1. The Role of the Adult Health Nurse
   NR 33

2. DEFINITION OF HEALTH
   - A PERSON’S LEVEL OF WELLNESS
   - A PROCESS OF ATTAINING FULL POTENTIAL
   - HOW DO THESE STATES INTERACT?

3. STRESS AND ILLNESS
   (independent study questions….for you to ponder……)
   - Can illness, in and of itself, be a stressor? Give an example.
     - How does it effect other states?
   - Can illness be a response to a non physiologic stressor? Describe a circumstance.
     - What change in other states can contribute to it?
   - Can an individual be ill, yet consider themselves healthy?
     - Why or why not?
   - If an individual develops adaptive skills to cope with illness can they be considered well?
     - Why or why not?

4. Nurses as Facilitators of Health
   - Assist clients in meeting biopsychosocial needs
   - Use evidenced-based practice protocols to manage care
     - adhere to standards of practice to prevent maladaption; primary prevention
     - identify and manage stressors that precipitate illness; secondary prevention
     - restore the client to maximal well-being when experiencing stressors; tertiary prevention

5. Example of Evidence-based Practice
   Healthy People 2010
   Government sponsored plan
   - Establishes goals to improve the nation’s health
     - increase the quality and years of healthy life
     - eliminate health disparities among different demographic groups

6. ILLNESS PREVENTION
   - Primary Prevention
     - avoid or delay occurrence of disease; promote health
   - Secondary Prevention
     - early possible detection of disease or condition; prevent adverse sequelae
   - Tertiary Prevention
     - rehabilitation to restore highest level of function in presence of disease; prevention of disease related deterioration
Is It Primary, Secondary or Tertiary?
- Getting a tuberculin test
- Exercising 30 minutes per day
- Attending physical therapy after TKR

The Profession of Nursing
- Professional Behaviors
  - Adhering to standards of professional practice; being accountable for one’s actions; practicing nursing within legal, ethical and regulatory frameworks; having concern for others; valuing the profession of nursing, and participating on ongoing professional development.

SCCC Core Component

The Role of the Medical-Surgical Nurse
- Critical thinker
- caregiver
- advocate
- continuing care planner
- care coordinator
- change agent
- educator
- candidate for sainthood!!!

How does the medical-surgical nurse prepare to assume this role?
- Approaching their studies and work with an open-mindedness, habit of inquiry, systematicity, an ability to accept feedback and integrate it to improve their performance
- Developing research skills to expand knowledge base
- practicing clinical skills to refine psychomotor performance
- Honing communication skills to enhance therapeutic communication with clients and other professionals
- sharpening critical thinking skills and behaviors to employ the nursing process and develop clinical judgement.

Knowledge in nursing

Systematic research of stressors
- Definition
- Pathophysiology
- Incidence, etiology, high risk populations
- Clinical manifestations/lab diagnostics
- Collaborative management
  - independent vs. non-independent nsg. function
  - (medications, treatments, procedures, etc.)
- Nursing diagnoses/collaborative problems
- Nursing interventions (NIC)
- Evaluation of outcomes (NOC)
14 Clinical skills in nursing

15 Systematic Approach to Skills Performance
   - Definition
   - Indications
   - Complications
   - Necessary equipment
   - Preparation
   - Procedural steps and rationale
   - Expected outcomes

16 Systematic Approach to Medications
   - Classification
   - Therapeutic action
   - Expected doses
   - Major side effects/adverse effects
   - Nursing considerations
     - Administration guidelines
     - What to watch for
     - Hospital / Unit specific P&P

17 Therapeutic communication in nursing

18 Skills in Communication
   - Types of communication
     - Assertive, passive, aggressive
     - Verbal and nonverbal
   - Skills in Communication
     - Listening:
       - Stephen Covey says
         - “seek first to understand, then be understood”
     - Articulation
     - Use of verbal and non-verbal information/uses to exchange information
     - Feedback
       - Interprets communication
     - Processed information is communicated to the sender using verbal and non-verbal communication
   - Characteristics of communication
     - Client/goal oriented
     - Respectful and sincere
     - Empathy and trust
     - Clear and understandable
     - Assertive and problem solving

19 Processes that employ therapeutic communication
   - Assessment/evaluation
     - use of inquiry to collect relevant data
   - Teaching and learning
     - strategies to share knowledge
   - Collaboration/managing care
     - interacting with all member of the healthcare team
   - Documentation
     - maintaining a record to communicate the client’s attainment of outcomes
Clinical Judgement in Adult Health Nursing

Registered nurses engage in clinical judgement the moment they receive report and continue to do so throughout the shift as they employ the nursing process.

Clinical Decision Making

- The systematic analysis and integration of knowledge and information to identify dysfunctional health patterns and stressors in order to formulate clinical judgements and implement therapeutic nursing interventions to assist the client towards a positive outcome. Evidence based practice directs the modification of client care as indicated by the evaluation of outcomes.

SCCC Core Component

It begins when the nurse receives report on the client.

What are Collaborative Problems?

- A diagnostic label that is derived from the analysis of a client’s situation which reveals
  - Medical and nursing interventions are required to assist the client to wellness, independent vs. non-indep nsg. functions
    - In this practice model, nurse’s do not use nursing diagnostic labels to relabel a medical problem
    - It is, what it is.
    - Nursing can quantify the number and frequency of actions requiring nursing judgement that previously were presumed to be in the domain of medicine
    - Have you heard of NIC/NOC?
  - Interventions in collaborative problems ensure that all care providers are on board with the plan that generally can be presumed when a client is experiencing a physiologic stressor:
    - Monitor and evaluate
    - Implement prescribed regimens
    - Integrate nursing actions to facilitate wellness
      - Clear, specific direction to enhance the client’s ability to achieve wellness

Developing Tentative diagnoses / collaborative problems

- Research the admitting stressors
  - List of problems that clients generally experiencing or are at risk for experiencing just because they are experiencing the physiologic stressor that resulted in their hospitalization
- Research the stressors by history
  - Lists of problems that clients may require closer monitoring or modification of their tertiary prevention plan.
  - They may be at greater risk for exacerbation due to admitting stressor
- Research treatments, labs, diagnostics
  - Lists of problems that arise from procedures, surgeries, medications to manage the stressor
- Research the client’s functional health patterns
  - List of problems that arise as we identify risk for criteria or actual defining characteristics of nursing diagnoses that require nursing intervention
  - Tailoring the plan of care uniquely to that client
  - Maintaining a holistic approach

Challenging Tentative Diagnoses / Collaborative Problems

- Initial survey of client yields pertinent data that may support or eliminate assumptions.
- Review of chart information, orders, labs/diagnostics enhances database.
- Eliciting data from client may yield new assumptions that need to be further investigated.

Components of Focused Assessment

Interview

- pertinent patterns are identified based on the tentative diagnoses of the client
- history taking framework is implemented determining pertinent positive and negative findings
  - The nurse asks the right questions from a framework of questions developed from having tentative
diagnoses and collaborative problems

Physical Assessment

27 Developing Inquiry for Focused Assessment
- How do I know what to ask in interview and examination?
  - Eliciting the defining characteristics of the diagnosis listed in Ackley
  - Collecting data from the initial interventions that focus on assessment in the collaborative problem
- Develop mastery only from repeated use of references at the time of data collection and seeking clarification from experts
  - Read your books in clinical as well as after!
    - Referencing topics on an as needed basis

28 Nurses develop conclusions, based on reasoning processes through the analysis of data…

That conclusion becomes the diagnostic label.

29 Organizing Nursing diagnoses/ collaborative problems into a Priority list (Four steps)
1. List the diagnoses/collaborative problems that relate to the current admitting stressors (check collaborative care in nursing text)
   - There are a cluster of collaborative problems that must be present
   - Review data:
     - If defining characteristics are present for tentative diagnoses, create a three part statement
     - If defining characteristics are not present, then create a two part statement as a “risk for” diagnosis
2. List the diagnoses/collaborative problems that relate to the stressors by history (check collaborative care in nursing text)
   - Identify the Collaborative Problems that they may be at greater risk for exacerbation due to admitting stressor
   - Identify actual and risk for diagnoses through researching the stressors by history

30 Organizing Nursing diagnoses/ collaborative problems into a Priority list (continued)
3. List the diagnoses/collaborative problems that relate to treatments, medications, labs, diagnostics (check skills book, text and drug guide)
   Identify collaborative problems/diagnoses that arise from procedures, surgeries, medications to manage the stressor
4. List the diagnoses that arise from analyzing the client’s functional health patterns
   Identify “risk for” criteria or actual defining characteristics of nursing diagnoses that require nursing intervention

31
- Life-Threatening Concerns
  - i.e.: A.B.C.’s
- Safety concerns
  - i.e.: risk for injury
- Patient Concerns
  - i.e.: contacting significant others
- Nursing Concerns
  - i.e.: documentation

32 Initial Client Assessment:
- LOC:  level of consciousness
- A:    airway
- B:    breathing
- C:    circulation/bleeding
- I/O:  everything going in/out
Nurses design plans of care to assist the client in achieving outcomes.

- Nurses make statements about what they would like to see the client achieve in order to manage or resolve the client’s response that triggered the diagnostic label.
- Interventions are nursing actions that directly and indirectly influence client’s health and environment.

The Nurse uses evaluation to monitor progress
- Subjective And Objective Data collected measures the client’s response to plan.
- The nurse’s note is a progress note. Data is organized to determine how the client is responding.
- The evaluation systematically looks at whether the interventions set forth allowed the client to reach the goal...
  - Were they client specific???
  - Do they need to be changed??

Monitor respiratory status, presence of adventitious breath sounds, ineffective cough, presence of sputum; color consistency, quantity.

RR 18, even and unlabored, Lungs bilateral rhonchi. occasional productive cough for thin, scant, yellow sputum. NAD.

Administer humidified O2 as ordered and monitor pulse oximetry q shift.

- position client HOB elevated
- instruct client in C&DB exercises
- encourage 2000 cc fluid/24 hours

- pulse ox 98% on 2 lpm humidified NC. HOB elevated 45 deg, Instructed to C&DB. States understanding, return demonstration given. po fluids encouraged, tolerated 500cc. HNV last 2 hours.

Nurse as Manager of Care

Examples of coordination of care
- Continuity of care
  - interdisciplinary rounds
- Coordination of care
  - discharge planning, home care evaluation
- Quality Management
  - performance improvement plans
  - JACHO standards ie: QI, QA
  - DOH regulations

Nurse as educator
Teaching-Learning Process Sample Case study (see handout)

- Review the client scenario
- supporting data
  - subjective/objective data that indicates that health teaching may be required

ASK YOURSELF……………
- How many pieces of data are needed?
- What is the advantage of stating more data?
- What is the difference between pertinent positive and pertinent negative data?
- Why do you think the list of subjective and objective data is longer than the written scenario?

Teaching-Learning Process Sample
Case study #1
- Assessment
  - identification of a learning need
- Supporting data
  - subjective/objective data that indicates that health teaching may be required

NR 33 TEACHING ASSIGNMENT EXAMPLE
- nr33teaching_assignment_example.doc

Teaching diagnostic labels
- deficient knowledge
- health seeking behaviors
- ineffective health maintenance
- ineffective management of therapeutic regimen
- noncompliance
- any nursing diagnosis where lack of knowledge is the related factor contributing to the problem

Deficient Knowledge
- The state in which the individual or group experiences a deficiency in cognitive knowledge or psychomotor skills concerning the condition or treatment plan.

Health Seeking Behaviors
- The state in which an individual in stable health actively seeks ways to alter personal health habits and/or the environment in order to move toward a higher level of wellness.

Effective Therapeutic Regimen Management
- A pattern in which the individual integrates into daily living a program for treatment of illness and its sequelae that is satisfactory for meeting health goals.

Ineffective Health Maintenance
- The state in which an individual or group experiences or is at risk for experiencing a disruption in health because of an unhealthy lifestyle or lack of knowledge to manage a condition.

Ineffective Therapeutic Regimen Management
- A pattern in which the individual experiences or is at risk to experience difficulty integrating into daily
living a program for treatment of illness and the sequelae of illness that meets specific health goals.

49  **Noncompliance**
- The state in which an individual or group desires to comply but factors are present that deter adherence to health related advice given by health professionals.

50  **Creating Learning Objective**
- Developing measurable outcomes (aka goal)
  - using an action verb
    - states understanding
    - return demonstration
  - established time frame
    - Short term
      - by end of counseling session
    - Long term
      - By discharge
      - Upon return to home

51  **Planning in Health Teaching**
- Selection of teaching methods/tools
  - verbal explanation
  - written instruction
  - brochures
  - videos
  - computer simulation
  - games
  - role playing
  - models/equipment

52  **Teaching interventions**

53  **Evaluation of Teaching**
- Post test
- Verbal query
- Return demonstration!!!!!

54  **Documentation of Teaching**
- 78 y/o fem presented to PMD for evaluation of HTN. Upon interview about HTN management client verbalized, “What is hypertension?”, BP 160/102, States isn’t clear about taking medications, extra pills noted- left in Rx bottle, states “feels fine, I don’t need to take the pills” appears confused, anxious at times. Counseling session regarding disease and medication management initiated using verbal instruction and written material (see HTN flow sheet) Client states understanding. Instructed in use of BP medication journal. Return demo given. Will return for follow-up in one week.

55  **Summary of Medical-surgical Nursing**
- Expanding understanding of core components
- Developing practical knowledge about collaborative care
- Developing diagnostic reasoning skills
- Understanding all roles and associated actions in the care of the medical surgical client
- Assuming the role of client educator

56  **Nutritional Considerations in Nursing Management of**
Medical/surgical Stressors

57 Implications of Nutrition in Nursing evidence in illness prevention plans
- Primary prevention
  - prevention of malnutrition, obesity, disease states
- Tertiary prevention
  - medical-surgical stressors discussed in NR33 require therapeutic dietary interventions to attain / maintain the full potential for wellness
    - Perioperative experiences
    - COPD
    - Protein calorie malnutrition seen in AIDS and Oncology
    - impaired swallowing
    - Diabetes
    - hypertension

58 Nutritional Assessment
- History taking and physical findings
  - interview
  - body measurements
    - Anthropometric measure
    - Body fat analysis/BMI measures
  - physical signs
- laboratory data
  - Serum albumin, proteins, electrolytes
  - lipids

59 Diagnosis/collaborative problems
- Diagnoses are not only nutrition specific
- Like deficient knowledge, nurses integrate nutritional management into a number of nursing diagnoses and collaborative problems
  - i.e.: small frequent meals for COPD clients are used in the plan of care for imbalanced nutrition or possibly in activity intolerance

60 Nursing Interventions
- Consultation
- Promoting and providing adequate and appropriate intake
- Monitoring for potential complications
- Client teaching

61 Evaluation of Outcomes
- S & O data is collected to measure achievement of outcomes
  - direct measures
    - increases/decreases in body weight
    - support of adequate intake in dietary journals
    - increase in total protein
    - therapeutic glucose levels
  - indirect measures
    - decrease exacerbations of COPD events
    - well controlled blood pressure