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Introduction to Nursing Care for Nursing Assistants NMS093

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Clinical Observations 1

Nursing Assistants Programme

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Learning Objectives

You will demonstrate an understanding of the rudiments of the following skills:

- Temperature recording using chemical (TempaDot), tympanic and electronic thermometers
- Pulse recording
- Counting respirations
- Normal ranges of all the above
- Charting all of the above

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Normal Ranges of Observations

Temperature

- 36^0 to 37.2^0 Celsius (C)

Pulse

- 60-80 beats per minute (BPM)
    - Record for one minute

Respirations

- 12-20 breaths per minute (BPM)
    - Record for one minute

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Temperature

Why do nurses need to record a patient's temperature?

- On admission (baseline)
- Before and after surgery or investigations (to detect infection)
- During blood transfusion (to detect reaction)
- To monitor condition

Define pyrexia

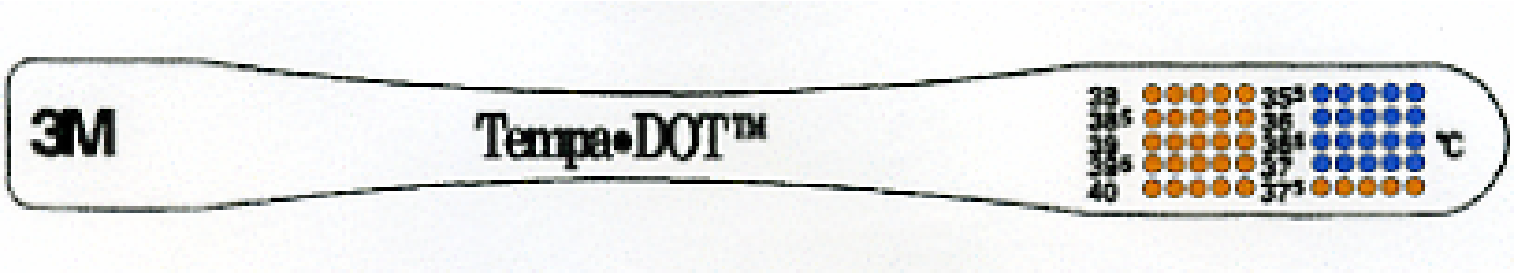
- A body temperature above normal

Define hypothermia

- A core body temperature below 35^0C

What do you need to check before oral temperature recording?

- Hot / cold drinks or cigarette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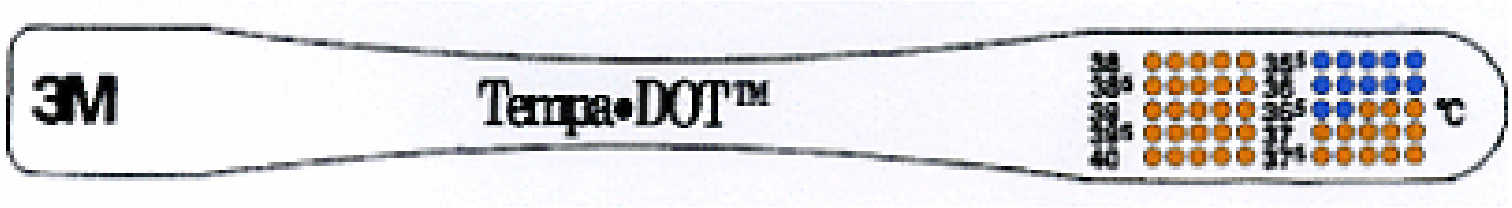
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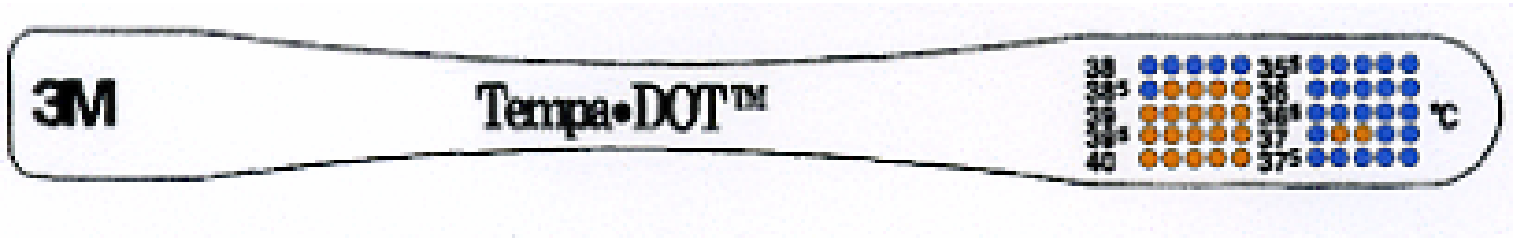
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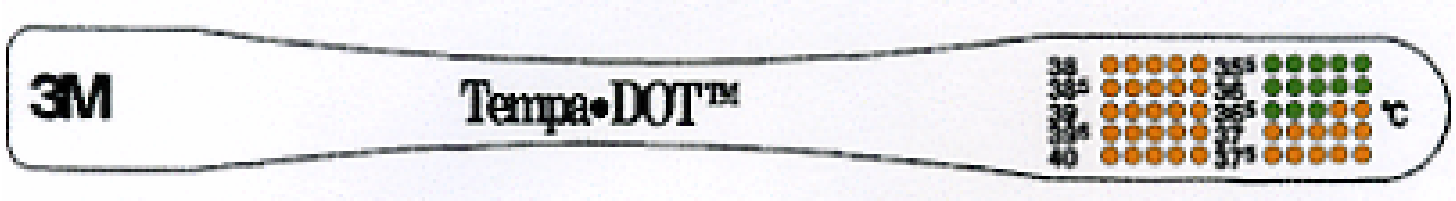
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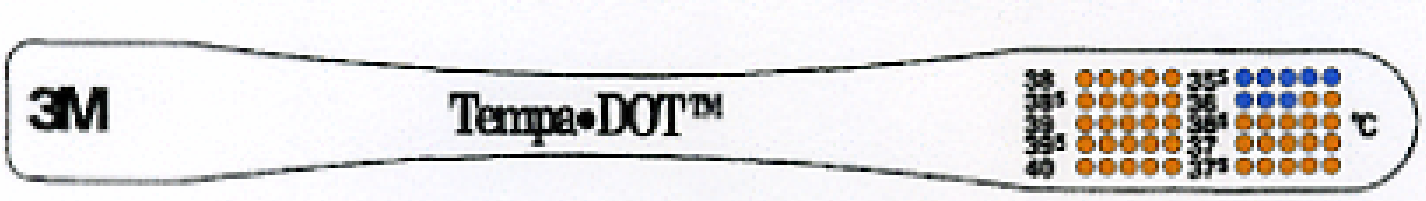
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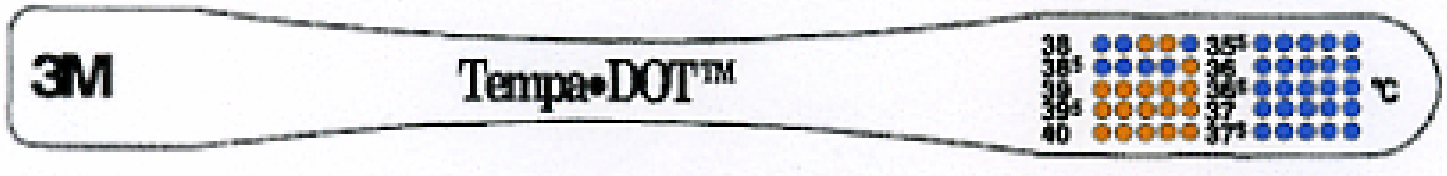
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Pulse

Define the following:

Pulse

- The wave of expansion in an artery during left ventricular contraction (systole)

Bradycardia

- A low pulse rate of < 60 bpm

Tachycardia

- A high pulse rate of > 100 bpm

Sinus rhythm

- The normal pattern of electrical activity in the heart when seen on an Electrocardiogram (ECG)

Arrhythmia

- A deviation of the normal ECG pattern

Respirations

- More accurate if patient is unaware that their respirations are being counted
- Record while pretending to record pulse
- Record over one minute
- Observe for depth of breathing i.e. shallow
- Observe for Cyanosis (blue discolouration)

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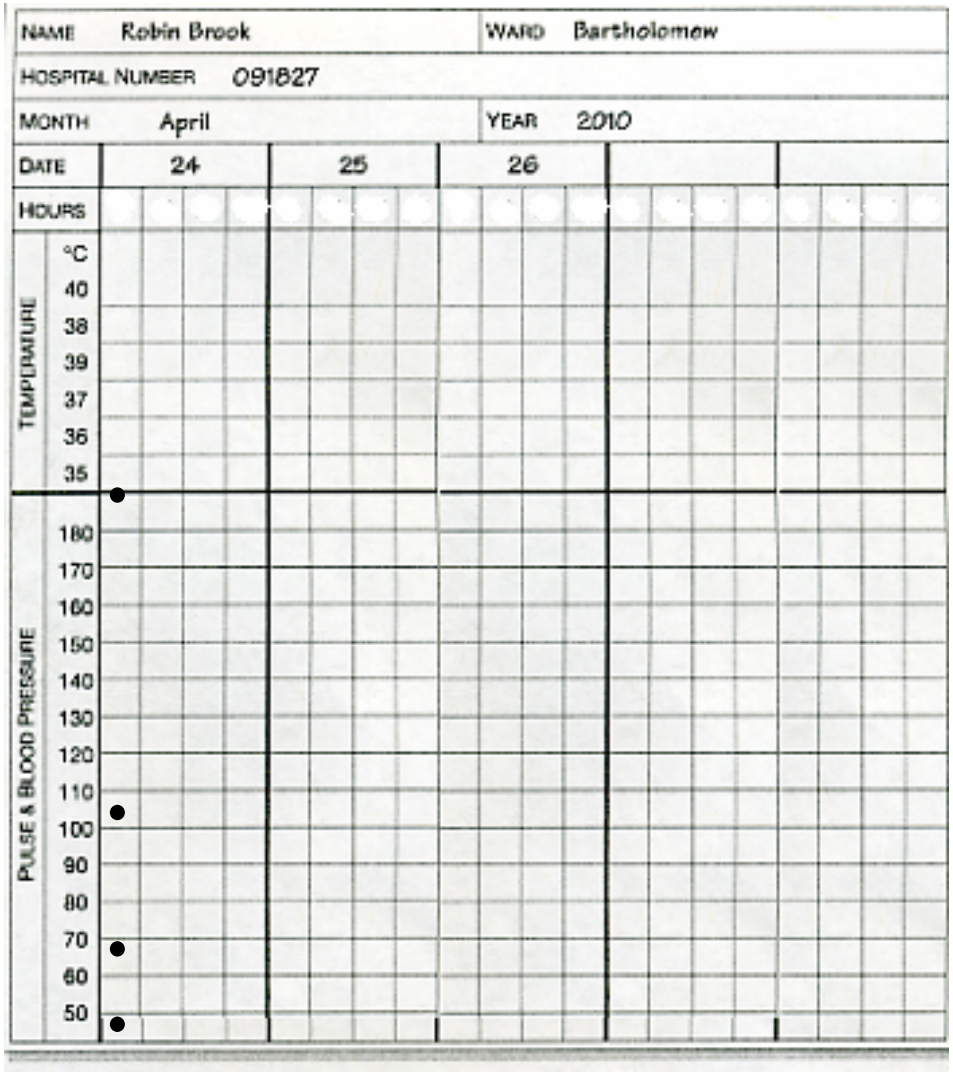
Charting Observations



NAME	Robin Brook	WARD	Bartholomew
HOSPITAL NUMBER	091827		
MONTH	April	YEAR	2010
DATE	24	25	26
HOURS			

TEMPERATURE °C: 40, 38, 39, 37, 36, 35

PULSE & BLOOD PRESSURE: 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50

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Charting Observations

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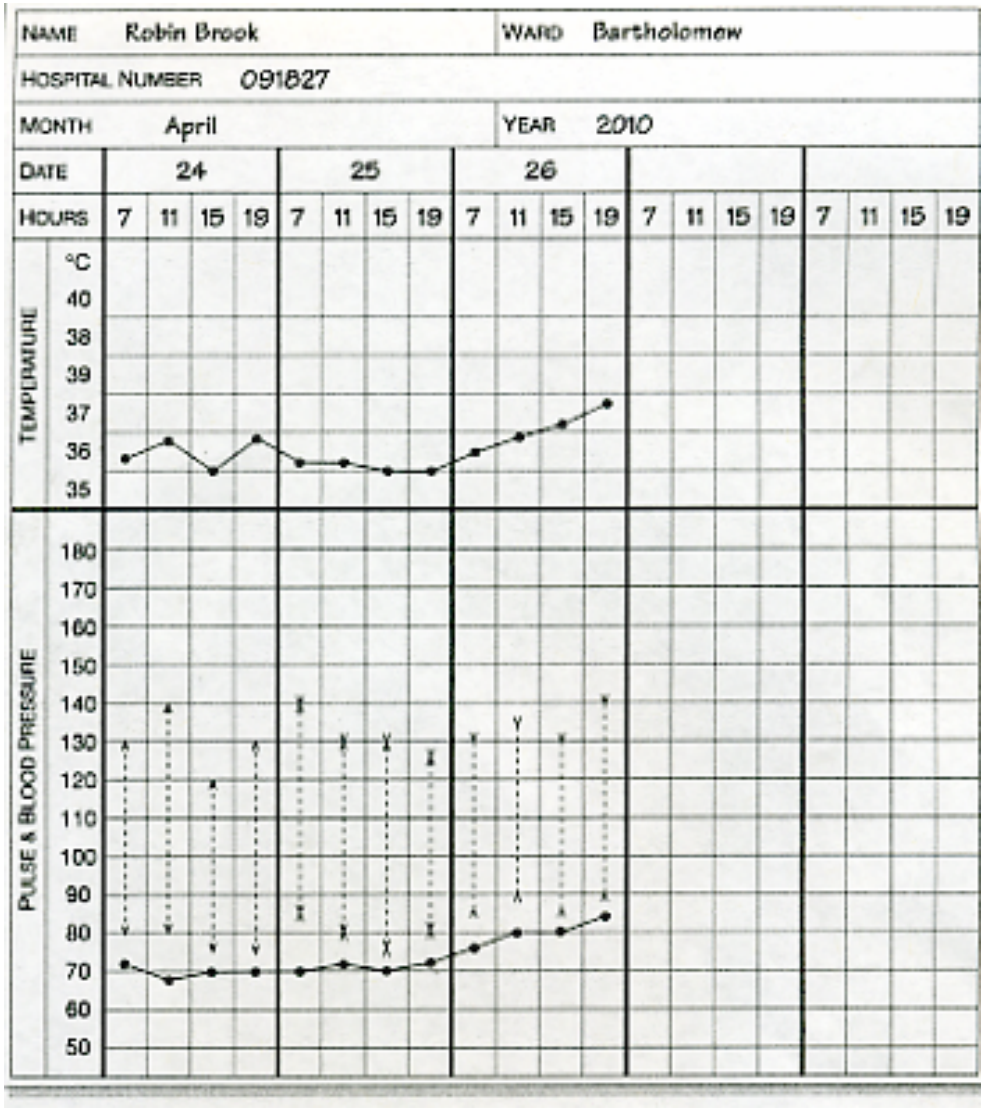

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Patient Risk (PAR) Score

Score	3	2	1	0	1	2	3
Temperature		**<35.0**	**35.0 – 35.9**	**36.0 – 37.4**	**37.5-38.4**	**38.5**	
Pulse	<40		40-49	50-99	100-114	115-129	≥ 130
Systolic BP	<70	70-79	80-99	100-179		≥ 180	
Resp Rate		<10		10-19	20-29	30-29	≥ 40
O2 Saturation	<85%	85-89%	90-94%	≥ 95%			
CNS			Confused	Alert	Voice	Pain	**Unconscious**
Urine output	Nil	<0.5 ml/Kg/h	Dialysis	0.5 ml/Kg/h	>3 ml/Kg/h		

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Nursing Assistants Programme

Communication in Care

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What is Communication?

" Communication is exchanging information so that each person clearly understands the other. If you do not understand each other, if you have not *conveyed meaning,* no communication has occurred."

(Jarvis, 2000, p. 58).

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Defining Communication

"Communication is a complex mixture of verbal and non-verbal behaviours integrated for the purpose of sharing information"

(Crowther, cited by Boggs (2003). In Arnold & Boggs (2003) Communication Styles Chapter 9, pp.17)

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Communication in Nursing

- "A person cannot not communicate"

- Purpose
  - To establish nurse-patient relationship
  - To be effective in expressing interest/concern for patient/family
  - To provide health care information

The Process of Communication

- Sending
  - Verbal & Nonverbal i.e. posture, gestures, facial expression, eye contact, touch, your seating position
- Receiving
  - How your message is interpreted & given meaning
- Feedback
  - Clarifying messages & modifying nonverbal & verbal responses

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Main Forms of Communication

- Verbal
  - Spoken or written word
- Non-verbal
  - Body language which adds depth to words

Ability to communicate may be affected by:

- Physical & emotional factors
  - Impaired vision, hearing, trauma, illness, medications, conscious state
  - Anxiety, grief, depression, psychoses
- Developmental stage
  - Very young, normal ageing process

- Sociocultural
  - Culture influences thinking, feelings, behaviour, responses

- Gender
  - Male & female communication patterns can differ

Elements of Professional Communication

Assume a professional helping role through:

- Courtesy
- Use of names
- Privacy & confidentiality
- Trustworthiness
- Autonomy & responsibility
- Assertiveness

Therapeutic Communication

Specific responses that encourage expressions of feelings & ideas & convey a nurse's acceptance & respect

- Active listening – being attentive
- Sharing observations
- Sharing empathy

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Evaluating our communication skills

- Reflecting on our practice.
  - What went well, what needs further effort
  - Did the patient respond and provide the information needed. If not, why?
  - Observe the communication skills of experienced nurses and find a role model to assist as you learn.
  - Practice!

Legal Concerns:

- A patients record/chart is a legal document; may be admissible in court. Reporting needs to be clear, comprehensive and concise.

If it’s not documented, it didn’t happen!

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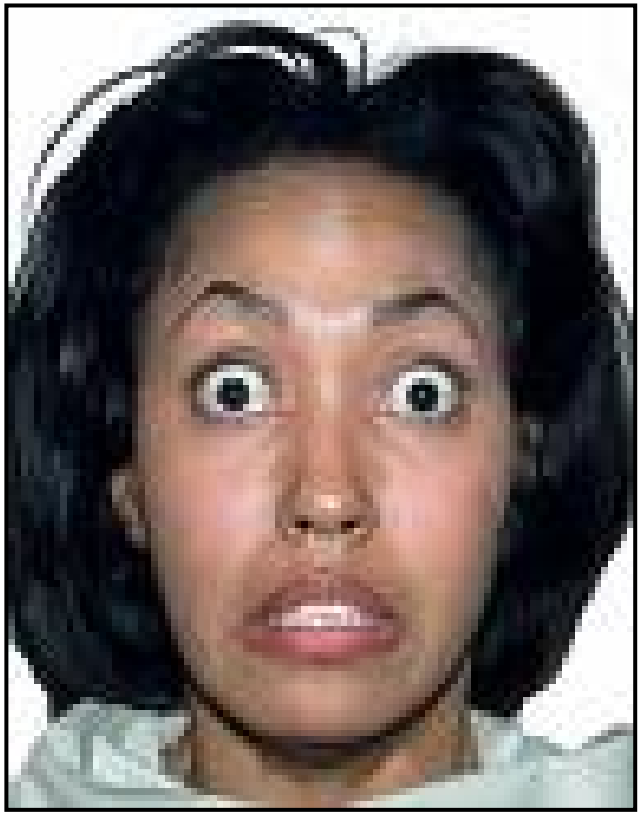
What do these images say ?



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What are they saying?

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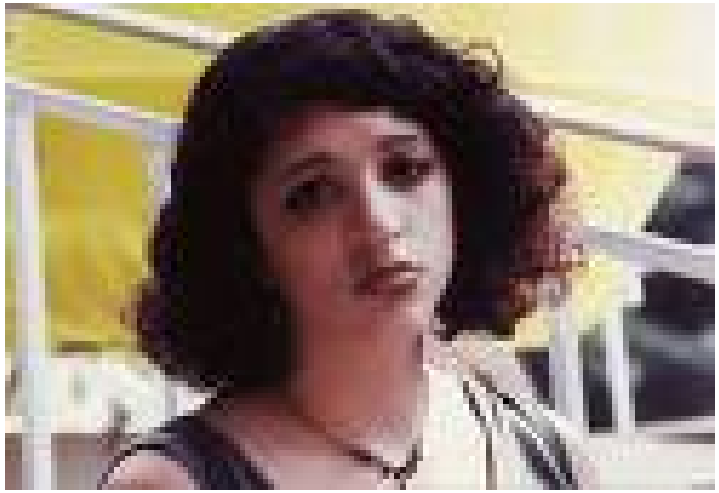

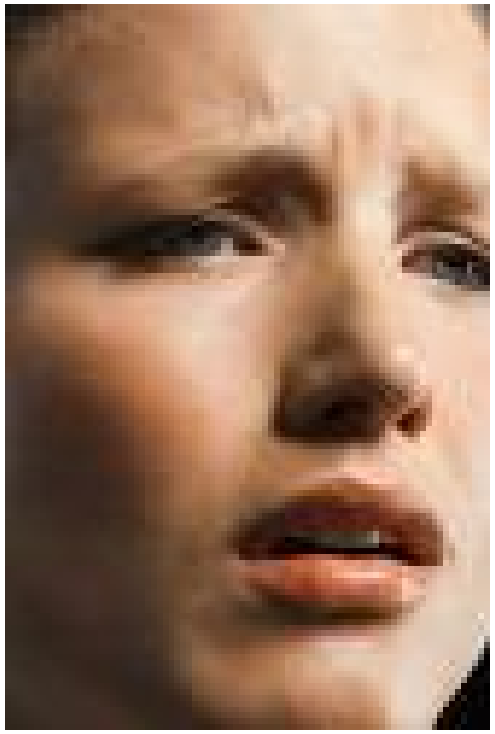

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What do these images say ?

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Now for a Non-Verbal Exercise

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Infection Prevention & Control

Nursing Assistants Programme

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Aims & Objectives

To Prevent and Reduce

- **Hospital acquired infections**
- **Remember! Many hospital acquired infections are carried on the hands of healthcare workers.**

Who is most vulnerable?

- **The Elderly**
- **The very young**
- **Those on long-term antibiotics**
- **People whose immune systems (your body's defences) are collapsing**

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Standard Precautions

- **Hand washing**
- **Appropriate glove usage**
- **Cover existing cuts and broken skin**
- **Protect own clothing with plastic aprons**
- **Protect eyes**
- **Use of personal protective equipment**

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Health Care Assistants make risk assessments

- When do you wear gloves or plastic apron? – *When you come into contact with bodily fluids or waste*
- Do you routinely wear gloves when in physical contact with a patient? – *NO! Only if they have a known infection, or if you are cleaning up body fluids*
- When do you wear a mask? – *Only if there is a risk of airborne contagion, e.g. when nursing a patient with active TB.*

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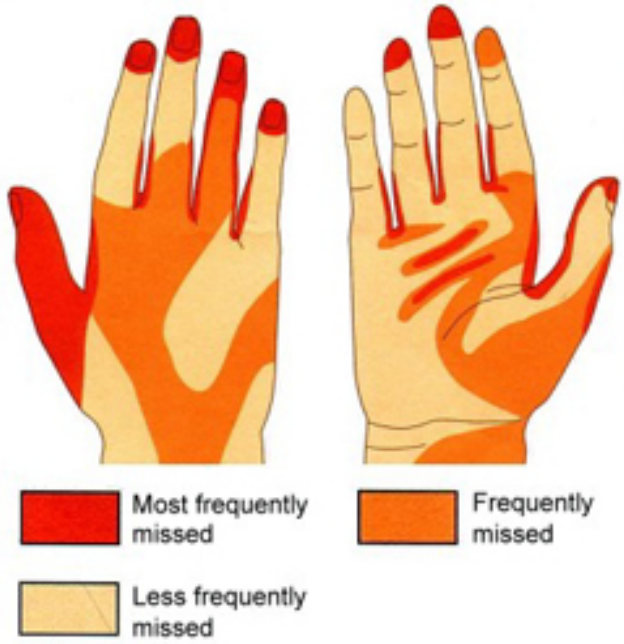
Cleaning caring hands

- If your hands are visibly contaminated, then cleaning with soap and water is required.
- If your hands are socially clean, then using alcohol based rubs is acceptable
- In either case, <u>always wash your hands before and after contact with each patient</u>, even when wearing gloves



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Clean your hands!

- **Alcohol based hand rubs used in all acute hospitals**
- **You can use alcohol rub when your hands are socially clean**
- **Must use soap and water if your patient has C.difficile**

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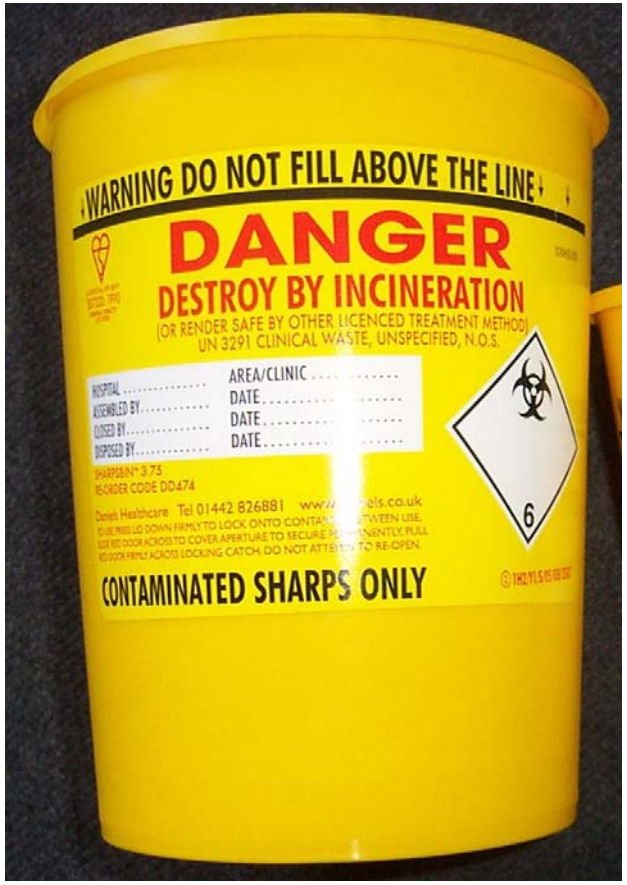
Disposing of sharps

- Needles and other sharp objects need to be put into special sharps bins
- Check what the local policy is on your ward.
- Take great care when disposing of needles.



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In the event of sharps injury/splash injury

- **Wash the affected area under running water**
- **Never scrub wound**
- **Cover with plaster**
- **Let the nurse in charge know**
- **Contact Occupational Health immediately**
- **Fill out accident form**

Bed Linen

- **Infected**
- **Used**
- **Disposal of at the bedside**
- **Bags not overfull**

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Managing Waste

- **<u>Clinical waste</u> – Soiled wipes, dressings etc. Use orange plastic bags.**
- **<u>Non clinical waste –</u> Papers, flowers, household rubbish. Use black plastic bags**

MRSA screening

- ***Remember –Never re-use any swab. They are single use only***

- **Swabs** (routine) from:-

  Nose, throat & perineum;
  Urine(if catheterised);
  Sputum(if expectorating);
  Intravenous lines
  Drain sites;
  Wound sites.

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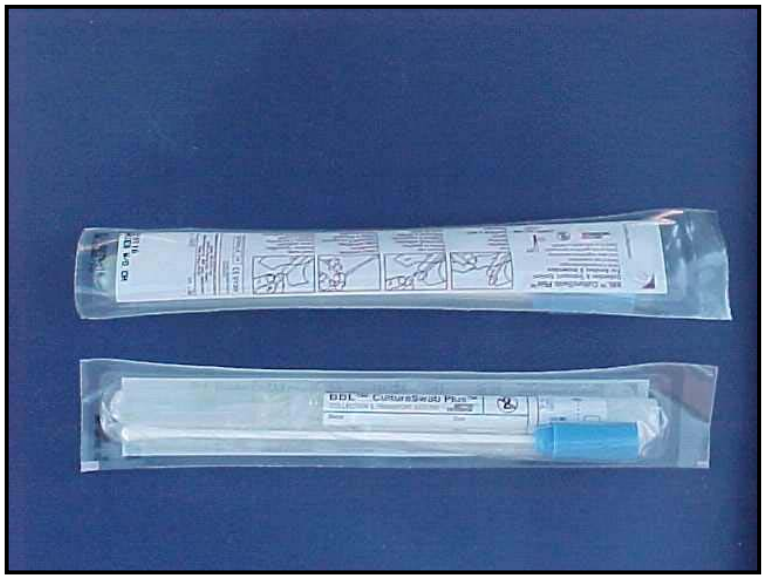
MRSA Swab Technique:

- Collect the required number of swabs and request form in a cardboard tray or kidney dish.
- Wash your hands and put on and apron and gloves.
- Explain the procedure to the patient to gain consent and co-operation.
- Check the expiry date of the swab and that the packaging is intact and/or the seal is unbroken

If the swab is packed inside the tube:

- Hold the tube in your non-dominant hand, open the top and remove the swab, taking care not to contaminate the tip.



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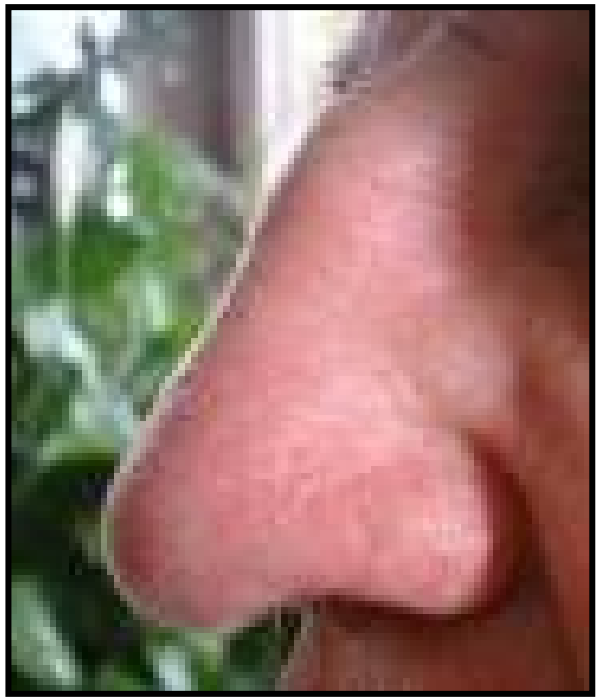
If the swab is packed separately:

- Open the packaging, hold the transport tube in your non-dominant hand
- Break the seal and remove the top.
- Hold the handle end of the swab stick in your dominant hand.
- If the policy states you should moisten the swab, either insert it into the tube to moisten the tip with transport medium or use sterile saline

- Warn the patient and then insert the tip of the swab just inside one nostril.
- Twist the swab and ‘roll’ it so that all surfaces of the tip make contact with the nostril.
- If indicated in the Trust policy, use the same swab and repeat in the other nostril.



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MRSA Swab Technique continued:

- Carefully place the swab in the transport tube taking care to ensure that the tip does not touch anything and push the cap firmly into place.
- Label the tube with patient's details and site of swab & place in plastic bag with the request form.
- Repeat the above technique for all other swabs required.
- Leave the clearly labelled swabs in the designated collection area e.g. specimen fridge.
- Remove gloves & apron and wash hands.
- Document MRSA screening in the nursing record.

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Clinical Observations 2

Nursing Assistants Programme

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Learning Objectives

You will demonstrate an understanding of the rudiments of the following skills:

- Oxygen Saturations
- Glasgow Coma Scale
- BP measurement using an aneroid (manual) and electronic sphygmomanometers.
- Normal ranges of all the above
- Charting all of the above

Normal Ranges of Observations

Blood Pressure

- 100/60 – 140/90 mmHg (Millimetres of Mercury)

Oxygen Saturation

- 95 to 100 percent (95%-100%)

Blood Pressure (cont)

Define the following:

Hypertension

- An abnormally high BP with a blood pressure of greater than 140 / 90 mmHg

Hypotension

- A systolic pressure of less than 90 mmHg

Blood Pressure

Define blood pressure

- Blood pressure is the pressure within the major arteries when the left ventricle pumps blood into the aorta. The pressure is produced when the flow meets resistance

What can affect the BP?

- Pain, fear, anxiety
- Severe infection (septicaemia)
- Bleeding
- Temperature
- Exercise

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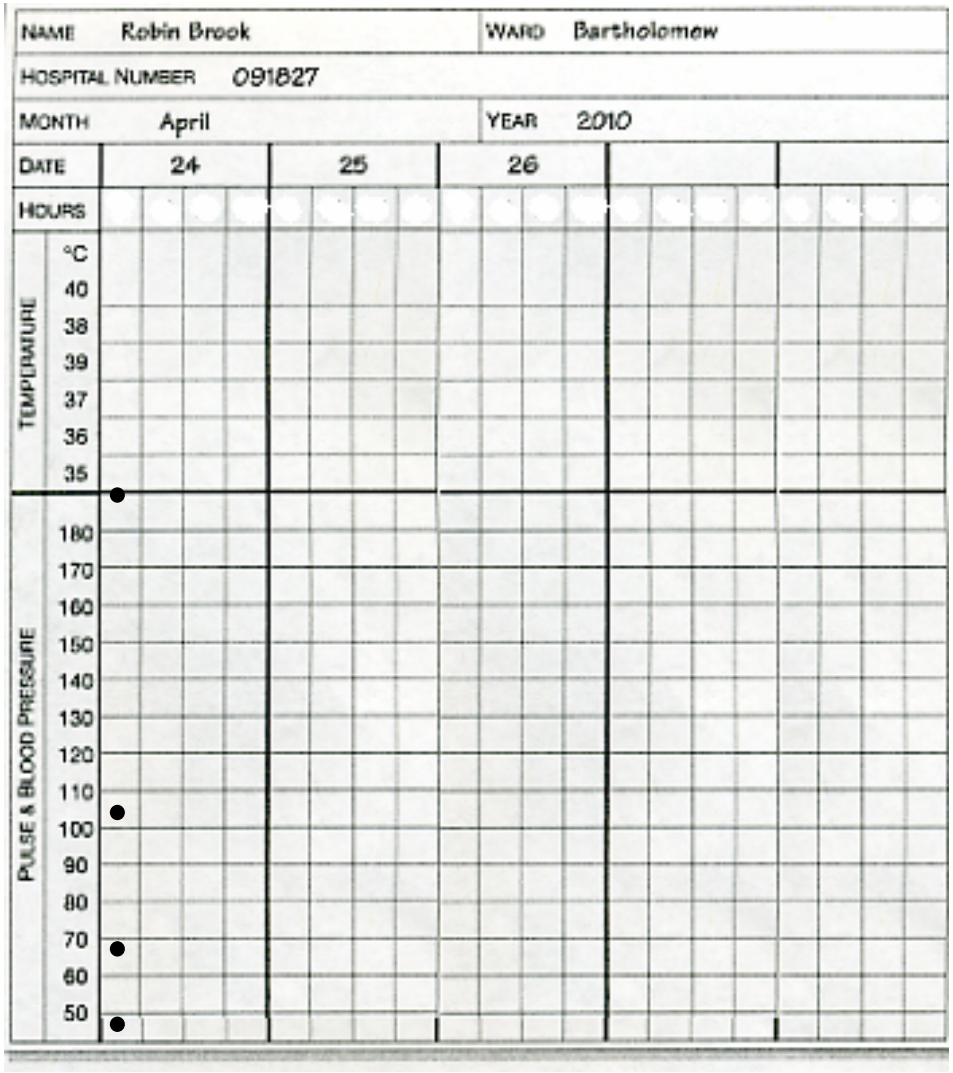
Charting Observations



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Charting Observations

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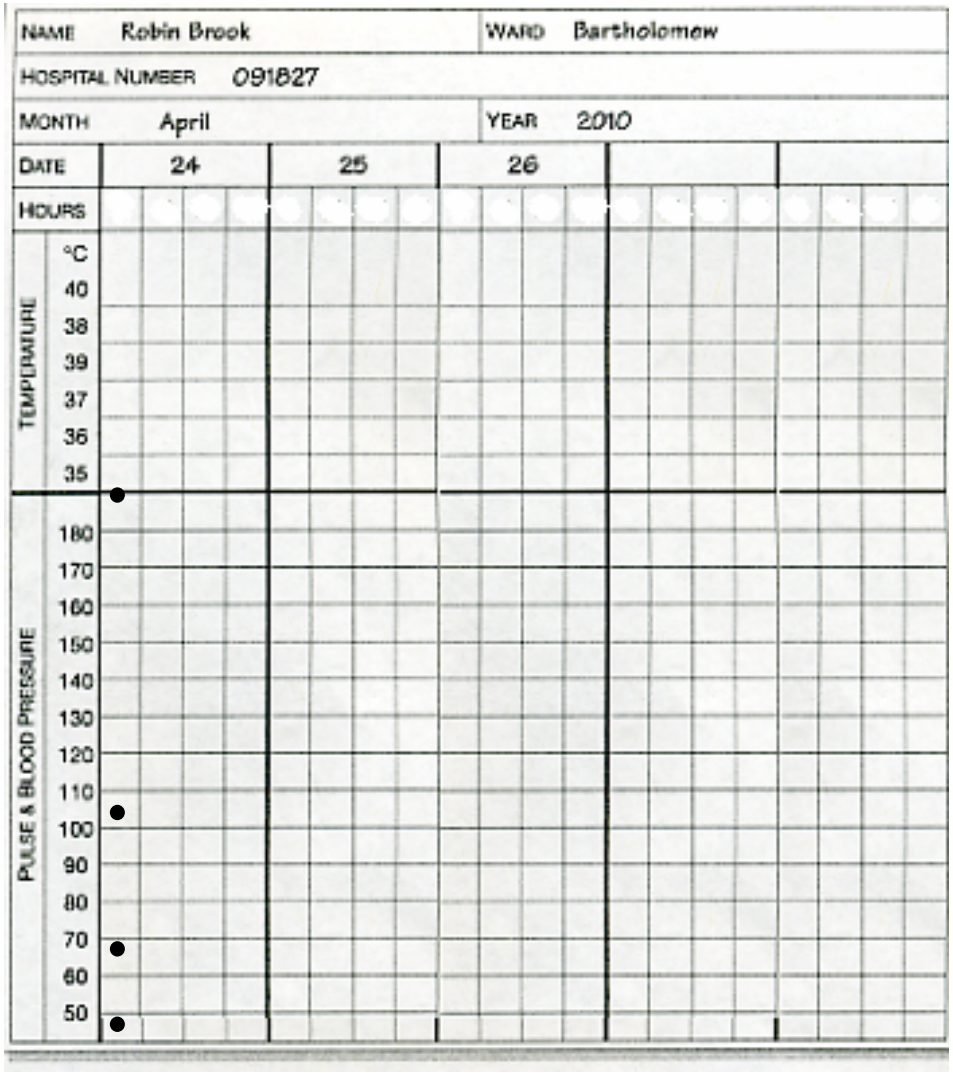

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Charting Observations

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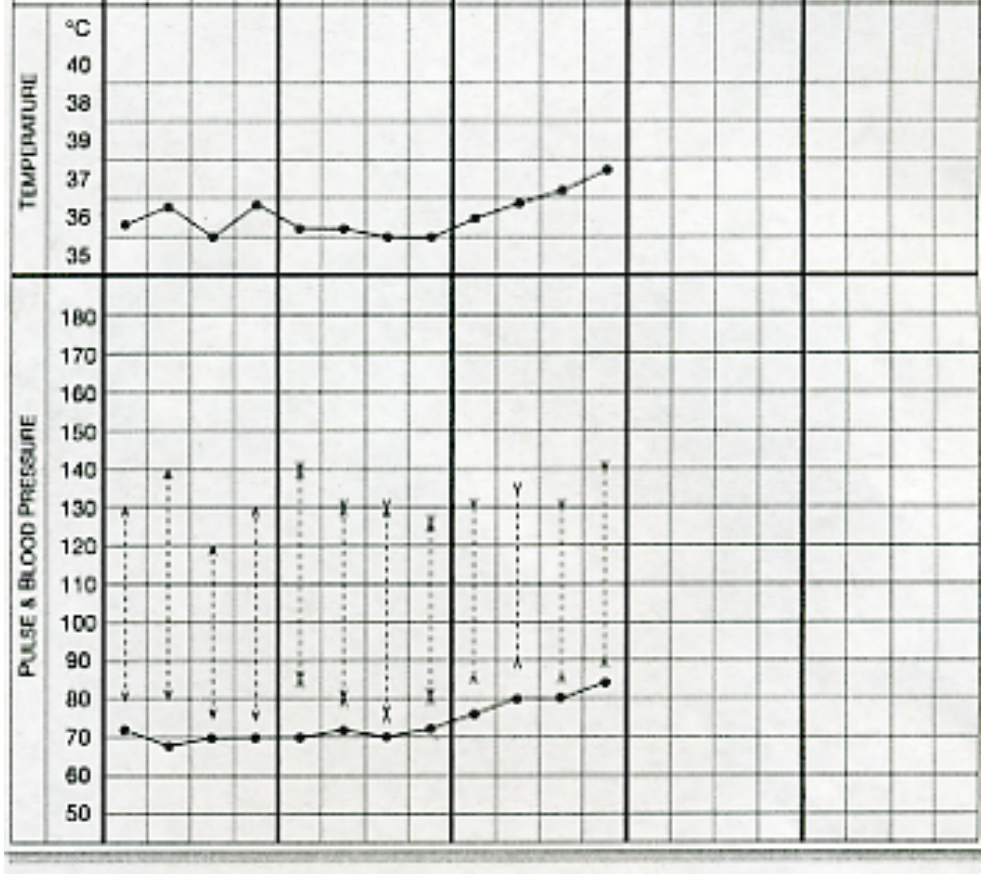

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Oxygen Saturation

- A **pulse oximeter** is a medical device that indirectly measures the oxygen saturation of a patient's blood.

Acceptable normal ranges are from 95 to 100 percent (95%-100%), although values down to 90% are common for a patient breathing room air. Useful for patients with respiratory or cardiac problems.

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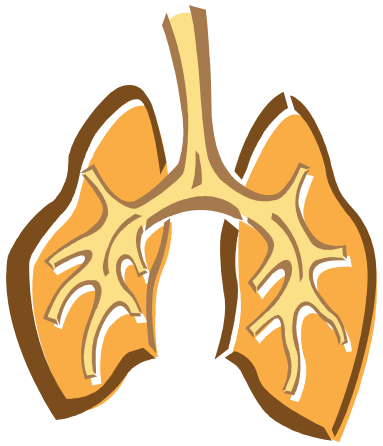
What does a peak flow meter measure?

‘The maximum speed (peak) of air leaving the lungs (flow) during a forced expiration’ (Blows, 2001, p83).



Peak Flow Rate Measurement

- Peak flow compares an air volume with a time, therefore measured in litres / minute
- The normal peak flow has to be calculated for each patient
- The normal calculated value will depend on the patient's age, sex and height
- Measured results need to be plotted against a graph based on criteria pertinent to the patient, ie male, female or child.

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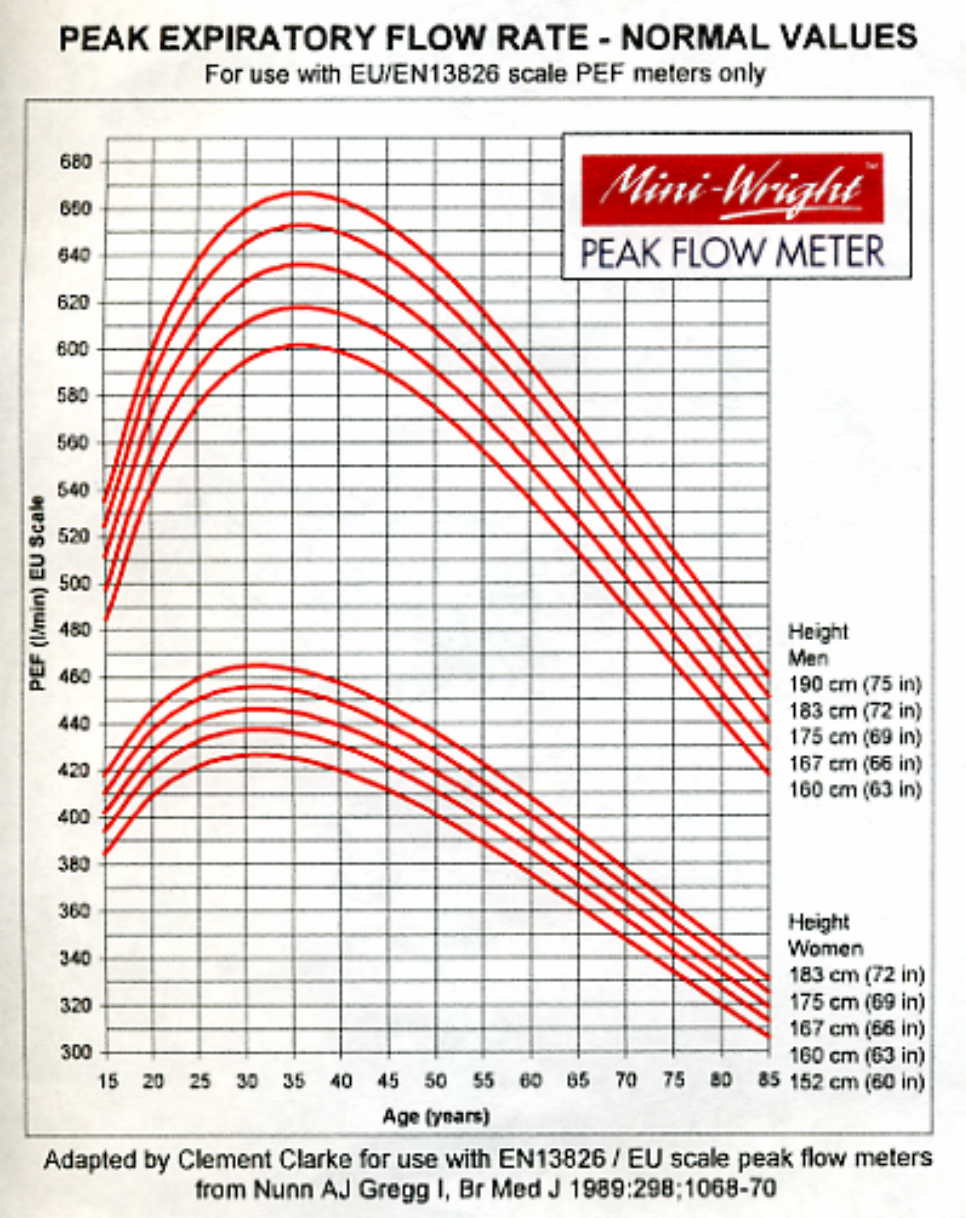

- In men, readings up to 100 L / min lower than predicted are within normal limits
- For women, equivalent figure is 85.

Peak Flow Rate Measurement

The test depends on:

- The lungs' ability to fill with the correct amount of inspired air
- The ability of the respiratory muscles to expire air from the lungs with force
- Patent airways that allow expected volumes of air to be expired

Skinner (2005)

Peak Flow – Preparation

- Explain procedure
- Ideally the patient should be standing. If the patients condition does not allow, they should sit upright.
- The patient should be rested

Nicol et al (2004, p 273)

Peak Flow - Procedure

- Attach a disposable mouthpiece
- Set the pointer at zero
- Instruct the patient to inhale deeply, place their lips around the mouthpiece and holding the meter horizontally, exhale forcibly or ‘huff’. Make sure the patients’ fingers do not occlude the pointer
- Note the measurement and repeat the procedure twice more
- Record the highest of 3 measurements

Nicol et al (2004, p 273)

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The Glasgow Coma Scale

- A neurological scale which aims to give a reliable, objective way of recording the conscious state of a person, for initial as well as continuing assessment.

- A patient is assessed against the criteria of the scale, and the resulting points give a patient score.

- Measured between 3 (indicating deep unconsciousness) and either 14 (original scale) or 15 (the more widely used modified or revised scale).

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The Glasgow Coma Scale

	1	2	3	4	5	6
Eyes	**Does not open eyes**	**Opens eyes in response to painful stimuli**	**Opens eyes in response to voice**	**Opens eyes spontaneously**	**N/A**	**N/A**
Verbal	**Makes no sounds**	**Incomprehensible sounds**	**Utters inappropriate words**	**Confused Disorientated**	**Orientated Converses normally**	**N/A**
Motor	**Makes no movements**	**Extension to painful stimuli**	**Abnormal flexion to painful stimuli**	**Flexion / Withdrawal to painful stimuli**	**Localises painful stimuli**	**Obeys commands**

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Patient Risk (PAR) Score

Score	3	2	1	0	1	2	3
Temperature		**<35.0**	**35.0 – 35.9**	**36.0 – 37.4**	**37.5-38.4**	**38.5**	
Pulse	<40		40-49	50-99	100-114	115-129	≥ 130
Systolic BP	<70	70-79	80-99	100-179		≥ 180	
Resp Rate		<10		10-19	20-29	30-29	≥ 40
O2 Saturation	<85%	85-89%	90-94%	≥ 95%			
CNS			Confused	Alert	Voice	Pain	**Unconscious**
Urine output	Nil	<0.5 ml/Kg/h	Dialysis	0.5-3 ml/Kg/h	>3 ml/Kg/h		

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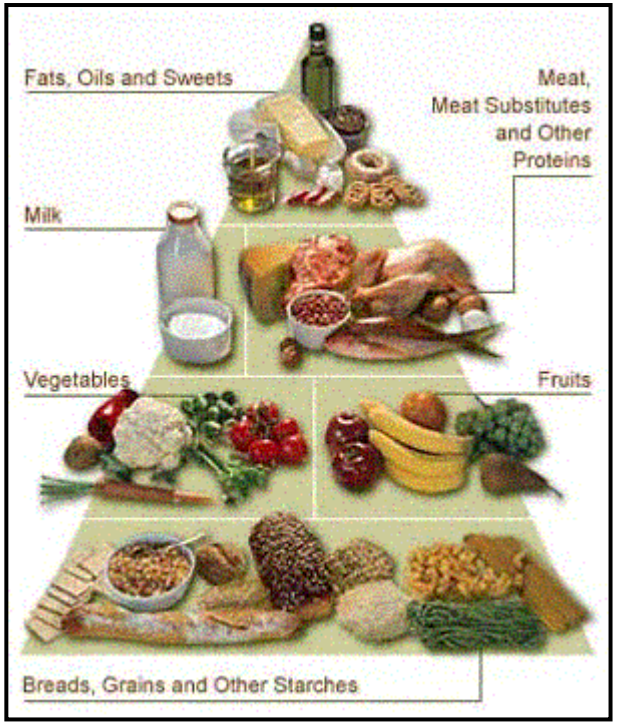
Assisting a Patient to Eat and Drink



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Hospital Malnutrition – a Major Problem

- “It is a national scandal that 6 out of 10 older people are at risk of becoming malnourished, or their situation getting worse, in hospital. Malnourished patients stay in hospital for longer, are three times as likely to develop complications during surgery, and have a higher mortality rate than well-fed patients. Ending the scandal of malnourished older people in hospitals will save lives.”
- Age Concern (2006). Hungry to be heard: The scandal of malnourished older people in hospital.

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NICE Guidelines

"Ensuring patients receive adequate nutrition is an essential part of basic patient care, yet we know malnutrition is still a big problem for the NHS. The guideline contains one obvious and simple message - *Do not let your patients starve and when you offer them nutrition support, do so by the safest, simplest most effective route*."

- New NICE guideline will help tackle the problem of malnutrition in the NHS, Press Release, National Institute for Health and Clinical Excellence, February 2006.

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Digesting Food

A&P of GI Tract: Mouth, oesophagus, stomach, gall bladder, large intestine, small intestine, rectum. A problem with any of these may affect the ability to eat and drink (e.g. sore mouth or haemorrhoids)

Digestive process:

Mouth: mechanical (teeth & tongue) & chemical (salivary amylase) digestion

Stomach: mechanical (muscle contraction) & chemical (gastric juices) digestion. Now called chyme

Small intestine: absorption of nutrients

Large intestine: absorption of water and passage of waste

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Food Pyramids and Inadequate Meals

- Just 17% of hospitals serve meals that are regarded as being 'good' quality. While the vast majority have an 'acceptable' standard of catering, 2% offer patients food classed as 'poor' many of which are in and around London.

DoH February 2003

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Barts and the London offer food variety…..

- Barts and the London cater for around 1,000 patients every day, ranging from 2 to 98 years old.
- The Trust has introduced a 14-day menu that aims to offer 56 different choices a month.

Barts and the London press release 17th February 2006

What Factors can affect diet?

Physical: disability; impaired appetite; dental problems; malabsorption; stroke; constipation; oral thrush; poor dexterity; poor vision/hearing etc.

Psychological/emotional: loneliness; bereavement; depression; comfort eating; bulimia; anorexia nervosa; appearance/smell of food; like & dislikes etc.

Socio-economic: cost of food; availability of fresh foods; junk food satisfying & cheap etc.

Cultural/religious: types of food & preparation methods; restrictions; fasting periods; ways of cooking etc.

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Those Most At Risk

Patients at risk of malnutrition:
Frail elderly people and babies
Patients with:

- neurological conditions e.g. stroke
- malignant disease
- severe respiratory conditions
- gastrointestinal problems
- Mental health problems e.g. depression, confusion
- Alcohol/drug problems

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Assisting Patients to Eat

- Feed patients slowly, let them know what they are eating
- Give them time to chew and swallow
- If the patient can't tell you what food they want, then feed them as you would yourself like to be fed
- Alternate what foods you give to the patient, for example a mouthful of meat followed by vegetables and then some rice, potatoes or pasta
- Make sure you provide drinking fluids of a suitable temperature
- Encourage and assist patients to eat, but *never* force a person to eat

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Nutritional Assessment

Have you unintentionally lost weight?
Have you been eating less than usual? Or more?

- Height & weight
- Dietary history: ? balanced diet; types of food; amount; likes & dislikes; alcohol intake etc.
- Physical assessment: ?over or under weight; BMI; skin; teeth; hair; nails; ? lethargic etc.
- Bowel habits: ? constipated, diarrhoea etc.

Nausea and vomiting

Causes – medication (e.g. chemotherapy, analgesics); pyrexia; poisoning (e.g. alcohol, food); pyloric stenosis; pregnancy; GI tract obstruction; head injury (raised ICP); self-induced.

Nausea – feeling of impending vomiting

Emesis = vomiting. (**Anti-emetic** = medication to prevent nausea & vomiting).

Haematemesis – vomiting blood. May be bright red (fresh bleeding) or brown like 'coffee grounds' (blood partially digested by gastric juices).

Projectile – vomit forcefully expelled from stomach. Occurs in pyloric stenosis & some neurological conditions.

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Patient Hygiene, Comfort & Bed Making

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Patient Hygiene

- **Bacteria of skin & mouth- Skin**: normal skin flora (commensals) *staphylococcus epidermidis.* **Mouth**: oral commensals on the back of the tongue act a bactericidal agents
- **Sweat glands:**
- Eccrine – palms, soles of feet, and forehead
- Apocine – axilla and anogenital area. Sweat contains fatty acids and when in prolonged contact with bacteria on the skin, Body odour occurs.
- **The eyes protect themselves** by the eyebrows and blinking protect the eyes and lacrimal fluid (tears) contains lysozyme, which moistens and lubricates the eye surface

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Patient Hygiene

- **Saliva is** 97-99% water and contains electrolytes, salivary amylase,
- lysozyme, IgA (Immunoglobulin A), urea and uric acid.

- **A dry mouth indicates dehydration because** … dehydration inhibits salivation in
- order to conserve fluid.

- **Skin - 2 layers lying on subcutaneous fat**

- **Epidermis** (stratum basale; spinosum; granulosum; lucidum & corneum) and **Dermis.**

- **Sweat & sebaceous glands** prevent it drying out.

- **Normal pH** is 4.0 – 6.8 (slightly acid) to protect against micro-organisms

Maintaining personal hygiene

- **Advantages** (Whiting, 1999)
- Comfort and to reduce anxiety & enhance well being
- Maintain skin integrity and Improve circulation
- Enable assessment of physiological & psychological status
- Facilitate nurse-patient communication.

- **Disadvantages** (Whiting, 1999)
- May be microbiologically ‘dirtier’ after blanket bath (Greaves, 1985)
- May feel embarrassed. May lack privacy
- Neonates may experience increased levels of stress.

Oral assessment & mouth care

- **Drying of the mouth & poor oral hygiene may be due to**: restricted fluid intake; mouth breathing; oxygen therapy; chemotherapy; respiratory tract infection; poor dexterity & inability to maintain oral hygiene.

- **Oral mucosa should appear** glistening pink (deep red in people with dark skins) and there should be no white patches, ulcers, sores or food debris.

Assisting with hygiene

- **Measures to prevent cross infection:** washing hands; wearing apron; wearing gloves if patient has infection; individual wash bowl; wash bowl left clean & dry; soap kept dry; wash cloth rinsed well and left to dry; washing in logical order (i.e. face first); disposable wash cloths used if incontinent; not 'flapping' bedclothes; used linen straight into linen skip without touching uniform; special bags for soiled & infected linen

- **Observe during bath/blanket bath:** bruises; rashes; pressure ulcers; jaundice; infestation; needle marks; dehydration/oedema; nutrition; incontinence etc

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Remember:

- A **toothbrush** should be used to clean the teeth wherever possible as this is the only effective way to remove dental plaque.

- **White patches** in the mouth may indicate oral candidiasis (thrush). When not in use, **dentures** should be stored in closed container bearing the patient's name. They should be left in clean water or denture cleansing solution if the patient prefers. They should not be stored dry as this may cause them to become warped.

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Complications of Immobility & Bed Rest Including using Thrombo-Embolic Deterrent Stockings (TEDs)

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Preventing Problems Associated with Immobility

- To examine some of the problems associated with reduced mobility
- To look at how we can promote safe movement
- To look at ways of assessing movement and members of the multidisciplinary team involved

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Pressure Ulcers

- What is a pressure ulcer?
- How are they caused?
- What can they look like?
- Where are they commonly found?
- How are they treated?
- What aids do we have to prevent pressure ulcers from occurring?

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Constipation & Urinary Tract Infections

- The bowel needs muscle movement around it to help move digestive contents along
- Reduced mobility means that a person is at high risk of developing constipation
- How can constipation be prevented or treated?
- Not going to the toilet often enough can increase the risk of urinary tract infections
- How can be prevent urine infections?

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Reduced Food & Drink Intake

- Eating and drinking in a poor position (not sitting in a chair with your feet resting on the floor)
- Not getting food and drink when hungry or thirsty
- Needing others to assist you to eat and drink
- Malnutrition can result
- Encourage patients to at least sit in a chair for mealtimes if able
- Help those with poor mobility to eat and drink

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Chest Infections

- Being in bed a lot, even sitting in a chair in a poor position can result in the lungs not expanding fully
- It is important to cough up sputum from the lungs, a good cough relies on the person being in a good upright position
- Un-cleared sputum and ‘shallow’ breathing may lead to an increased risk of chest infections
- Listen to your patients’ breathing and coughing, help them to sit up and supply tissues and a bowl
- Encourage them to cough well and breathe deeply
- Monitor respiration rate and temperature carefully if you have a patient with poor mobility

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Blood Clots (Thrombosis/Embolism)

- Technical term: deep vein thrombosis (DVT) or pulmonary embolism (PE)
- Reduced mobility can increase the risk of developing these
- Encourage your patients to do leg and ankle exercises if they cannot walk frequently & to perform deep breathing exercises
- ‘TED’ stockings are often used to help prevent DVT – how to put them on
- Ensure that you take them off each day to wash the feet and check the skin on the foot/heel. Replace after this.

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Psychological Impact

- Not being able to move about freely can make people feel frustrated or depressed
- Talk with your patients and listen to them
- Privacy and dignity for patients who have reduced mobility
- Boredom – ways to relieve it
- Try to give your patient choices so that they feel that they have some control over their care

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Promoting Safe Mobility & Exercise

- Registered Nurse (RN) should formally assess mobility and make recommendations for safe movement
- If you are unsure whether a patient is safe to move – ask
- Encourage light exercises e.g. leg or arm raises if patient is able
- Use moving and handling aids with assistance from an experienced colleague

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Assessing Movement

- Can the patient walk/sit/turn/stand?
- What could they manage before they came into hospital?
- What do the Registered Nurses think is a realistic aim for that patient?
- Tell a RN if you think a patients movement is getting worse
- Physiotherapists are expert mobility assessors – try to observe them do their work and ask what you can do with the patient when they have gone

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Mr Walker

- Mr Walker has recently had a stroke which has caused weakness in his right arm and leg.
- The physiotherapist has helped him to stand using a standing frame, but he cannot stand for more than a few seconds without it
- He is right handed and cannot feed himself easily, brush his teeth or write with his left hand
- What problems could occur for Mr Walker?
- What can you do to help him?

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Miss Sitt

- Miss Sitt has had surgery to her knee
- She is very keen to move about after her operation but she has had a fall in the bathroom which has knocked her confidence
- She is reluctant to get out of her chair but is very embarrassed to use a commode
- How can you help Miss Sitt?

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Assisting with Toileting and Elimination Needs

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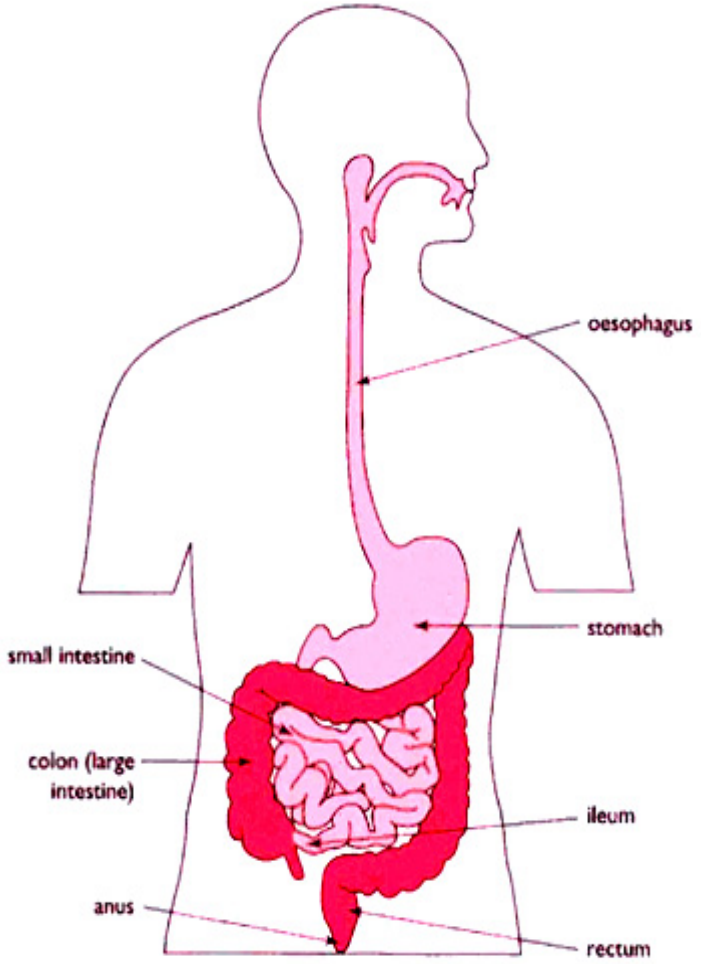
Assisting with elimination needs

A & P of GI tract: mouth; oesophagus; stomach; small intestine (bowel); large intestine; rectum & anus.
(NB diagram in workbook does not show urinary system)

Urine – About **180 litres** of blood is processed by the kidneys each day which results in the removal of wastes and toxins and the formation of urine. This passes into the bladder via the ureters.

Urinary pH = 4.5 – 8.0
Specific gravity = 1010 - 1025



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Urinalysis

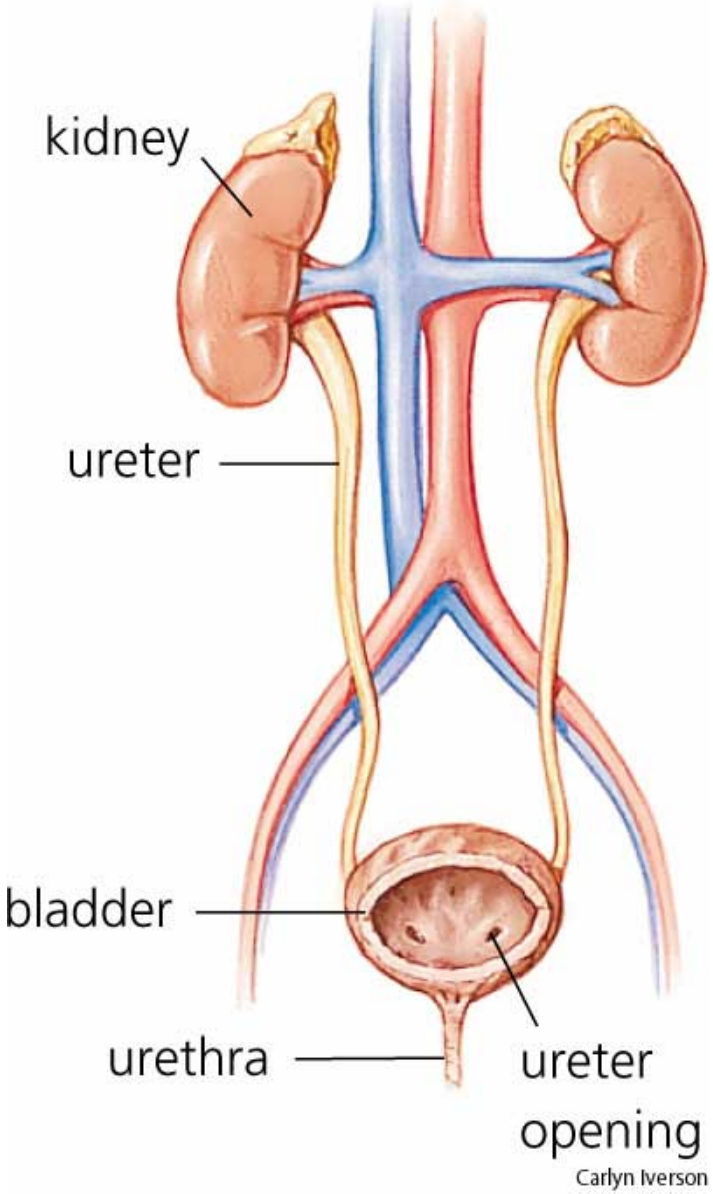
Blood: Urinary tract infection; renal stones; enlarged prostate etc. (In menstruating women, may be contamination)

Protein: Infection; congestive heart failure; pyelonephritis; pre-eclampsia etc.

Glucose: Diabetes; pancreatitis; Cushing's syndrome; patients on high dose steroids etc.

Ketones: Breakdown of body fat e.g. in diabetes; fasting, starvation or severe dieting.

Bilirubin: liver disease; biliary tract obstruction (e.g. gall stones). False positive if not fresh sample.



Terminology - urine

Micturition act of passing urine

Anuria no urine output

Polyuria large volumes of urine

Glycosuria glucose in the urine

Cystitis inflammation of the bladder causing urgency & pain when passing urine

Retention inability to pass urine despite full bladder, often due to an enlarged prostate

Diuresis increased production of urine (often in response to diuretic medication)

Oliguria low urine output

Haematuria blood in the urine

Proteinuria protein in the urine

Frequency the need to pass urine more often – usually small amounts each time. May be sign of infection.

Terminology – faeces (stools)

Malaena: black tar-like stools

Constipation: hard faeces that is difficult to pass

Steatorrhoea: pale coloured, fatty, foul-smelling stools

Diarrhoea: frequent, loose stools

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Pain Assessment

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Learning Outcomes

- **Aim:** To identify and understand the principles of pain assessment

- **Outcomes:**
  - To be able to define the meaning of pain
  - To develop an understanding of the principles relating to pain assessment
  - To identify the implications for practice

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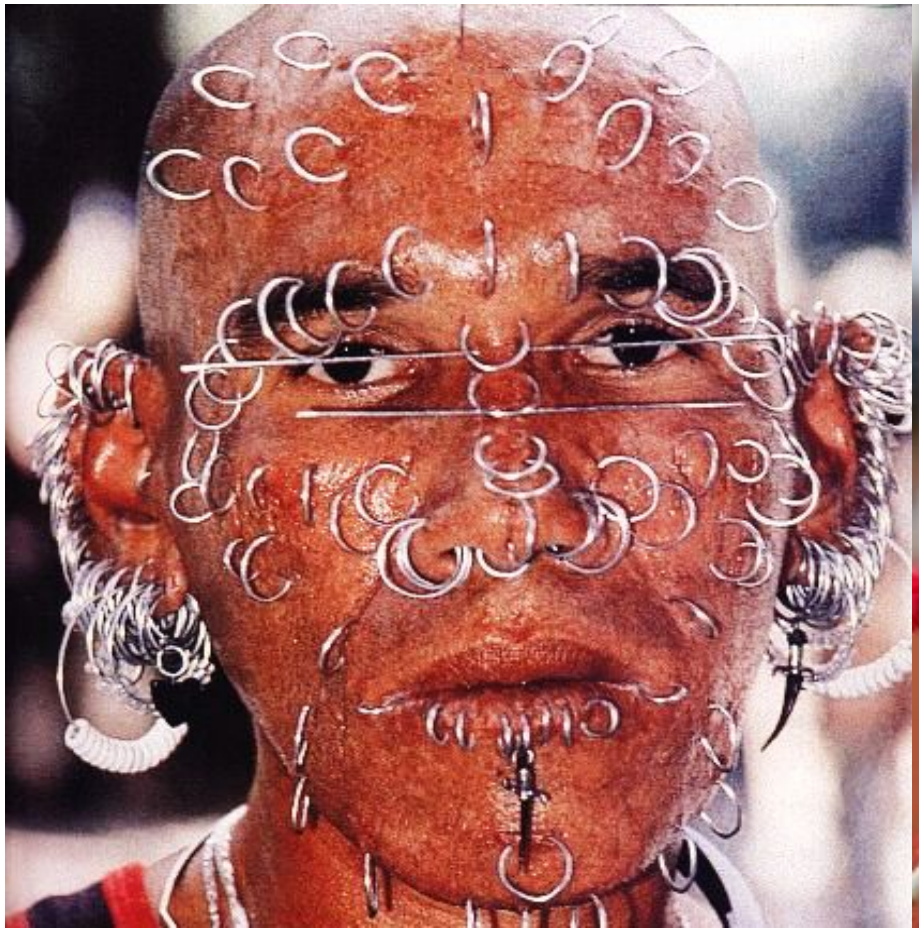
“Pain is whatever the patient says it is…



existing whenever he/she says it does” **(McCaffrey 1983)**

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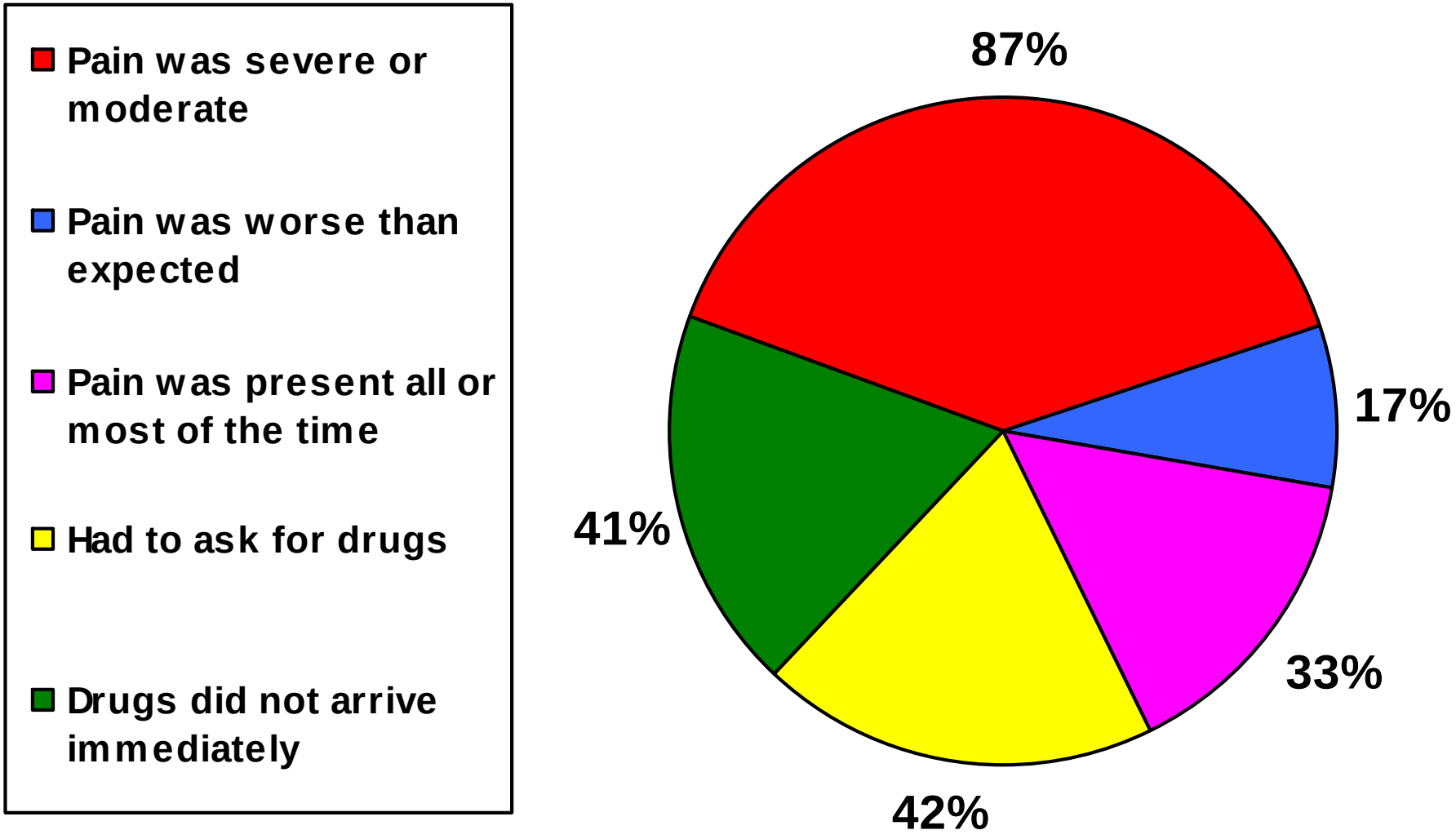
Pain in hospital from a survey of 36 NHS hospitals



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Definitions of Pain

- pain has been defined as…
  'the sensation one feels when hurt (in body or mind); suffering, distress'

- 'an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms as such damage (Hinchliff et al 2004).

- However, pain is an individual sensation and assessing pain is a difficult task for practitioners (Hollinworth 2000).

- Pain can be exacerbated by underlying pathologies/Disease/Infection
  - May not be related to the wound itself, may be contributory factors to the pain response felt by the patient.
    - Pathologies may include peripheral vascular disease, diabetic neuropathy, malignancy, arthritis and dermatological conditions.
      - **All these should be considered as part of the overall assessment.**

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Principles of Assessment

- Effective assessment of pain is a fundamental part of nursing care and accountability for the accuracy of pain assessment lies firmly within the domain of nursing.

- There are three key areas for consideration in the assessment of pain.

- Who, When & What.

Pain factors to be considered

- The severity of the pain
- Frequency
- Regular pain assessment

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What should be assessed?

- The location, duration, intensity and characteristics of the pain.
- The underlying condition
- Is the pain acute, chronic or acute on chronic?
- Any medical/nursing treatment being given.
- Precipitating or exacerbating factors, eg, mobility/immobility, time of day, eating/drinking.
- Related symptoms, eg, nausea, vomiting, breathlessness or sleeplessness.
- Coping strategies used by the patient - pharmacological and non-pharmacological.
- Meaning or significance of the pain for the patient

Types of Pain

- **Acute Pain**

  is usually of sudden onset and commonly associated with a specific injury, acute pain indicates that damage or injury has occurred. Decreases with healing

- **Chronic Pain**

  Chronic pain is constant or intermittent pain that persists over a period of time. It lasts beyond the expected healing time and often cannot be contributed to a specific cause or injury.

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Descriptions of pain

- Continuous, steady, constant
- Rhythmic, periodic, intermittent
- Burning, stinging, or prickly
- Stabbing/sharp
- Dull/diffused
- Throbbing
- Cramp
- Pressing/tight.

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Pain assessment tools

Visual Analogue Scale

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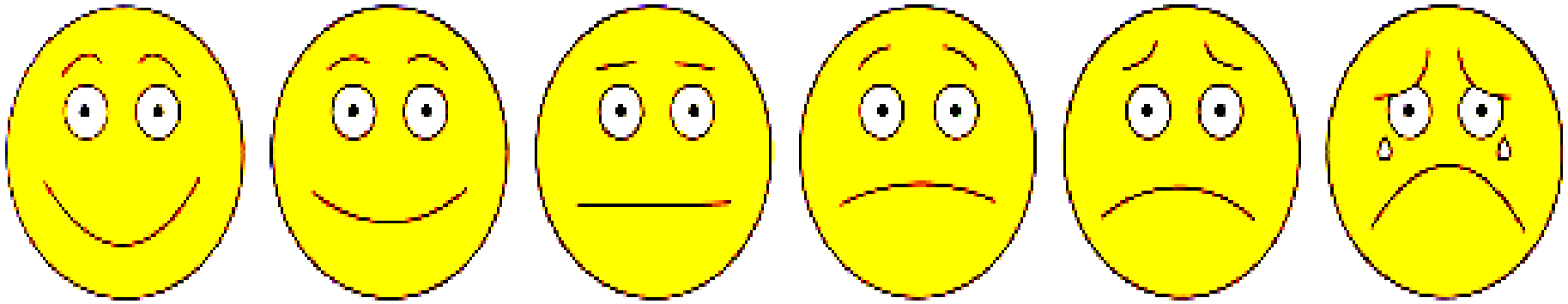
Pain assessment tools



0	2	4	6	8	10
No hurt	Hurts little bit	Hurts little more	Hurts even more	Hurts whole lot	Hurts worst

Wong-Baker FACES Pain Rating Scale

PCA

Patient Controlled Analgesia

- **Advantages**
  safe, effective analgesia; reduces delay and saves nursing time; high levels of patient satisfaction; few complications; lock-out mechanism to prevent accidental overdose
- **Disadvantages**
  Relies on patient compliance; cost of pumps etc;

Resources

- Brooker C Nicol M (Eds) (2003) Nursing Adults: The Practice of Caring. Edinburgh. Mosby.
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Care of the dying person & last offices

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- **"Too many patients still experience distressing symptoms, poor nursing care, poor psychological and social support and inadequate communication from healthcare professionals during the final stages of an illness. This can have a lasting effect on carers and those close to the patient, who often carry the burden of care. The care of all dying patients must improve to the level of the best".**

- (Department of Health. *The NHS cancer plan: a plan for investment, a plan for reform*. London: Stationery Office, 2000:7.21; www.doh.gov.uk/cancer/)

Aims

- To understand and meet the needs of people in the last few hours of life.

- To discuss the last offices for patients.

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What would be a good death?

- Consider any patients you have seen at the end of their lives
- Was this what you might consider a “good death”?
- Have you seen any that you might consider a “bad death”?

A 'Good Death'

- To be treated as an individual, with dignity and respect
- To have your voice heard in decisions about treatment and care
- Most people want detailed information about their condition, treatment and services
- Good face to face communication
- Optimal symptom control
- Psychological, social and spiritual support
- To die in their place of choice
- Family and carer support
- Bereavement services

www.nice.org.uk (2004) Improving Supportive and Palliative care for adults with Cancer

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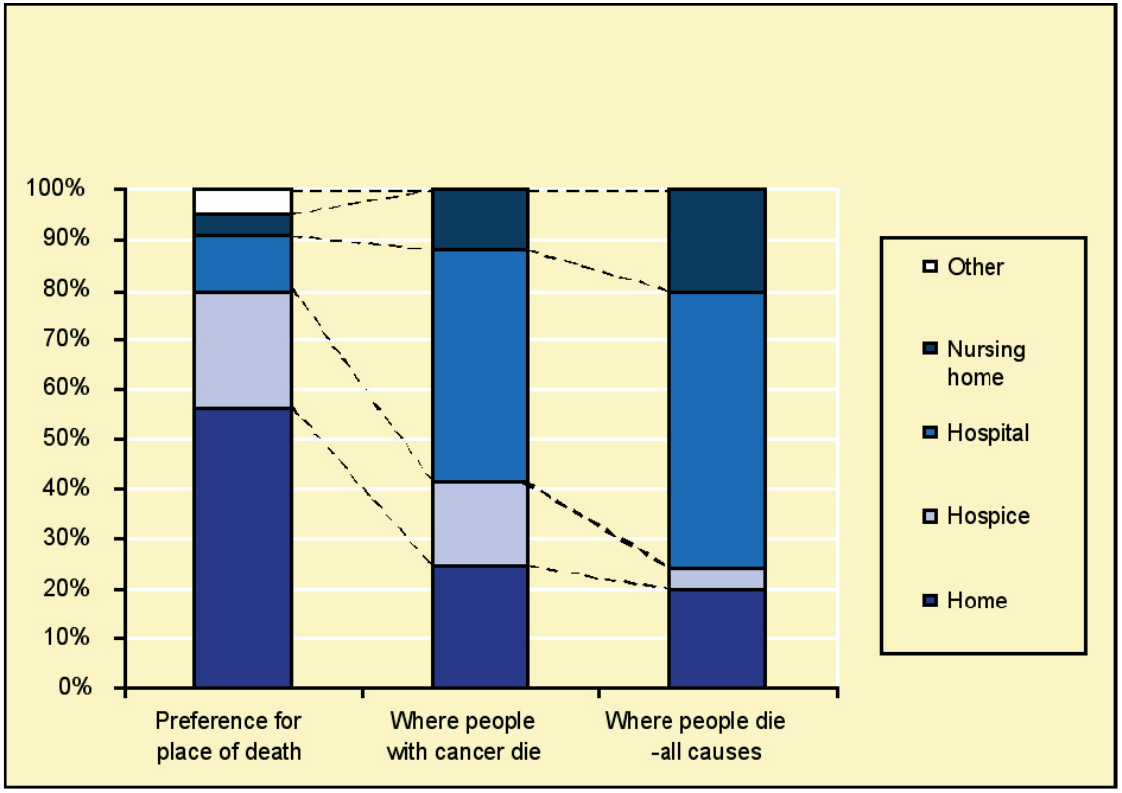
Preferred and actual place of death

Higginson I (2003) *Priorities for end of life care in England, Scotland and Wales* NCPC



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Attitudes towards death and dying

- What are the general attitudes of society to death and dying?
- What are your attitudes?
- What are the effects of carers attitudes?

Attitudes towards the dying

- Death denial
- Inadequate preparation for role
- Negative attitudes have a negative effect on the quality of care

Managing the end of life

- An interprofessional care pathway is being introduced (2006-2008) which supports and documents the use of best practice in the care of people at the end of life

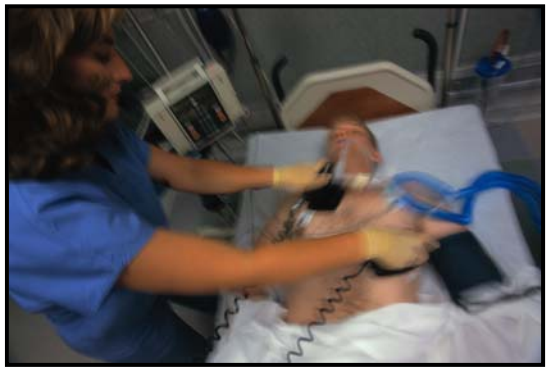
  “The Liverpool Care Pathway”

The Liverpool Care Pathway

- For the last hours/days of life
- Provision of comfort/ symptom control
- Psychological support measures
- Religious/spiritual support
- Communication with family
- Communication within healthcare team

Diagnosing dying

- A multiprofessional team must agree that the patient has reached the last few hours
- All possible reversible causes must be eliminated
- An assessment of specific needs takes place
- Not for Resuscitation



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Support measures

- Inappropriate interventions are discontinued
- Communication with patient
- Communication with family and attention to their needs
- Religious/spiritual needs assessed

Comfort measures/ symptom control goals

- Patient is pain free
- Patient is not agitated
- Patient is not nauseated
- Excessive respiratory secretions are not a problem
- Breathlessness is not distressing
- Patients mouth is moist and clean

Comfort…Continued

- Passing urine is not a problem
- Patient is comfortable, clean and in a safe environment
- Patient is not agitated or distressed due to constipation or diarrhoea

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At death

- Who to contact
- Laying out/ Last offices
- Local procedures
- Bereavement advice

References

- www.nice.org.uk – Improving Supportive and Palliative care for adults with Cancer

- www.dh.gov.uk/en/policyandguidance/organisationpolicy/endoflifecare