics of communication
- Identify the techniques of effective communication
- Explain the helping relationship
- Discuss on the techniques of therapeutic communication

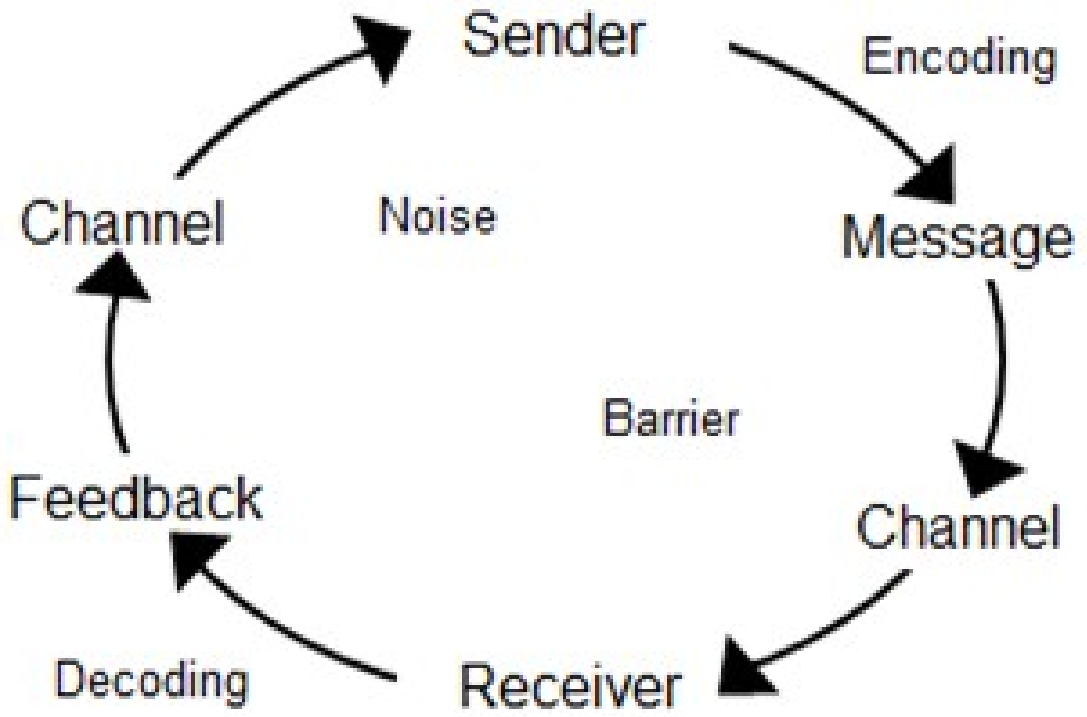
Definition:

- Communication is the process of generating, giving, receiving and interpreting information.
- It is a complex process of **s**ending and receiving verbal and nonverbal messages.
- The process of creating common understanding
- The means through which people exchange information, feelings, and ideas with each other
- It is a basic component of human relationships, including nursing.

- Communication is the process of sharing of ideas ,information, knowledge, and experience among people to take action.
- Communication may take place between one person and another, between an individual and a group or between two groups .

- Communication facilitates creation of awareness, acceptance and action at an individual , group and inter group level.
- Communication is the fundamental element of the nurse client relation ship , client teaching , case management and the activities performed by nurse.

The Communication Process



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Components of communication

1. Sender /Source (encoder) - the one who conveys the message to another person.

- **Peoples are exposed to communication from different source but most likely to accept a communication from a person or organization that they trust i.e. has high source credibility.**

2. Message: the thought, idea, or emotion conveyed.

- It consists of what is actual communicated including actual appeals, words, and pictures and sounds that you use to get the ideas across.
- **Messages may be verbal , non verbal , or written materials.**

A message is said to be good if it:

- Is epidemiologically correct (evidence based)
- Requires minimum times/effort.
- Is realistic
- Is culturally acceptable
- Meets a felt need
- Is easy to understand

3. Channel means of transmitting the idea which can be verbal or nonverbal

- A channel is a physical means of which message travels from a source to a receiver or from a receiver to a source.

- **The commonest types of channels are verbal, visual, printed materials or a combined audio visual and printed materials.**

4. Receiver (audience or Decoder): the person who receives and interprets the message.

- Not all messages reach the receiver as intended by the sender.
- Receiving is influenced by different factors such as psychological, linguistic and receiver factors(physiological wellbeing , and cognitive process).

- The first step in planning any communication is consider the intended audience.

- What factors or characteristics that should considered in audience before communication?

- Before communication ,the following characteristics of audiences should be analyzed

1. Educational factors:

- Can they read?
- What type of appeals might convince them?

2. Socio-cultural factors:

- What do they already believe and feel about the topic of communication?

3. Patterns of communication:

- How people show respect when talking to another person?
- What time of the day and which programs do they listen?
- Which places do they pass that might be good

5. Feed back: the receiver's response to the sender.

- **The function of feed back is to provide the sender with information about the receivers perceptions of a situation.**
- Having this information , the sender can then adjust the delivery of the message to communicate more effectively.

Type of communication

1. **Verbal communication**

- Is an exchange of information using words and includes both the spoken and the written word.
- Verbal communication depends on language.
- The verbal form of communication is used extensively by nurses when speaking with clients, giving oral reports to other nurses, writing care plans and recording in nursing progress reports.
- **Characteristics: simple, brief, clear, well timed, relevant, adaptable, reliable/true.**

2. Nonverbal communication

- Is the exchange of information without the use of words.
- It is communication through gestures, facial expressions, posture, body movement, and eye contact.
- It expresses more of true meaning of a message than does verbal communication.
- Verbal and nonverbal communication must be congruent, or in agreement

Levels of Communication

1. **Interpersonal** Communication: One-one, face to face interaction between the nurse and another person.
2. **Transpersonal Communication**: Interaction that occurs within a person's spiritual domain (prayer)

Levels of Communication

3. **Small-Group Communication**: a small number of people meet and share a common goal (committee)
4. **Intrapersonal Communication**: Powerful form of communication that occurs within an individual (self-talk-nurses need to try to replace negative talk with positive thoughts)
5. **Public Communication**: Interaction with an audience(requires nurses to use eye contact, gestures, etc)

Basic Characteristics of communication

- Communication is a reciprocal process in which both the sender and receiver of messages participate simultaneously
- Communication is a continuous and reciprocal process
- Communicating person receives and sends messages through verbal and nonverbal means.
- Verbal and nonverbal communication occurs

Basic Characteristics of communication…

- Involvement of more than one sense organ
- Non verbal communication is considered as being a more accurate expression of true feelings. There is a proverb that says" Action speaks more than thousand words.
- There must be feedback: Communicating persons respond to messages they receive.

Basic Characteristics of communication…

- Validation is necessary to determine the accuracy of not only the message but also the meanings of the message.
- Exchanging message requires knowledge
- Past experiences influence messages, sent and interpretation
- Communication is influenced by the way people feel at the moment or about the subject

Basic Characteristics of communication…

- **Effective message** should be clear, complete, concise, convincing/ undoubted
- **Communication can be effective** if it is right information, to right people, at right time & place

Effective communication is when you:

- Listen carefully to understand what the other person means
- Use language that the other person can understand
- Use correct spelling when you have to write a message down
- Provides opportunity for dialogue and discussions.

Cont…

- Builds on people existing beliefs and practices.
- Is entertaining and attracts the communities attention
- The proper media or channel has been chosen
- A good presentation has been made
- Two - way communication has been established
- All barriers have been removed

Barriers To Effective Communication

- Barriers (obstacles) can inhibit communication ,resulting in misunderstanding, lack of response or motivation and distortion of the message.
- This can lead to conflicting of views and the inability to make effective decisions.

Barriers to Effective Communication

- Distractions
- Poor timing
- Emotions
- Personality differences
- Differences in knowledge and assumptions
- Stress
- Noise
- Inappropriate medium
- Assumptions/Misconceptions
- Language differences
- Poor listening skills

- **The Audience Must Remove Their Own Barriers.**

  Members Of The Audience Could Be:

✓ the non –listener type-who refuse to listen

✓ the know-it-all type-who thinks he/she knows the answer to everything

✓ the impatient type-who is reluctant to sit and jumps to conclusion

✓ the negative personality-who enjoys saying ‘no’ to everyone

Communication Techniques in Nursing

Conversation skills

- Control the tone of your voice so that you are conveying exactly what you mean to say.
- be knowledgably about the topic of conversation and have accurate information
- Be flexible
- Be clear and concise
- Avoid words that may be interpreted differently
- Be truthful
- Keep an open mind
- Take advantage of available opportunities

2 Listening Skills

- Is a skill that involves both hearing and interpreting what is said.
- It requires attention and concentration to sort out, evaluate, and validate clues so that one understands the true meanings in what is being said.
- Listening requires concentrating on the client and what is being said.

Techniques to improve listening skills

- Whenever possible sit when communicating with a client.
- Be alert but relaxed and take sufficient time so that the client feels at ease during the conversation.
- If culturally appropriate maintain eye contact with the client
- Indicate that you are paying attention to what the client is saying
- Think before responding to the client.
- Listen for themes in the client's comments.

Use of silence

- The nurse can use silence appropriately by taking the time to wait for the client to initiate or continue speaking.
- During period of silence, the nurse has the opportunity to observe the clients verbal and nonverbal messages simultaneously.
- Periods of silence during communication demonstrating comfort and satisfaction in the nurse-client relationship

Interviewing Techniques

- Interview is a major tool in nursing for the collection of data during the assessment step of the nursing process.
- **Purpose**: to obtain accurate and thorough information

Interpersonal Skills in Nursing

- **Interpersonal skills are communication skills required for positive relationships between persons.**
- These skills are essential for a nurse to establish and promote good nurse client relationship.

Some of the interpersonal skills are

1. Warmth and friendliness
2. Openness
3. Empathy
4. Competence
5. Consideration of client variable

Factors facilitating positive interaction

1. Have a purpose for interaction
2. Choose a comfortable environment
3. Provide privacy
4. Confidentiality
5. Client focus

A five main categories of feedback:

1. Evaluative
2. Interpretive
3. Supportive
4. Probing
5. Understanding

PRINCIPLES OF COMMUNICATION

- The perception of the sender and receiver should be as close as possible to each other
- There should be involvement of more than one sense organ
- The more the communication takes place face to face the more its effectiveness
- feedback should be there

When do effective communication occur?

- **The seven C's of effective communication:**

1. Clarify the message
2. Communicate a benefit
3. Consistent
4. Carter to the heart and head
5. Create trust
6. Call to action
7. Command attention

What is the prerequisite for effective communication???

Communicator should be:

- ✓Knowledgeable
- ✓Credible, sincere, honest, intellectual
- ✓Skillful
- ✓Positive in his attitude to the receiver and subject
- ✓Able to ensure feedback

Effective communication skills

1. Listening
2. Nonverbal communication
3. Managing stress
4. Emotional awareness

Barriers to effective communication

- Are factors/barriers that **hinder or influence** communication process

Generally communication barriers can be categorized as follows:

- ✓**Physical barriers**
- ✓ **Intellectual barriers**
- ✓**Emotional barriers**
- ✓**Environmental barriers**
- ✓**Cultural barriers**
- ✓**Language barrier**

Physical barriers: include difficulties in hearing and seeing.

Intellectual barriers: may occur because of the natural ability, home background or schooling that affects the **perception and understanding of the receiver.**

Emotional barriers : include the readiness, willingness or eagerness of the receiver — and the emotional status of the educator

- **Environmental barriers:** might occur if there is too much noise or if the room is too congested.
- **Cultural barriers:** include those customs, beliefs or religious attitudes that may cause problems.
- **Economic and social class** differences and language variation, as well as age differences, may also be difficult to overcome.
- Either too high or too low status of the educator (sender) compared to the audience may affect communication

Facilitate group discussion

Therapeutic Communication

- Is the use of communication or the purpose of creating a **beneficial outcome for the client**.
- The accompanying display lists characteristics of therapeutic communication.
- Its purpose is to improve the client's ability to function.

Interpersonal relationship (therapeutic relationship) or Nurse – client relationship (helping relationship)

- The helping relationship is some times called therapeutic or client nurse relationship.
- Therapeutic communication is communication (usually verbal) with client that is helpful & beneficial, creating a healing, curative & safe by using communication.

Therapeutic Communication

Characteristic

- Is purposeful and goal-directed
- Has well-defined boundaries
- Is client-focused
- Is nonjudgmental
- Uses well-planned, selected techniques

Phases of a helping relationship

It has three phases.

Orientation phase

- In this phase the nurse & patient identify each other
- The patient & nurse establish activities like
    - Goal of relationship
    - Location, frequency & length of contact
    - Duration of relationship

Working phase

- It is the longest phase
- Is the actual intervention- may include counseling, teaching direct care etc.
- The pt actively participate, express feeling, cooperate in activities that work together to achieve the goal.

Termination phase

- It occurs when the conclusion of the initial agreement is acknowledged. E.g. Discharge the patient.
- When professional leaves on vocation or for employment else where
- The patient verbalize feeling about termination

Summary Therapeutic Communication Techniques

- **Ask relevant questions**- ask questions one at a time, to explore the topic before going on
- **Provide information**- provide information that the client needs to know helps to empower the client
- **Paraphrasing**- by restating the client's message, the client knows that the nurse is listening
- **Clarifyin**g-assess whether the client understood the information

Summary Therapeutic Communication Techniques…

- **Focusing**-focus on key issues in the conversation
- **Summarizing**-brings s sense of closure to the conversation
- **Self-disclosing**- way of showing the client that the information is understood and shows respect for the client
- **Confronting**-help the client realize his/her inconsistencies in feelings, attitudes, or beliefs

Conduct interview

- **Team:** is a group of peoples who influence each other for a common goal

Group dynamics

- refers to the **interactions between people who** are talking together in a group setting.
- The dynamics of any group can and will influence the productivity of the group.

Team

- Formal
- Informal

Team types

- Work team
- Managerial
- Special
- Multi purpose
- Self directed

Elements of team

- Communication
- Commitment and trust
- Diversity capacity
- Adaptation
- Creative freedom

Stages of team development

1. Forming
2. Storming
3. Norming
4. Performing
5. Closing and Celebration

Forming

- Members first get together during this stage.
- Individually, they are considering questions like, “What am I here for?”, “Who else is here?” and “Who am I comfortable with?”
- It is important for members to get involved with each other, including **introducing themselves to each other.**

Storming

- During this stage, members are be**ginning to voice their individual differences**, join with others who share the same beliefs, and jockey for position in the group.

- Therefore, it is important for members to continue to be highly involved with each other, including to voice any concerns in order to feel **represented and understood.**

- The team leader should help members to voice their views, and to achieve consensus about their **purpose and priorities**.

Norming

- In this stage, members are beginning to **share a common commitment to the purpose of the group**, including to its overall goals and how each of the goals can be achieved.
- The team leader should focus on **continuing to clarify the roles of each member**, and a clear and workable structure and process for the group to achieve its goals.

Performing

- In this stage, the team is **working effectively and efficiently toward achieving its goals**.

- The style of leadership becomes more indirect as members take on **stronger participation and involvement in the group process**.

- Ideally, the style includes helping members to reflect on their experiences and to learn from them.

Closing and Celebration

- At this stage, it is clear to members and their organization that the team has achieved its goals (or a major milestone along the way toward the goal).

- It is critical to acknowledge this point in the life of the team

Styles of personal Communication

- Communication can be expressed in an aggressive, passive, or assertive style.

1. **Aggressive Communication**
2. **Passive Communication**
3. **Assertive Communication**

Aggressive Communication

- The assumption behind aggressive communication is ‘**your needs do not matter’ (I win/you lose).**

Passive Communication

- assumption behind passive communication is ‘My needs do not matter’ (You win/I lose).
- Assertive Communication
- avoiding conflict and maintaining good relationships (I win/you win).

UNIT SIX

NURSING PROCESS

Learning objectives

At the end of this unit, the students will be able to:

- Define nursing process
- List the five component of nursing process
- Describe the purpose of nursing process
- List the characteristics of nursing process
- Define nursing diagnosis
- List the five type of nursing diagnosis
- List the three component of nursing diagnosis
- List essential steps in the planning process

Nursing process

- A systematic problem-solving approach used to identify, prevent and treat actual or potential health problems and promote wellness.
- A series of steps or acts that lead to accomplishment of some goal or purpose.
- Is the cornerstone of the nursing profession.

Purpose of Nursing Process

- To identify a client’s health status, actual or potential health care problems or needs.
- To establish plans to meet the identified needs.
- To deliver specific nursing interventions to meet those needs.
- It helps nurses in arriving at decisions and in predicting and evaluating consequences.
- Used for applying a scientific approach or a problem solving approach to nursing practice.
- To reducing hospital stays
- To promotes continuity of care

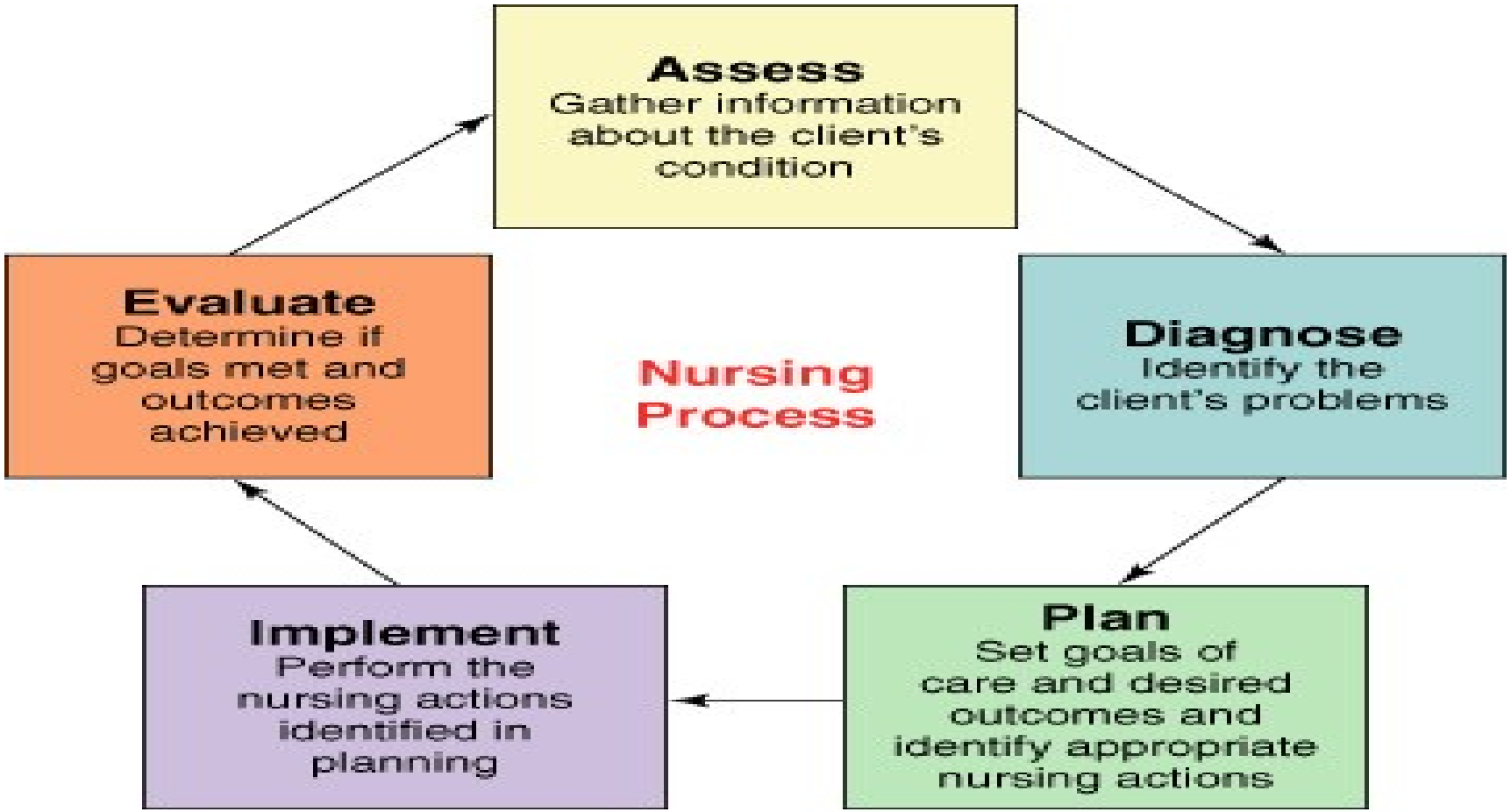
Characteristics of Nursing Process

- Cyclical and interrelated
- Patient centered
- Problem oriented
- Goal directed
- Orderly, planned and systematic
- Used for all setting
- Universally applicable

Phases/ components of nursing process

- Assessment
- Nursing diagnosis
- Planning
- Implementation
- Evaluation

Steps of the Nursing Process



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Nursing Assessment

- The first phase
- It is the systematic collection of data to determine the patient’s health status and identify any actual or potential health problems.
- Includes nursing history, physical assessment, & diagnostic tests

Nursing Assessment cont…

❖Data collection is **vital step** in nursing process

❖Focus on **patient's response to health problems**.

❖Data collection takes place during **every nurse- patient interaction**

Assessment data are gathered through

- Conduct the health history.
- Perform the physical assessment.
- Interview the patient's family or significant others.
- Study the health record.

Reasons for doing assessment

- To establish baseline information
- To determine the client’s normal function.
- To determine the client’s risk for diagnosis
- To determine presence or absence of diagnosis
- To provide data for the diagnostic phase.

Assessment skills

- **Observation**: ability to observe and identify problems

*Looking, watching, examining, analyzing, surveying

*Uses different senses: vision, smell, hearing, touch.

- **Interviewing** (history taking): the ability to communicate with others.
- **Physical examination**: Analysis of bodily function using techniques of inspection, palpation, percussion

Types of Data

Subjective data

- Symptoms or covert data
- Are the verbal statements provided by the Patient
- Examples
  - Nausea, pain and fatigue



Figure 12-4 In the interview, both the seating arrangement and the distance from the patient are important in establishing a relaxed and comfortable environment for data collection. (Photo © B. Proud)

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Types of Data cont…

Objective data

- Signs or overt data
- Are detectable by an observer
- Can be measured or tested
- They can be seen, heard, felt, or smelt
- They are obtained by observation or P/E

E.g. Vital sign measurement, laboratory results, change in physical appearance



Figure 12-5 The nurse provides a physical examination. No matter what the setting or the age of the patient, the physical examination should include appraisal of health status, identification of health problems, and establishment of a database for nursing intervention. (Photo © B. Proud)

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Types of Data cont…

BOX 2-2 Examples of Objective and Subjective Data

OBJECTIVE DATA	SUBJECTIVE DATA
Weight	Pain
Temperature	Nausea
Skin color	Depression
Blood cell count	Fatigue
Vomiting	Anxiety
Bleeding	Loneliness

Functional Health Pattern

- **Gordon's functional health pattern is** a method devised by **Marjory Gordon** to be used by nurses in the **nursing process** to provide a more comprehensive **nursing assessment** of the patient.
- Gordon's functional health patterns (Gordon, 1977) provides a systematic framework for data collection that focuses on 11 functional health patterns.

The eleven patterns are as follows:

1.Health perception/health management patterns

2.Nutritional/metabolic patterns

3. Elimination pattern

4. Activity/Exercise patterns

5. Cognitive/perceptual patterns

6. Sleep/Rest patterns

7. Self - Perception/Self – Concept patterns

8. Role/relationship pattern

9. Sexuality/Reproductive pattern

10. Coping/Stress – tolerance patterns

11. Value/belief pattern


Nursing
Diagnosis

Nursing Diagnosis

= Analysis of data

- 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.

❖ The goal of a nursing diagnosis is to identify actual and potential responses.

COMPONENTS OF A NURSING DIAGNOSIS

- The first component is a problem statement or **diagnostic label**.
- The diagnostic label is the name of the nursing diagnosis as listed in the NANDA.

This is some list represents the NANDA-approved nursing diagnoses for clinical use and testing.

- Diarrhea
- Risk for constipation
- Impaired urinary elimination
- Decreased cardiac output
- Impaired gas exchange
- Ineffective airway clearance
- Risk for trauma
- Risk for aspiration

☞The second component is the **etiology.**

☞The **etiology** is the related cause or contributor to the problem.

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

e.g. Disturbed Body Image RT loss of left lower extremity.

Activity Intolerance RT decreased oxygen-carrying capacity of cells.

☞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).

e.g. ineffective airway clearance RT fatigue AEB dyspnea at rest

Nursing diagnosis VS Medical Diagnosis

Nursing Diagnosis	**Medical Diagnosis**
Made by the nurse	Made by a physician
Describes clients response	Refers to the disease process
Responses vary between individuals	Somewhat uniform between clients
Changes as client responses change	Remains same during disease process
Nurse orders interventions	Physician orders interventions
Actual & potential	Actual only

- 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.

Types of Nursing Diagnoses

1- **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 coccyx.

2- **Risk/potential 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.

3- **Wellness nursing diagnosis**

- Is a change from a certain level of wellness to a higher level of wellness
- 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.
- The diagnostic statement will begin with "**Potential for Enhanced**" or" **Readiness for Enhanced**."

Example

– Readiness for enhanced spiritual well being

- Readiness for Enhanced Self-Esteem.

4- **Possible/ probable Nursing Diagnoses**

- Is made when not enough evidence supports the presence of the problem but the nurse thinks that is highly probable and wants to collect more information.
- “possible” alerts the nurse the need for further data collection.

- Possible Nursing Diagnoses are two part statement includes diagnostic label, related factors (unknown).

- Example- Possible self – esteem disturbance related to unknown etiology

Planning



Planning

- Once the nursing diagnoses have been identified, the planning component of the nursing process begins.
- It is a process of analyzing a system or designing basis for how some thing can be achieved or solved in particular manner and with in specified time frame.

Planning cont…

- Determination of nursing care in an organized, individualized and goal directed manner.

- The primary purpose of planning is to design a plan of care for and with the patient that once implemented, results in the prevention, reduction, or resolution of patient health problems and the attainment of the patients health expectations.

Elements of planning

- Establishing priority
- Writing goals/expected out comes that determine the evaluation strategy
- Electing nursing strategies.
- Writing nursing orders.

Planning cont…

❖**Priority Setting**: because all problems of the patient may not be solved at the same time.

- There is always a need to solve those that do not give time
- Therefore, selecting priority problems should be in the first phase of planning.
- Maslow’s hierarchy of needs provides a useful framework for prioritizing problems, with importance being given first to physical needs; once those lower-level needs are met, higher-level needs can be addressed.

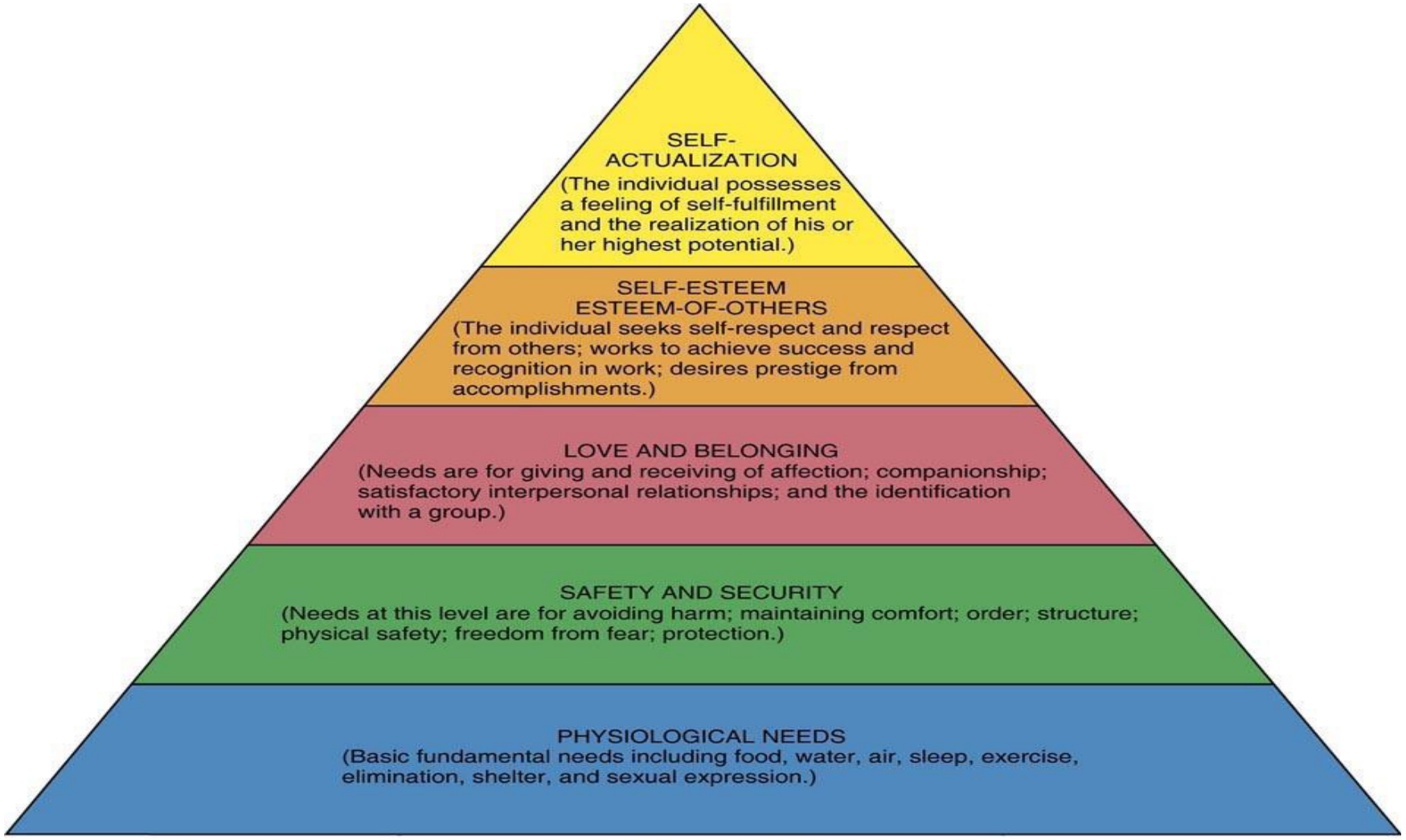
Setting Priorities

- To set priorities, look at the identified problems
- Ask some key questions:
  1. What problems need immediate attention?
  2. What problems have simple solutions?
  3. What problems must be referred?
  4. What problems must be recorded on the plan of care?

Maslow’s Hierarchy of Needs

- Physiologic needs
- Safety and security
- Belongingness and affection
- Esteem and self-respect
- Self-actualization, which includes self-fulfillment, desire to know and understand, and aesthetic needs.

Maslow's Hierarchy of Needs cont...



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Maslow’s Hierarchy of Needs cont…

- Lower-level needs always remain, but a person’s ability to pursue higher-level needs indicates that he or she is moving toward psychological health and well-being.

Planning cont…

- After establishing priorities the nurse and client set goals for each nursing diagnosis

Goal setting and Establishing 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.

Planning cont…

Establishing goals and expected outcomes…

- GOAL has the following characters tics:

  “SMART”

  - Specific
  - Measurable
  - Attainable
  - Relevant
  - Time Bound

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: Peripheral

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.

Purpose of Goals:

a) provide direction for planning nursing interventions

b) Serve as criteria for evaluating client progress.

c) Enable the client and the nurse to determine when the problem has been resolved.

Types of Goals:

A. Short Term Goals:

- in a short period of time, usually in a few hours or days.

B. Long Term Goals:

- Is a statement written in objective format demonstrating an expectation to be achieved in resolution of the nursing diagnosis over a longer period of time, usually over weeks or months.

Selecting nursing interventions and activities

- Nursing interventions are identified and written during the planning step of nursing process; however, they are actually performed during the implementing step.
- Nursing interventions are treatment, based upon clinical judgment and knowledge that a nurse performs to enhance patient / client outcomes.

Criteria for Choosing Appropriate Intervention

- Safe and appropriate for the client's age, health, and condition
- Achievable with the resources available
- Congruent with the client's values, beliefs, and culture
- Based on nursing knowledge and experience or knowledge from relevant sciences
- Within established standards of care as determined by law

Writing Nursing Orders

- After choosing the appropriate nursing intervention, the nurse writes them on care plan as nursing orders.
- Nursing orders are instructions for specific activities the nurse performs to help the client meet established health care goals.

The component of nursing order

A. Date.

- The nursing orders are dated when they are written and reviewed regularly at intervals that depend on the individual's needs.

B. Action verb.

- The verb starts the order and must be precise. Sometimes a modifier for a verb can make nursing order more precise.

The component of nursing order

C. Content area.

- The content is the where and the what of the order.

D. Time element.

- The time element answers when, how long or how often the nursing action is to occur.

E. Signature.

- The signature of the nurse prescribing the order shows the nurse's accountability and has legal significance.

Table 6 components of nursing orders

Date	Action	Content	Time element	Signature
21/10/2005 E.C	Instruct	(client) to avoid drinking liquids with meals if nausea occurs	Evening shift, 21/10/2005 E.C	Abebe .G RN
21/11/2005 E.C	Palpate	Uterine fundus for firmness	Hourly X2,then q2h,X24h	Zaid.T RN


Implementation

Nursing Interventions/implementation

- This is the “Doing” step
- Specific nursing activities /actions that a nurse must perform to prevent complications , provide comfort (physical, psychological and spiritual) and promote, maintain and restore health.
- The implementation phase of the nursing process involves carrying out the proposed plan of nursing care.

Nursing Interventions/implementation cont…

- It is the actual initiation of the plan and recording of nursing actions and client response to these actions.
- It is focused on resolving the patient’s nursing diagnoses and collaborative problems and achieving expected outcomes, thus meeting the patient’s health needs.

Implementing- “Doing”

- Monitor VS q4h
- Maintain prescribed diet
- Teach client amount of sodium restriction, foods high in sodium, use of nutrition labels, food preparation and sodium substitutes.

- Teach potential complications of hypertension to instill importance of maintaining Na restrictions

Implementing – “Doing”

- Teach the client- hypertension can’t be cured but it can be controlled.
- Remind the client to continue medication even though no S/S are present.
- Teach client importance of life style changes: (weight reduction, smoking cessation, increasing activity)
- Stress the importance of ongoing follow-up care even though the patient feels well.


Evaluation

Evaluation

- It is the final step of the nursing process, allows the nurse to determine the patient's response to the nursing interventions and the extent to which the objectives have been achieved.
- 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 cont…

- The way nurses determine whether a client has reached a goal.
- It is the analysis of the client’s response
- Evaluation helps to determine the effectiveness of nursing care.
- Ongoing part of the nursing process
- Determining the status of the goals and outcomes of care

Evaluation cont…

Goal and Expected outcome comparison

To determine how well the plan worked

Process

1. Gathering data
2. Compare data with Expected outcome
3. Make judgment
    a. outcome achieved
    b. outcome not achieved
    c. partially achieved

If not**-----check**

- Interventions
- Human responses
- Outcomes
- Related factors

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.

Documentation

- Nursing care which is **not documented** is considered as a care which is **not performed** at all
- Documentation is good to:
  - Communicate
  - Continuity of care
  - Avoid time wastage
  - Save other resources as well
- Therefore, any nursing action performed should be documented

Summary

The Steps of the nursing process

- **A**ssessment: Getting the facts
- **D**iagnosis: What is the problem?
- **P**lanning: What do you want to happen?
- **O**utcome identification: How can you make it happen?
- **I**mplementation: Doing, delegating, documenting
- **E**valuation: Did it work?