Part 1 Fundamentals of Nursing Care

Rapid Adult Nursing, First Edition. Andrée le May.

A

Adult nursing

Definition

Adult nursing comprises the skilled, dignified care of adults. It focuses on acute and chronic physical conditions rather than mental illness. Adults are nursed in a variety of settings – the community, hospitals and longer-term care settings.

Excellent care for adults through their lifespan is about what nurses do, and how nurses do it, in partnership with patients, their families and carers, as well as in collaboration with other members of the multi-disciplinary health and social care team.

Fundamental to excellent nursing is the merging of technically competent care with the maintenance and/or enhancement of the patient's (and their family's and carer's) dignity.

Care that is technically competent but does not promote the patient's dignity is inadequate; care that promotes dignity but is not technically competent is also inadequate. Excellent nursing is therefore underpinned by the following:

- Safeguarding dignity.
- Skilled, appropriate communication.
- Accurate assessment and monitoring.
- Tailored symptom control and management.
- Attentive risk assessment and management.
- Tailored health education and promotion.
- Thorough discharge planning.
- Evaluation of the outcomes of care and care processes.
- Use of the best evidence from research, theory, audit and service/practice development.

Nurses are accountable for the care they provide and must practise within the legal and ethical frameworks laid down by their professional and regulatory bodies.

Assessment and monitoring

Definition

Assessment is the systematic collection of key information to inform care. Monitoring is the regular updating of this information. Assessment and monitoring are iterative processes.

Accurate assessment and ongoing monitoring of a patient's physical and mental health are critical to the provision of effective, safe and timely care and the plotting of progress/deterioration. Assessment and monitoring of the patient's relatives' responses to the illness/condition and its consequences also need to be conducted. All nurses, regardless of the healthcare setting in which they work, undertake various types of assessment and monitoring.

Skilled assessment is linked to the ability to prioritise care that needs to be done urgently (e.g. through using early-warning scales) and care that can wait.

Successful assessment and monitoring involve nurses merging hard data (e.g. from measurement equipment and assessment scales) with soft data (e.g. from talking, watching and listening to patients, their families and their healthcare team members) to form a complete picture of the patient's condition and their response(s) to it and to nursing care and treatments.

Assessments can range from the comprehensive (e.g. covering physical, psychological, social, emotional, spiritual and cultural dimensions) to the specific (e.g. taking a temperature or monitoring wound healing).

Making a comprehensive nursing assessment should be done in partnership with the patient and their family/carers and it underpins the delivery of care. All nursing assessments should inform and be informed by those made by other health and social care workers.

The specific assessment and monitoring of elements of a patient's health can help in the early detection of general health problems (e.g. hypertension); in establishing the effectiveness of treatments (e.g. in type 1 diabetes); in determining the progression of an acute illness (e.g. an infection) or a long-term condition (e.g. multiple sclerosis), the impact of one type of illness on another (e.g. an acute respiratory infection on asthma) and the generation of one illness because of another (e.g. depression resulting from chronic obstructive pulmonary disease).

Accurate baseline assessments are essential if improvement or deterioration of a patient's health is to be identified swiftly and managed appropriately through ongoing monitoring.

The results of assessment and monitoring need to be accurately recorded in a patient's care plan or notes.

Initial assessments and deviations from the expected course of a patient's condition need to be effectively communicated to relevant healthcare team members. Using a structured approach to communicating your assessment and planning (e.g. SBAR: Situation, Background, Assessment and Recommendation) can be useful in effectively explaining requirements to patients, their families and members of the multi-disciplinary team.

Following an initial nursing assessment, the majority of ongoing monitoring is likely to focus on four key areas:

- The patient's physical health and present condition set against the treatment plan.
- The patient's mental health and present condition set against the treatment plan.
- Any special requirements the patient has.
- The patient's and the carer's requirements for social support.

Audit

Definition

Audit is a cyclical process of measuring care against agreed criteria (or standards), deciding whether alterations need to be made to care, making changes, and measuring again to see whether the change has been effective. Audits are used to provide information that can help inform best practice and should be carried out regularly.

Figure 1 The clinical audit cycle.

Audit can be done either at a national or at a local level.

Copeland (2005, p. 16) provided the following criteria to help practitioners develop a good local audit:

1. Should be part of a structured programme.
2. Topics chosen should in the main be high risk; high volume or high cost or reflect National Clinical Audits, NSFs (National Service Frameworks) or NICE [National Institute for Health and Care Excellence] guidance.
3. Service users should be part of the clinical audit process.
4. Should be multidisciplinary in nature.
5. Clinical audit should include assessment of process and outcome of care.
6. Standards should be derived from good quality guidelines.
7. The sample size chosen should be adequate to produce credible results.
8. Managers should be actively involved in audit and in particular in the development of action plans from audit enquiry.
9. Action plans should address the local barriers to change and identify those responsible for service improvement.
10. Re-audit should be applied to ascertain whether improvements in care have been implemented as a result of clinical audit.
11. Systems, structures and specific mechanisms should be made available to monitor service improvements once the audit cycle has been completed.
12. Each audit should have a local lead.

C

Communication

Definition

Communication is the transfer of information between one person and another, and their reaction to it. Communication permeates everything that nurses do, and being able to communicate effectively with patients, their families/carers and colleagues is an essential feature of skilled nursing practice. Skilled communication enhances care.

Communication includes a variety of different verbal and non-verbal cues and skills. Verbal communication comprises speech and language – this includes the way we use words, tones and inflections; the way we phrase what we say; and the questions that we ask in order to communicate what we are thinking and feeling. Non-verbal communication involves many things: touch, facial expressions, eye contact and the way we look at each other, gestures, body movements, posture and body positions, our use of space, the clothes we wear and our appearance, and even the timing of communication. Non-verbal communication supports verbal communication, but it is a powerful way of communicating information on its own. Silence is also a powerful means of communication.

Written communications are important to convey information between members of the multi-disciplinary team and to help patients and their families/carers retain information about their illness and treatment.

Communication is influenced by many things, including culture, age, mood, emotion, uncertainty, stress, anxiety, knowledge and skills. When considering patients and their families, it is important to remember that the effectiveness of communication can be affected by age-related or disease-linked problems, such as hearing loss, sight loss or alterations, speech alterations, emotions, mood, memory changes and cognitive impairment. Nurses need to minimise these barriers and also to reduce organisational barriers such as lack of privacy, having insufficient time to clarify uncertainties or misunderstandings, and communicating complicated information in noisy environments that make talking and hearing difficult. Altered mental capacity may mean that a patient is unable to communicate their wishes, understand information given to them or use it in decision making.

When communicating within the multi-disciplinary team, it is also important to reduce barriers associated with busyness, stress and status. Using a structured approach to communication such as SBAR (i.e. giving details of the current Situation your patient is in, providing essential Background to this, giving your Assessment of what is happening and your Recommendation about what needs to happen next) is useful, especially in situations where urgent attention and clarity of information are needed.

Effective communication is about using the right verbal and non-verbal skills for the person (or people) involved in each interaction. Useful communication skills include:

- Establishing rapport.
- Active and empathic listening.
- Responding and being able to summarise information accurately.
- Not being afraid to keep quiet (or to speak out).
- Using questions to find out more (particularly open questions).
- Using reinforcement (e.g. ‘go on’, nodding) to encourage communication.
- Using story-telling to find out more or engage people in conversation as appropriate.
- Using touch appropriately, particularly expressive touch.
- Observing people’s reactions and changing your communication style in response.
- Being non-judgemental and open.
- Showing respect and maintaining dignity through both actions and words.
- Remembering that the ‘little things’ (e.g. smiling and eye contact) are important.
- Evaluating how well your interactions with people go is important in either reinforcing effective skills or improving things for next time.

Continuing professional development

Definition

Continuing professional development (CPD) is about ensuring that your knowledge and skills are up to date and that you remain competent to practise throughout your career. CPD is something that every healthcare professional has to do.

CPD is sometimes described as continuing personal and professional development (CPPD), and this reflects the breadth of opportunities that can count as CPD.

The Nursing and Midwifery Council (NMC) requirements for CPD must be met every time you renew your registration. For nurses working in the UK, CPD may include regularly updating skills and knowledge, reflecting on practice and their day-to-day work and teaching/mentoring others. All of these involve continuous learning and development. Taking part in and implementing the learning gained from these activities enables nurses to give safe, up-to-date, highly skilled care.

CPD is not, for instance, just about going on courses and collecting certificates – it involves thinking about how you will use your learning to develop yourself as well as your care. This self-development can be structured by writing a personal development plan (PDP) and sharing it with your manager or mentor. A PDP helps you plan what you intend to learn or improve in the future. Clinical supervision also helps with your personal development.

All the CPD you do should be recorded in a portfolio. This will provide you with a useful record of what you have achieved, which will be helpful for constructing your curriculum vitae or for presentation to the NMC if it checks your CPD activities when you re-register/re-validate. Your portfolio should document what you have done, what you have learnt from it and how it has influenced your practice; it should make reference to your PDP.

CPD does not just have to be about developing clinical knowledge and skills. It is important to develop other skills as well in order to enhance the care that you provide. For example, you might choose to develop some managerial skills, delegation skills or leadership skills – all of these will make you a more competent practitioner.

All in all, CPD is about making you a more accomplished nurse.

D

Dignity

Definition

Dignity is often said to be hard to define. The available definitions tend to focus on either the professional view of dignity or the public's view. The challenge is to integrate them.

Professional definitions of dignity are frequently abstract and are inclined to focus on the behaviours, values and attitudes that professionals need to have. For example, 'Dignity is concerned with how people feel, think and behave in relation to the worth or value of themselves and others. To treat someone with dignity is to treat them as being of worth, in a way that is respectful of them as valued individuals' (RCN, 2008).

Public reports (e.g. Francis, 2013) and research (e.g. Cairns et al., 2013), however, suggest that patients and the public see dignity in more pragmatic terms, focusing on whether or not certain important aspects of daily living can be completed while relying on others for assistance. These include having privacy, being able to go to the toilet when needed, being able to wash after using the toilet, having food and drink that can be consumed when needed and when wanted, being helped with eating and drinking if necessary, being listened to and having opinions respected.

Integrating the professional and the public views of dignity is important to the provision of excellent care, so that patients and their family feel that they have experienced competent, individualised care that allows them to maintain their dignity. Dignity is maintained in the following ways.

What nurses do, for instance:

- Work with patients and their families/carers to identify and understand their individual needs and decide, with them, what care is required to meet these needs.
- Undertake such care in a timely and respectful manner.

How nurses do it, for instance:

- Treat each patient as an individual.
- Listen to and respect their views.
- Work in partnership with each patient and their family/carers.
- Offer choice wherever possible.
- Promote privacy.
- Ensure that people can voice satisfaction and dissatisfaction with care without fearing reprisal.

When nurses do it, for instance:

- Identify with patients (and their family/carers) mutually convenient times for care whenever possible.
- Ensure that medications, designed to fit the patient's needs rather than the treatment plan, are given on time (particularly night sedation).
- Question practice that they think is inappropriate.

Discharge planning

Definition

Discharge planning always occurs in partnership with the patient and their family/carers as well as with other members of the multi-disciplinary team. Planning a person's discharge from nursing care should start during their initial assessment, when care is being planned and agreed. For patients having surgery or any other planned procedure, discharge planning will have been discussed during their pre-assessment visit. In primary care, discharge from nursing care is usually negotiated between the patient, their family/carers and the nursing team/nurse.

In hospital wards, patients are often given an expected date of discharge (EDD) once their medical condition has been stabilised. Having an EDD helps all members of the multi-disciplinary team, the patient and their family/carers plan ahead.

Discharge planning is usually led by a senior member in the nursing team or the patient's key worker. A person's discharge from any care environment should be coordinated, efficiently undertaken and, where appropriate, ensure the smooth passage of a person's care from one service to another. Hospitals will have discharge policies to guide discharge planning. Some wards will have their own tailored policy.

Inadequate discharge planning can result in patients and their families/carers being unprepared for the realities of returning home from hospital or transferring to another care environment (e.g. a nursing or residential home), or in them receiving unsuitable care. Poor discharge planning may mean that patients have to stay in hospital longer or are re-admitted, or that they recover less well.

Discharge planning should take into account all the aspects of a comprehensive assessment (e.g. the physical, psychological, social, emotional, spiritual and cultural dimensions). For some people, it will also be necessary during this process to discuss economic and environmental factors, such as housing, benefits and return to work, alongside daily routines such as shopping and cooking.

Referral to members of the multi-disciplinary team for assessment should be made as soon as possible.

Some patients may decide to discharge themselves from hospital against medical advice and this needs to be reported appropriately and recorded.

Some people will have particular care needs following discharge from hospital or transfer between services. This group includes people who are elderly, who are dying, whose condition is unpredictable, who live alone, who require equipment with which they are not yet familiar, who are homeless or live in poor housing conditions, and those with learning difficulties or ongoing health problems.

Effective discharge is achieved when:

- The discharge plan is agreed in partnership with the patient, their family/carers and the multi-disciplinary team.
- The patient and family/carers are fully informed of the plan and help shape it.
- A named nurse/key worker is appointed to coordinate a patient's discharge from any healthcare service.
- All relevant documents are updated and information is transferred to all appropriate services in time to ensure that continuity of care is maintained.
- Relevant services are introduced into the care package at the right time to ensure continuity of care.
- Success is monitored.
- Deviations from the plan are identified and corrected.

Documentation

Definition

Clearly, succinctly and accurately recording care given, or to be given, is a vital part of communication within the healthcare team and between services. Accurate documentation promotes continuity of care.

Professional and statutory bodies lay down guidance for record keeping. Care and observations of a patient's condition are recorded through a variety of paper and/or electronic means, including:

- Patient records (e.g. including nursing assessments)
- Care plans
- Medication charts
- Observational charts (e.g. vital signs, fluid balance, Glasgow Coma Scale, pain scales)
- Printouts from monitors (e.g. ECGs [electrocardiograms])
- Risk assessment charts (e.g. early warning scores, pressure ulcer risk assessment)
- Letters/emails/text messages
- Photographs (e.g. of wounds)

Written information (either on paper or electronically) is an indispensable way of recording care and should be presented so that it can be understood by any reader. Information should be recorded clearly without using ambiguous terms or abbreviations. Where handwriting is used, it should be legible and in ink.

While record keeping is an essential part of care, all necessary steps should be taken not to allow it to drive patient care or to intrude excessively into the time devoted to patient contact.

E

Eating and drinking

Definition

Eating and drinking the right things are important in maintaining health and aiding recovery from illnesses, surgery or accidents. The body requires particular nutrients to stay healthy (proteins, fats, carbohydrates, vitamins, minerals and fluids). In ill health or following surgery, the body may require extra nutrients for repair. Imbalances of nutrients can alter the body's homeostasis.

Eating and drinking are social activities, and doing them alone may increase feelings of social isolation in some groups of people (e.g. older people eating by themselves in their rooms in residential or nursing homes).

Malnutrition is any imbalance between the person's nutritional needs and their diet. It can be assessed using the Malnutrition Universal Screening Tool (MUST).

Eating and drinking difficulties can occur for a variety of reasons, for example nausea and/or vomiting; a sore mouth or ill-fitting dentures; difficulty swallowing; difficulty using equipment such as cutlery following paralysis or as a result of severe dementia; anorexia; early satiety; allergies or intolerances; or particular diseases (e.g. diabetes).

Nurses, alongside dieticians, catering staff, occupational therapists, physiotherapists, speech and language therapists and healthcare assistants, have an important role to play in making sure that patients consume an appropriate diet. This is not merely about eating and drinking the right things, it is also about the functional ability to eat and drink (e.g. having sufficient dexterity to open food packaging, having dentures that fit and are in place, being able to reach drinks or meals that are left at the bedside, having the right adapted cutlery/plates/mats or being able to swallow).

Nurses need to assess whether a patient has consumed an appropriate amount of food and drink each day. This will involve finding out whether food is left uneaten, why this happened and making appropriate changes.

Nutrition screening will include:

- Asking about usual diet (food and drink).
- Asking about food preferences/allergies.
- Asking about normal food habits (e.g. Does the patient usually eat breakfast? Which meal is the largest during the day? Does the patient eat sandwiches for supper?).
- Discussing feeding difficulties (e.g. using special cutlery, ill-fitting dentures, sore mouth).
- Checking weight, height and Body Mass Index (BMI) on admission or more regularly.
- Checking BMI in primary care to determine the need for lifestyle changes in relation to weight gain or loss.
- Observing the patient (e.g. pallor, skin tone, under/overweight, oedema, mood).
- Noting results from blood tests (e.g. for anaemia).
- Evaluating nutritional intake (e.g. Are meals left unfinished? Is there a mismatch between fluid intake and output? Does the person feel hungry after eating?).

Some people will require nutritional support, for example oral supplements/sip feeds (high calories, high protein or high vitamin), or feeding using special preparations put directly into the gastro-intestinal tract via a naso-gastric (NG) tube or a percutaneous endoscopic gastrostomy (PEG), or intravenously using total parenteral nutrition (TPN).

Some people will have special dietary requirements. For instance, people with coeliac disease require a gluten-free diet, people with constipation may require a high-fibre diet, people with heart failure or cirrhosis of the liver may have a low-salt diet to help, alongside diuretics, control oedema.

Evaluation

Definition

Evaluation is about judging how effective nursing has been and is therefore closely linked to monitoring and assessment. Evaluation is used here to refer to an assessment of a completed episode of care, whereas monitoring is seen as a continuous evaluative exercise that is iterated with assessment.

At a broad level, evaluation centres on determining whether a patient's condition has improved, remained stable or deteriorated. At a more specific level, the achievement (or not) of each patient-centred goal set during the assessment process should be evaluated. Each goal should have an accompanying measurable outcome (e.g. the patient will walk for 20 minutes each day) that can be evaluated. Understanding why a patient does not reach goals is important to planning future care, both for the patient and for others. Understanding what has helped a patient to reach goals, but was not part of the care plan, is also useful.

A patient's and their family's/carer's satisfaction with care can also be evaluated and this can be done by asking them or by using a short satisfaction survey.

The results of individual patient evaluations should be recorded in the care plan or nursing notes and communicated to others in the multi-disciplinary team as required. Individual evaluations can be collated in audits to get a broader view of how successful care has been.

Discussing evaluations within the nursing team or the multi-disciplinary team can help to improve care or celebrate successful care, and also help to identify areas for audit.

Evaluations should be done against agreed outcomes, which should be 'SMART':

- Specific
- Measurable
- Achievable
- Realistic
- Timely

Evidence-based practice

Definition

Evidence-based practice is usually defined as 'the application of valid, relevant research-based information in nurse decision making' (Cullum et al., 2008, p. 2). While applying valid and relevant research to practice is essential, it is also important to remember that rigorous and relevant research may not always be available to base practice on. In this case, practitioners need to consider what other sorts of evidence could be used to support effective and efficient care. Other sources of evidence might include:

- Evidence from structured evaluations of practice (audit or other analyses of safety records, complaints etc.).
- Evidence from theory that is not grounded in research.
- Evidence from your experiences (professional and general).
- Evidence from your patients and/or their families and carers.
- Evidence passed on by role models/experts.
- Evidence from policy directives or guidelines.

Sometimes none of these is relevant and you have to search more widely for knowledge to help you to provide appropriate care. This might include searching for unpublished evidence in reports, research abstracts or conference proceedings using the internet or the media. Wherever the evidence comes from, it will require careful appraisal before it can be implemented. Attention needs to be paid to establishing the rigour of the evidence – research or otherwise. For research evidence this is primarily about reliability and validity and there are many crib sheets and tools that can help you do this (e.g. the series of CASP tools available at http://www.casp-uk.net/). For other sorts of evidence you should establish authenticity and robustness. To do this you might try to find out, for instance, the extent to which the evidence has been used elsewhere or evaluated before you use it.

Once you have decided that the evidence is suitable for use, it is important to establish its clinical relevance to the situation in which you intend to use it. Use these questions to help you do this (le May, 1999 and le May & Gabbay, 2010):

Is the evidence relevant clinically for the client?

1. What benefits will the implementation of this evidence have for patients/carers/staff?
2. What risks are associated with implementation/non-implementation?

Can the evidence be used by the organisation within which care is being given?

1. Are there enough resources for implementation?
2. What are the opportunities for and constraints to implementing this evidence?

Once you have established that the evidence can be trusted and is clinically relevant to your client, then you can use it in your practice and evaluate its effects and usefulness.

Fundamentals of nursing care

Definition

Excellent care is about what we do and how we do it.

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- Attentive risk assessment and management.
- Tailored health education and promotion.
- Thorough discharge planning.
- Evaluation of the outcomes of care and care processes.
- The use of the best evidence from research, theory, audit and service/practice development.

H

Health education and promotion

Definition

The World Health Organisation (WHO) defines health education as 'any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge and influencing their attitudes'.

Health promotion is defined by the WHO as 'the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.'

Increased knowledge and changed behaviour in individuals and communities/populations are the goals of health education and promotion. Behaviour change can occur as a result of a person changing what they do (e.g. stopping smoking), or by governments making laws that alter many people's behaviours (e.g. banning smoking in public places), or by communities exerting pressure to change behaviour (e.g. publicising the effects of passive smoking).

Educating people about their health and encouraging them to lead healthier lifestyles and to feel in control of their health and alterations to it are essential features of nursing.

All nurses, whatever their practice setting, will be involved in educating patients and their families/carers about health, and ways to improve their health or maintain a healthy lifestyle. These can range from education about medication to how to increase exercise and reduce weight. Some nurses, largely public health nurses and occupational health nurses, will take part in developing local and national policy on health improvements or creating healthy workplaces, hospitals and schools.

The basic principles of educating someone about health issues are:

- Work out what the person needs to know.
- Work out what the person does know.
- Work out the best way to fill the gap (if there is one), starting from where the person is.

Remember that when people are ill/uncomfortable/anxious their concentration level may be low, so it is important to be clear and concise in what you say and to use simple, easy-to-follow language. Make sure that you give information in small chunks and check out the person's understanding of what you said. It is useful to supplement oral information with written information. Always tell a person where to get advice if they forget what you say or something unexpected or unexplained happens, and if possible set up another time to check out what they know as a result of your intervention.

Infection prevention and control

Definition

Infection control and prevention are part of everyone's life. For example, we wash our hands after using the toilet or before we eat, and we stay at home when we are ill and likely to pass on infections to other people.

Nurses deliver care to people who may be infectious or vulnerable to cross-infection from other people, and so need to take extra precautions. Nurses protect people against infections in several ways. These include:

- Health education and promotion (e.g. teaching about infection control, encouraging vaccinations and immunisations).
- Preventing cross-infection between patients in hospital or in the community by vigilant hand washing (or the use of alcohol gel); the correct use of gloves, gowns and masks; the correct disposal of infected materials and sharps; and the use of isolation if appropriate (either to protect an immunocompromised person from developing infection or to stop other patients from coming into contact with someone whose illness is contagious).
- Preventing wound infections, bladder infections or intravenous infusion (IVI) site infections by using scrupulous aseptic techniques.
- Recognising infection so that treatment can be started as soon as possible (e.g. acting on changes in vital signs – elevated temperature, respirations or pulse; noticing heat, swelling, redness, pus or pain at the site of the infection; acting on reports of feelings of general malaise, confusion and specific condition-related responses, e.g. nausea, vomiting and diarrhoea in gastro-intestinal infections or frequency of micturition in urinary tract infections or cough with/without sputum in respiratory tract infections).
- Ensuring that anti-infective medications are taken as prescribed.
- Ensuring that the rules of basic hygiene are adhered to, for instance offering bed-bound patients hand-washing or hand-cleansing facilities after using a bedpan, bottle or commode, and before meals.

Leadership

Definition

Leadership is often described as being about our relationships with other people and the way we constructively influence them, and how we make things happen in teams, services and/or organisations. There are three key interacting elements in this influencing relationship within nursing: the leader, the people/person being influenced (sometimes known as followers, especially when we are thinking about teams of people) and the job/task being done. In nursing particularly, the job/task often involves other groups of people – either patients/service users and their families and carers or our health and social care colleagues. Leadership is largely about people and the way they communicate and behave.

Nurses are leaders in many situations – they lead episodes of care with patients and their friends and families; they lead teams of people providing care or those taking part in service development or improvement projects; they lead groups of students through mentorship and their peers through clinical supervision; and they lead health and social care organisations at various levels, from team leader to chief executive. Whatever the situation in which nurses are leading, the core element in that leadership process/relationship is ensuring that the most appropriate and effective care possible is given. Nurses often do that by influencing other people.

Good leaders are generally thought to have some or all of the following personal qualities and abilities: they are calm, enthusiastic, courageous and self-motivating; they have humility and integrity; they are seen to be tough but fair; and they possess and represent the qualities expected or required by the group of people they are leading. They use these qualities to help them to influence others, articulate their vision clearly, make and take decisions, work creatively and collaboratively, and be responsive and flexible. They motivate and encourage others to use their talents while being politically astute.

Leading people successfully requires nurses to be resourceful and adapt their leadership style and approach to suit the range of different situations (and people) that they encounter every day. Whoever or whatever it is that nurses are leading, their leadership needs to be clear, consistent and strong in order to ensure that dignified, high-quality care is delivered within a positive and supportive working environment.

M

Management

Definition

Management, just like leadership, is about working with and influencing people. Unlike leadership, the main purpose of management is to achieve the goals of the organisation. Management is therefore largely associated with specific, goal-oriented functions. Leaders do not generally have to achieve the same goal-oriented work as managers and so may be more able to be creative in what they do.

Planning, organising, motivating and controlling are the common functions of management (Rigolosi, 2013); although these functions can be described separately, they are often interlinked. *Planning* is about identifying problems, detailing long- and short-term goals, deciding on objectives and then working out how the goals and objectives are to be achieved. Goals and objectives need to be kept simple, meaningful, achievable and realistic; they also need to have a timescale attached to them (this is sometimes referred to as setting SMART goals/objectives). *Organising* is about getting together all the resources needed to achieve your goals – these resources include not only people with the right knowledge and skills, but also finance and equipment. *Motivating* other people to achieve the goals that are set is an important and sometimes challenging aspect of management. If people are not motivated they will not work effectively or efficiently, and this will have a negative impact on the organisation's effectiveness. Goal setting must therefore not only reflect the abilities of the people involved and available resources, but also the team and manager's motivation. *Controlling* does not mean controlling in terms of stopping people doing things or being manipulative; here controlling is about setting up ways to evaluate progress, either at the end of a job/project (summative evaluation) or at points during the job in order to act on this feedback (formative evaluation) to make the job go better. This ongoing, formative type of evaluation means that if necessary, plans can be adjusted as jobs/projects progress.

Managers need several particular skills to function well. These can be categorised as technical, human and conceptual skills. Sometimes technical skills are referred to as 'hard' skills and human skills as 'soft' skills. Technical skills are associated with using the appropriate knowledge, techniques and equipment to perform a task or achieve a goal (e.g. showing a junior member of the ward team how to set up an ECG or collating information using a particular software package). Human skills are about working with people and enabling them to contribute effectively to meeting goals. This involves understanding what motivates people and being able to communicate easily and clearly with them. Conceptual skills are about understanding the complexity of the organisation and recognising how what you and the various teams around you do fits with the overall goals of the organisation (e.g. how managing trolley waits in the Emergency Department fits with the overall organisational goal of preventing people waiting longer than necessary anywhere in the hospital).

Managers usually combine all of these skills, but sometimes people at different levels of management use some skills more than others. For instance, a Ward Sister/Charge Nurse is more likely to use more technical and human skills than conceptual ones, whereas the Chief Executive of a hospital would use more conceptual and human skills.

In order to be effective, all managers need to know what and who they are responsible and accountable for.

Medicines management

Definition

Medicines management in the widest sense is 'the clinical, cost-effective and safe use of medicines to ensure patients get the maximum benefit from the medicines they need, while at the same time minimising potential harm' (MHRA, 2004). In NMC (2013 update) Medicines Management Standards. NMC, London.

In nursing, medicines management refers to the prescribing, dispensing, storage, administration and disposal of medicinal products.

(N.B. Students must never engage in any aspect of medicines management without direct supervision.)

Avoiding harm and keeping people safe are vital dimensions of medicines management. In order to achieve them, nurses need to ensure that they comply with the standards of their professional and statutory body. These standards are likely to focus on your involvement in the following:

- Methods of supply and/or administration.
- Checking any direction to administer a medicinal product.
- Storage and transportation.
- Administration of medicines.
- Assessment of the effectiveness of and a patient's response to medicines.
- Assessment of patients who are self-administering medicines or whose carers are doing this.
- Communication with patients about medicines.
- Titration when a range of doses is prescribed to ensure the best response in the patient (e.g. symptom control).
- Preparing medications.
- Use of compliance aids.
- Disposal of medicinal products.
- Delegation and accountability.
- Management of adverse events.
- Reporting of adverse reactions.

As you progress through your nursing course you will gain supervised experience of all aspects of medicines management, so that on registration as a nurse you will be able to adhere to the standards laid down by your professional and statutory body. Some nurses have gained specialist qualifications enabling them to prescribe medicinal products.

As a student, regardless of seniority, you are responsible for reporting patients' adverse reactions to medicinal products immediately, to either a senior nursing colleague or a doctor. Documenting these reactions is essential.

Any deviations from medication plans that you observe should also be reported to your seniors.

Moving and positioning

Definition

Nurses undertake many activities that involve moving and positioning patients (or equipment involved in their care). These include helping a person to move from one place to another, to transfer between their bed and a chair, to change position in bed, or to undertake activities of daily living such as transferring to the toilet, having a bath or shower and dressing.

Inappropriate moving and positioning practice may cause:

- Discomfort and a lack of dignity for the person being moved.
- Accidents that can hurt the person being moved and the person doing the moving.
- Back pain and musculoskeletal disorders for the nurse that can lead to time off work or an inability to continue working in that job.

When you make your initial assessment of a patient, include a risk assessment of their moving and positioning needs. The Health and Safety Executive (HSE, 2013 http://www.hse.gov.uk/healthservices/moving-handling.htm) recommends focusing on:

- the extent of the individual's ability to support their own weight and any other relevant factors, for example pain, disability, spasm, fatigue, tissue viability or tendency to fall;
- the extent to which the individual can participate in/cooperate with transfers;
- whether the individual needs assistance to reposition themselves/sit up when in their bed/chair and how this will be achieved, e.g. provision of an electric profiling bed;
- the specific equipment needed … and, if applicable, type of bed, bath and chair, as well as specific handling equipment, type of hoist and sling, sling size and attachments;
- the assistance needed for different types of transfer, including the number of staff needed – although hoists can be operated by one person, hoisting tasks often require two staff to ensure safe transfer;
- the arrangements for reducing the risk and for dealing with falls, if the individual is at risk.

Use this risk assessment to plan a person's care and minimise risk to them and to you and your colleagues. Record your assessment for others to use and make sure it is updated when the patient's condition or needs change. In addition to any initial moving and positioning assessment, every time you undertake nursing care make a rapid assessment of any risk involved. Take appropriate action to manage any risk so that no harm will be caused.

To reduce the risks of inappropriate moving and positioning, employers offer regular annual mandatory training. It is important to minimise the risk of undignified care, accidents and harm by adhering to your organisation's manual handling policies and following these principles of good practice.

Always tell colleagues if their moving and positioning practices are deficient.

P

Practice development

Definition

Practice development is about changing nursing practice to make care better and to improve the environment in which nurses and other members of the multi-disciplinary team work – and of course, within which care is delivered. Practice development is not a new idea: it emerged from the first Nursing Development Units (NDUs), which started developing nursing practice in England in the 1980s. Since then many designated development units have grown up, but you do not need to work in one of these to make improvements to practice – every nurse can do this either as part of their daily individual practice or more collectively as part of the nursing team.

One of the important features of practice development is that it is the people who actually deliver care who are involved in developing practice; it is not a top-down managerial exercise. The essence of sound practice development lies in ownership and involvement, which in turn may lead to feelings of empowerment.

Practice development is a way of thinking *and* working that requires nurses to be innovative and entrepreneurial.

Generally practice development projects need to achieve the following (based on work by McCormack et al., 2006, p. 11):

- Be person centred.
- Work from a clear set of values (e.g. respect, trust, dignity).
- Promote collaboration, participation and shared ownership.
- Use ways to facilitate critical reflection (e.g. action learning).
- Use the best evidence available (usually from research).
- Evaluate the way you did things (process) and the outcomes.
- Use a facilitative and inclusive style to enable change to occur.
- Tell other people what you have done and learnt.

Quality improvement

Definition

In order to ensure that care is the best it can be, services need to be monitored for their quality. This involves informal and formal evaluation – for instance, a nurse and a patient might routinely evaluate care against the goals they have set, or an audit might be carried out on a ward to compare care provided with the local standards expected, or units/hospitals may be monitored by outside agencies to determine how they meet certain nationally determined standards. Once exercises like this have been done, it is often necessary to improve care.

There are several ways to improve care, but increasingly formal improvement processes such as PDSA (Plan: Do: Study: Act) or LEAN thinking are being used. PDSA is usually used for small-scale change, whereas LEAN thinking is often described as a way of achieving larger-scale change across an organisation(s) or broader health system. These techniques focus on the skills and resources needed to make care better and tailoring these to suit the specific environment within which care needs to be altered.

PDSA was popularised by the Institute for Healthcare Improvement (IHI; http://www.ihi.org/IHI/) in North America and has been used across the world in order to make improvements to healthcare. Essentially, PDSA is about finding the answers to three key questions: What are we trying to accomplish? What change can we make that will result in an improvement? How will we know that a change is an improvement? The cycle is used to 'test a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act)'. The PDSA cycle is most often associated with small-scale change at particular hot spots in an organisation or an individual care pathway. PDSA is useful because it enables you to make a change in care for a group of people or for a ward; if succcessful, these changes can then be scaled up for several similar units or a hospital. PDSA is also useful because it is a bottom-up approach to quality improvement, so once you have decided that something needs to change you can get people involved in order that they own the change. In that way you are more likely to create sustainable change, rather than a short-lived change that no one wants.

R

Research

Definition

Research is about systematically generating new knowledge to answer specific questions. Nurses need this knowledge to help deliver the best care possible.

There are many different sorts of research designs that help to create new knowledge, such as randomised controlled trials, surveys, case studies, ethnographies and phenomenological studies. Each of these creates different types of data and so gives different answers to research questions. For instance, randomised controlled trials can tell us if an intervention works or not when compared to the usual care, whereas a phenomenological study tells us about people's experiences of care.

Increasingly there is a view that we need to know what works (and does not), why it works and how people feel about it or experience it. To do this, researchers are frequently using more than one method within a study (e.g. mixed-methods designs).

All nurses are expected to be aware of and able to utilise research findings and evaluate their usefulness in everyday practice. Using the most up-to-date and appropriate research and tailoring it to meet the needs of each patient is a fundamental component of skilled, high-quality nursing care.

To use research knowledge effectively, you need to be able to assess the rigour of the research done and its usefulness for practice. This may be daunting, so start by deciding whether there is a good fit between the research question(s) being answered and the question you need an answer to in practice. If there is a good fit, then before deciding to use the research, assess how rigorously it was conducted by asking a few questions. For example:

- Were the research design and methods appropriate for answering the research question?
- Were there enough participants in the study to justify the findings?
- Were threats to validity, reliability and credibility taken into account?
- Have the results been analysed appropriately?
- Do the results answer the research question?
- Are limitations clearly discussed?
- Are the conclusions based on the results and are they justified?

If the research is rigorous and relevant, then the findings can be implemented and evaluated in practice.

Risk assessment and management

Definition

Avoiding harm and keeping people safe are vital dimensions of nursing care.

In order to achieve them, nurses need to be able to do the following:

- Identify, assess and report (as necessary) actual and potential threats to a person's safety and health (the risk is the chance that someone might be harmed by one of these threats).
- Understand the cause(s) of these risks and what can be done to lessen them.
- Implement ways to avoid, reduce or control them (management).
- Evaluate the success of their actions.

Risks could include a patient's likelihood of falling at home, of taking the wrong medication at the wrong time if self-medicating, of acquiring an infection while in hospital or of developing a venous thromboembolism after a period of inactivity.

Organisational policies and procedures guide the assessment and management of risks to patients, their families/carers, colleagues and yourself. Sometimes checklists (e.g. pre-operatively) or risk measurement scales (e.g. for assessing the risk of developing pressure ulcers) are used to ensure that risks are assessed and minimised.

Risk management is a term also used by organisations to describe the structures and processes they have put in place and use to identify and manage risk.

Patient safety incidents are unintended or unforeseen events that could have harmed or did harm a patient. These should always be taken seriously and investigated to work out what went wrong and what could be done to stop the same thing happening again. Learning from this analysis is important. This process should usually be blame free.

Knowing the part you play in maintaining patient safety is critical – a good example of this is the relationship between thorough hand washing and infection control. Being mindful of the safety of colleagues and yourself is also important. If you think that a patient or a colleague is at risk, tell an appropriate person.

Teamwork

Definition

Teamwork can simply be defined as working with other people to achieve a common goal.

In healthcare teamwork can encompass many things, including working with other professionals in multi-disciplinary or inter-professional teams; working across agencies in inter-agency collaborations (e.g. healthcare, social care and housing); working with patients, their family and their friends; or working with other nurses in a uni-professional team. Whatever the sort of team, streamlined, coordinated care is the goal.

Nurses fit into this complex system of teams in a variety of different ways, ranging from facilitating the complicated negotiation of services and treatments to maintaining routine functioning for a patient. Nurses are often seen as the key people who help others navigate their way around care and services.

Effective teamwork involves the following aspects:

- Ensuring that the right people are part of the team – this means that the patient and their family are always involved.
- Making sure that everyone understands the goals the team is trying to achieve.
- Matching the skills and knowledge of team members to these goals.
- Ensuring that everyone knows what is expected of them.
- Creating an environment within which people trust each other and are able to clarify their responsibilities and take decisions collaboratively and independently within explicit boundaries.
- Ensuring that everyone can voice concerns and be supported in their work.
- Making sure that communication is clear within and outwith the team.
- Giving the team members opportunities to meet and review their work so they can make improvements as care is delivered.
- Enabling the team to celebrate success and examine areas for improvement in a non-judgemental way.

Wound management

Definition

Wound management is a very important aspect of nursing in the hospital and the community. Wounds may be deliberately formed (surgical incisions) or be the result of injury (accident) or a complication of illness (e.g. diabetes) or altered circulation (leg ulcers), which may sometimes be coupled with pressure (e.g. pressure ulcers). Wounds can be acute (short lived) or chronic (long term).

Wound healing can be achieved in a number of different ways, for instance:

- The edges of a wound can be joined together by sutures, staples or other forms of closure (healing by primary intention).
- If wound edges cannot be brought together, the wound is left to heal through contraction and epithelialisation (healing by secondary intention).
- The edges of some wounds cannot be joined immediately and will be left for a short time before joining (healing by tertiary intention).

There are four broad phases to wound healing: haemostasis, inflammation, proliferation/epithelialisation and maturation, when the wound becomes strengthened and scar tissue is formed, thins and fades.

Wound healing can be delayed by poor nutrition, alterations in temperature, ongoing excess exudate, poor dressing (or inappropriate) technique or use of the wrong dressings. During all procedures associated with wounds (e.g. dressing, drain emptying or removal, suture removal) nurses must ensure that they protect patients, through asepsis, against acquired infections.

The principles of wound management include:

- Making sure that the patient knows when you are going to change dressings and that suitable analgesia has been given beforehand.
- Ensuring privacy.
- Picking the right dressings for the wound (e.g. alginates, occlusive, hydrocolloid, hydrogel, foams).
- Choosing the right cleansing agents.
- Ensuring that you have all the equipment needed before starting to expose the wound.
- Remembering hand washing/cleansing with antibacterial substances and asepsis throughout the procedure.
- Evaluating the wound every time a dressing is changed (Dougherty & Lister, 2011) and recording:
  - Size
  - Wound bed (necrotic – black, slough – yellow, granulating – red, epithelialising – pink)
  - Skin around the wound (e.g. intact, healthy, inflamed – allergy to dressing/tape)
  - Exudate (amount)
  - Odour
  - Bleeding
  - Pain
  - Infection (take swab)
- Recording observations and communicating any concerns to a senior member of the team.