UNIT-I

Introduction to Medical - Surgical Nursing & History of Medical - Surgical Nursing

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- At the end of the Lecture, the students will able to
- 1.Understand about history of medical surgical nursing
- 2. Define nursing process
- 3. list out the steps of nursing process
- 4.Explain the steps of Nursing process
- 5. Understand the process of application of nursing process for a patient.

Medical-Surgical Nursing

- Medical-surgical nursing is a specialty area of practice that provides nursing services to patients from adolescence
- Nurses specialized in Medical surgical nursing areas working in through inpatient and outpatient clinical settings.
- These settings may include traditional hospital medical-surgical units, clinics, ambulatory care units, urgent care centers, home health care agencies, and long-term care facilities (Academy of Medical-Surgical Nurses [AMSN], 2012, 2016
- To practice as a Medical-surgical nurse, the nurses should demonstrate proficiency in their role by completing certification requirements. They may also enhance practice by completing graduate degree programs in nursing (AMSN, 2012).

Different courses in Medical surgical nursing and Advanced Nursing Roles

- Nursing students, after completion of the undergraduate programme ,they can choose their specialization . They can registered in nurse researchers, nurse administrators, nurse informatics specialists, and nurse educators,
- They may also enroll in either master's programs in nursing
- or doctor of nursing practice (DNP) programs (American Association of Colleges of Nursing [AACN], 2015)
- Certified nurse practitioners (CNPs),
- Clinical nurse specialists (CNSs),
- Certified nurse-midwives (CNMs),
- Certified registered nurse anesthetists (CRNAs),
- all of them are collectively called as advanced practice registered nurses (APRNs)

APRN

The Future of Nursing

منظمة الطب في 2010 قالوا إن مستقبل التمريض لا يمكن فصله عن مستقبل الطب

- Leading Change, Advancing Health (Institution of medicine ,IOM, 2010) identified that the future of the profession of nursing was inextricably tied into the future of health care in the nation.
- This IOM report recommended that nurses practice, "to the full extent of their education and training" (p. 1), to meet the growing primary care needs of health care consumers.

الممرضين لتدريبهم ليلبوا
حاجة الرعاية الأولية المتزايدة

Inter professional Collaborative Practice

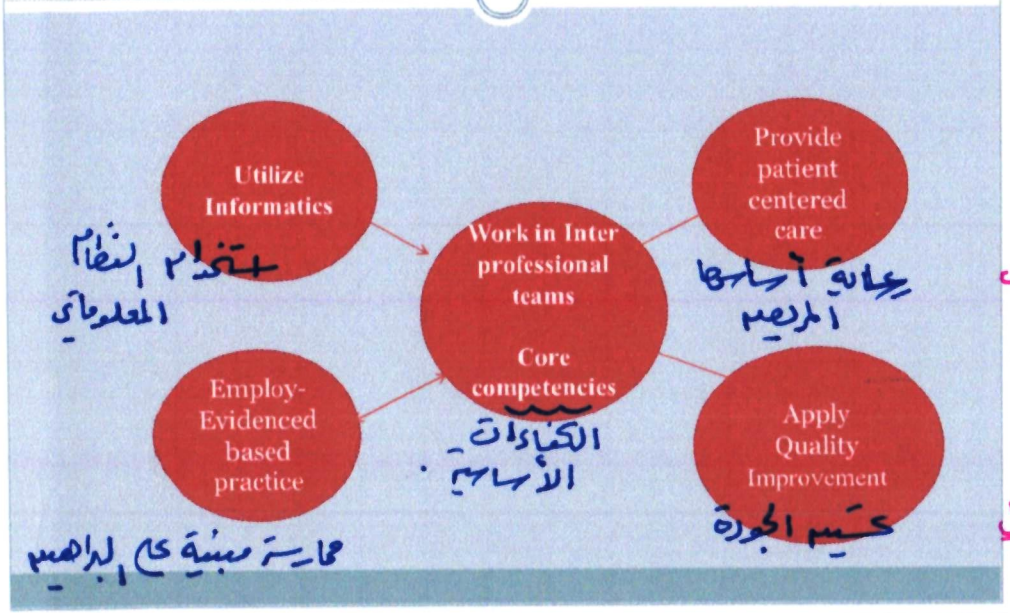
الممارسة التعاونية بين التخصصات

- Medical surgical nurses need to practice inter professional collaborative practice.
- The goal of working together is to building a safer and better patient-centered and community/population oriented US health care
- .
- In recent health professionals to integrate interdisciplinary core competencies into respective curricula to include patient-centered care, interdisciplinary teamwork and collaboration, EBP, quality improvement, safety, and informatics.

- Inter professional collaborative practice involves employing multiple health professionals to work together with patients, families, and communities to deliver best practices, thus assuring best patient outcomes. Inter professional teamwork is viewed as central to this model,

توظيف العديد من التخصصات الصحية للعمل سوياً مع المرضى والعائلات والمجتمع .. لإعطاء أفضل ممارسة ⇐ أفضل نتائج .

Inter professional team model(Refer page no:



The Nursing Process

- **Definition**
- The nursing process is a deliberate problem-solving approach for meeting people's health care and nursing needs
- **Steps in nursing process**
- Assessment
- Diagnosis
- Planning
- Implementation
- Evaluation

Assessment

- Assessment means systematic collection of data. the data are collected through
- Interview,
- Observation
- Physical examination
- **Assessment types**

1.The initial or baseline assessment

Itis a systematic process of collecting predetermined data during the first contact with the patient.

- 2.Ongoing assessment and monitoring are crucial to remain aware of changing patient needs and the effectiveness of nursing care

assessment → initial or baseline
assessment → orgoing / monitoring

- **Assessment -steps**
- 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

Physical Assessment

- **Physical Assessment**
- A physical assessment may be carried out before, during, or after the health history, depending on a patient's physical and emotional status and the immediate priorities of the situation.

The purpose of the physical assessment is

- to identify those aspects of a patient's physical, psychological, and emotional state that indicate a need for nursing care.
- It requires the use of sight, hearing, touch, and smell as well as appropriate interview skills and physical examination techniques.

- **Other Components of the Assessment**
- Additional relevant information should be obtained from the patient's family or significant others, from other members of the health care team, and from the patient's health record or chart.
- Depending on the patient's immediate needs, this information may have been completed before the health history and the physical assessment were obtained.
- A review of a past medical history or records from previous admissions may provide important information for consideration.
- Whatever the sequence of events, the nurse should use all available sources of pertinent data to complete the nursing assessment

- Recording the data after the health history and physical assessment is most impotent steps.
- The information obtained is recorded in the patient's permanent record.
- These records are more commonly becoming electronic record.

Health History

- **Health History**
- The health history is conducted to determine a person's state of wellness or illness and is collected by planned interview.
- **Components of Health History**
- Biographic data
- Chief complain CC
- History of present illness HPI
- Past medical history PMH
- Family history's

Social history :

Ask about:

- Family relation.
- Education level.
- Economic status.
- Home condition.

Life style:

Ask about: Smoking, drinking alcohol, drug use, for how long.

- Dietary habit.
- Exercise

يجب الحفاظ على خصوصية المريض عند استخدام EHR

- Health records are used and when their individually identifiable health information is disclosed to third parties" (p. 1). It is imperative that the patient's right to privacy and confidentiality are not violated through the use of EHRs.
- Regardless of whether the record is in a traditional paper format or an EHR, it must provide a means of communication among members of the health care team and facilitate coordinated planning and continuity of care (Perez-Rivas et al., 2015).
- The record fulfills other functions as well: It serves as the legal and business record for a health care agency and for the professional staff members who are responsible for the patient's care.
- health records فوائد السجلات
  1. provide communication b/w health professionals
  2. Facilitate planning and continuity of care
  3. legal and business record

Diagnosis

حكم طبي بخصوص استجابة المريض للمشاكل الصحية وأمراض الحياة

Diagnosis

- **Diagnosis**: Identification of the following two types of patient problems:
- **Nursing diagnoses:** According to Carpenito (2017), "Are clinical judgments about individual, family, or community responses to actual or potential health problems/life processes" that can be managed by independent nursing interventions .

Steps in Nursing Diagnosis

- Steps in Nursing Diagnosis
- 1. Identify the patient's nursing problems or potential 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.

Nursing Diagnoses

- NANDA International (NANDA-I; formerly known as the North American Nursing Diagnosis Association) is the official organization responsible for developing the taxonomy of nursing diagnoses and formulating nursing diagnoses that are acceptable for study.
- Approved nursing diagnoses, designed by nurses, are compiled and categorized by NANDA-I in a taxonomy that is updated to maintain currency. The revised diagnostic labels identified by NANDA-I
- Currently, NANDA-I has identified 235 accepted nursing diagnoses, which include defining characteristics as well as risk factors for potential problems
- (Refer Brunner and Suddarth"s,Text book of Medical Surgical Nursing.14th edition by Dr.Janice L Hinkle, Keny H. Publized by Wolters kluwer.Page no:277-280)

How to choosing a Nursing Diagnosis

- When identifying a nursing diagnosis for a particular patient, nurses must first identify the commonalities among the assessment data collected.
- These common features lead to the categorization of related data that reveal the existence of a problem and the need for nursing intervention.
- The identified problems are then defined as specific nursing diagnoses.
- Nursing diagnoses represent (1) actual or (2) potential health problems, (3) state of health promotion, or (4) potential risks that can be managed by independent nursing actions

- It is important to remember that nursing diagnoses are not medical diagnoses; they are not medical treatments prescribed by the physician, and they are not diagnostic studies. Rather, they are succinct statements of specific patient problems that guide nurses in the development of the plan of nursing care.

nursing dx	medical dx
identify response to health and illness	Focus on curing pathology
can change from day to day	remains the same until dz goes.

Components of nursing diagnosis

1- Problem: (diagnostic lable)

There are words that have been added to some NANDA label to give additional meaning. e.g. altered, impaired , decrease, ineffective, acute , chronic, Knowledge deficit. Ineffective breathing pattern.

2-Etiology :(related factor and risk factor):

identifies one or more probable causes of the health problem.

3- Defining characteristics:

- Are cluster of sign and symptoms that indicate the presence of a particular diagnostic label.

Evidenced by

Examples

- Activity intolerance related to weakness and fatigue.
- Ineffective peripheral tissue perfusion related to decreased hemoglobin
- Imbalanced nutrition: less than body requirements related to fatigue and inadequate intake of essential nutrients

Planning:

- **Planning:**
- Development of measurable goals and outcomes as well as a plan of care designed to assist the patient in resolving the diagnosed problems and achieving the identified goals and desired outcomes.
- **Steps in Planning**
- Once the nursing diagnoses have been identified, the planning component of the nursing process begins.
- This phase involves the following steps:
- 1. Assigning priorities to the nursing diagnoses and collaborative problems
- 2. Specifying expected outcomes
- 3.Specifying the immediate, intermediate, and long-term goals of nursing action
- 4. Identifying specific nursing interventions appropriate for attaining the outcomes

- 5. Identifying interdependent interventions
- 6. Documenting the nursing diagnoses, collaborative problems, expected outcomes, nursing goals, and nursing interventions on the plan of nursing care
- 7. Communicating to appropriate personnel any assessment data that point to health care needs that can best be met by other members of the health care team

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Assigning priorities

- Consideration must be given to the urgency of the problems, with the most critical problems receiving the highest priority.
- Maslow hierarchy of needs provides one framework for prioritizing problems, with importance being given first to physical needs; once those basic needs are met, higher-level needs can be addressed.

Establishing Expected Outcomes

- Expected outcomes of the nursing interventions, identified either as long term or short term, are written in terms of the patient's behaviors and the time period in which the outcomes are to be met.
- The outcomes must be attainable and quantifiable (Carpenito, 2017).

يعني في صراعين في حكم الـ outcomes

- These outcomes can be associated with nursing diagnoses and interventions and can be used when appropriate.
- However, the NOC may need to be adapted to establish realistic criteria for the specific patient involved.
- The expected outcomes that define the patient's desired behavior are used to measure the progress made toward resolving the problem.
- The expected outcomes also serve as the basis for evaluating the effectiveness of the nursing interventions and for deciding whether additional nursing care is needed or whether the plan of care needs to be revised.

1. To measure the progress made toward resolving the problem.
2. evaluating the effectiveness of nursing interventions.
3. to decide → additional nursing care?
   → plan should be revised?

- For example,
- **Nursing diagnosis**
- Impaired physical mobility related to pain and edema following total knee replacement may be stated as follows
- Immediate goal: Stands at bedside for 5 minutes 6 to 12 hours after surgery
- Intermediate goal: Ambulates 15 to 20 minutes with walker or crutches in hospital and home.
- Long-term goal: Ambulates independently 1 to 2 miles each day.

الخطوة الثالثة Establishing Goals

- Types of goals
- Immediate,
- Intermediate, and
- long-term Goals
- The patient and family are included in establishing goals for the nursing actions.
- Immediate goals are those that can be attained within a short time frame.
- Intermediate and long-term goals require a longer time frame to be achieved and usually involve preventing complications and other health problems and promoting self-care and rehabilitation.

(1) (2) (3) مهم

الخطوة الرابعة Identifying specific nursing interventions appropriate for attaining the outcomes

- In planning appropriate nursing actions to achieve the desired goals and outcomes, the nurse, with input from the patient and significant others, identifies individualized interventions based on the patient's circumstances and preferences that address each outcome.
- Interventions should identify the activities needed, who will implement them, as well as the frequency. Determination of interdisciplinary activities is made in collaboration with other health care providers as needed.
- The patient's medications and other prescribed treatments should be integrated into the plan of care to assist the nurse in determining how all interventions contribute to resolution of the identified problems.

(3) (1) (2) (4)

- The nurse identifies and plans patient education and demonstration as needed to assist the patient in learning certain self-care activities.
- Planned interventions should be ethical and appropriate to the patient's culture, age, developmental level, and gender.
- Standardized interventions, such as those found on standardized care plans or in the Nursing Interventions Classification (NIC)
- It is important to individualize prewritten interventions to promote optimal effectiveness for each patient. Actions of nurses should be based on established standard

- Listed under each intervention are multiple discrete nursing actions that together constitute a comprehensive approach to the treatment of a particular condition. Not all actions are applicable to every patient; nursing judgment and critical thinking will determine which actions to implement. The following is an example of a nursing intervention

Example

- Ventilation Assistance
- Definition Promotion of an optimal spontaneous breathing pattern that maximizes oxygen and carbon dioxide exchange in the lungs
- **Activities**
- Maintain a patent airway. Position to alleviate dyspnea.
- Position to facilitate ventilation–perfusion matching ("good lung down"), as appropriate. Assist with frequent position changes, as appropriate. Position to minimize respiratory efforts (e.g., elevate head of bed and provide overbed table for patient to lean on).

3 Monitor the effects of position change on oxygenation (e.g., arterial blood gases, SaO2, Sv -O2). Encourage 4 slow deep breathing, turning, and coughing.

5 Assist with incentive spirometer, as appropriate.

6 Auscultate breath sounds, noting areas of decreased or absent ventilation and presence of adventitious sounds.

7 Monitor for respiratory muscle fatigue. Initiate and 8 maintain supplemental oxygen, as prescribed.

9 Administer appropriate pain medication to prevent hypoventilation. Ambulate three to four times per day, as appropriate. 10

Implementation

- The implementation phase of the nursing process involves carrying out the proposed plan of nursing care. The nurse assumes responsibility for the implementation and coordinates the activities of all those involved in implementation, including the patient and family, and other members of the health care team so that the schedule of activities facilitates the patient's recovery.
- The plan of nursing care serves as the basis for implementation as such: The immediate, intermediate, and long-term goals are used as a focus for the implementation of the designated nursing interventions.

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- **Steps in Implementation**:
- Actualization or carrying out of the plan of care through nursing interventions.
- Implementation Put the plan of nursing care into action.
- 1. Coordinate the activities of the patient, family or significant others, nursing team members, and other health care team members.
- 2. Record the patient's responses to the nursing actions

- While implementing nursing care, the nurse continually assesses the patient and the patient's individual response to the nursing care. Revisions are made in the plan of care as the patient's condition, problems, and responses change and when reordering of priorities is required. Implementation includes direct or indirect execution of the planned interventions.

مستقل
التطبيق < تعاوني

- Although many nursing actions are independent, others are interdependent, such as carrying out prescribed treatments, administering medications and therapies, and collaborating with other health care team members to accomplish specific expected outcomes and to monitor and manage potential complications.
- Such interdependent functioning is just that—interdependent. Requests or prescriptions from other health care team members should not be followed blindly but must be assessed critically and questioned when necessary.
- The implementation phase of the nursing process ends when the nursing interventions have been completed.

عندما تنتهي فترة العلاج ⇐ تنتهي فترة التطبيق

Evaluation

- **Evaluation:** تحديد استجابة المريض للعلاج
- Determination of the patient's responses to the nursing interventions and the extent to which the outcomes have been achieved ومقارنتها بالنتائج المتوقعة
- **Steps in 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. إدخال المريض وعائلته في التقييم

- 4. Identify alterations that need to be made in the nursing diagnoses, collaborative problems, goals, nursing interventions, and expected outcomes. حدد اي هل تحتاج تغيرات في تشخيص التمريض
- 5. Continue all steps of the nursing process: assessment, diagnosis, planning, implementation, and evaluation. نرجع نعيد البرسيس من الأول

Evaluation

٤. المتوقعة حصلنا على النتائج

Evaluation

- By asking questions like
- nursing diagnoses and collaborative problems accurate?
- Did the patient achieve the expected outcomes within the critical time periods?
- Have the patient's nursing diagnoses been resolved? التشخيص اشتل؟
- Have the collaborative problems been resolved? Do priorities need to be reordered? اختلت الأولويات هل يعاد ترتيبها؟
- Have the patient's nursing needs been met? Should the nursing interventions be continued, revised, or discontinued? العلاج يستمر؟ يتعدل؟ يتوقف

هل يوجد مشاكل جديدة غير مخطط لها؟

ما هي العوامل التي أثرت على تحقيق الأهداف؟

- Have new problems evolved for which nursing interventions have not been planned or implemented?
- What factors influenced the achievement or lack of achievement of the objectives? Should changes be made to the expected outcomes and outcome criteria?
- Objective data that provide answers to these questions are collected from all available sources (e.g., patients, families, significant others, health care team members). These data are included in patients' records and must be substantiated by direct patient observation before the outcomes are documented

Documentation of Outcomes and Revision of the Plan

يجب توثيق النتائج بدقة وموضوعية

- Outcomes are documented concisely and objectively.
- Documentation should relate outcomes to the nursing diagnoses and collaborative problems, describe the patient's responses to the interventions,
- indicate whether the outcomes were met, and include any additional pertinent data.

يجب توثيق العلاقة بين الاستجابة للتدخلات التمريضية والمشاكل الصحية