Curriculum Development Centers Program

Awardee of The Office of the National Coordinator for Health Information Technology

Component 2: The Culture of Health Care

Unit 6: Nursing Care Processes
Lecture 3

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Focus of this Lecture

- Routine activities for the staff nurse
- Additional activities
- Documentation for the nurse
- Technical tools

Typical Routine for a Hospital Staff Nurse

- Work hours – 8 to 12 hour shifts
- 4 to 5 acutely ill patients
- Prepare for patient care:
  review patient records: diagnosis, history, treatment and care orders, medications; review plan of care and take report from the previous nurse
- Review patient care plan

Routine (continued)

- Assess patient (complete assessment at first visit then a focused assessment at least 4 hours
- Administer medications, check IVs, lab test
- Follow through on plan of care and make changes as needed
- Provide comfort measures, pain assessment and control
- Activities of daily living, dressing changes, ambulation, nutritional provisions

Other Routine Activities

- Collaborate with other personnel: MD, Nurses, CNA, PT, RT, Radiology, Lab services, nutrition, Social Services, discharge planners
- Education for patient and family
- Manage IV's – start or discontinue
- Lab work- blood draws, specimen collection

Non-patient Routine Activities

- Attend an in-service on new equipment
- Cover for other nurses as they take lunch
- Mentor Nursing Students

Documentation

- Documentation is a vital component of safe, ethical and effective nursing practice, regardless of the context of practice or whether the documentation is paper-based or electronic.
- All components of a patient record is a legal document; data placed there must be factual, accurate, complete, dated and signed.

Purpose

- Documentation refers to written or electronically generated information about a client, describing the care or services provided to that client (e.g., charting, recording, nurses' notes, or progress notes).
- Documentation is an accurate account of events that have occurred and when they occurred.

Expectations

- A nurse is expected to record and maintain documentation that is clear, timely, accurate, reflective of observations, permanent, legible and chronological.
- Accurate, timely documentation reflects care provided; meets professional, legislative and agency standards; promotes enhanced nursing care;
- Facilitates communication between nurses and other healthcare providers.

What would a nurse chart?

- Vital signs
- Assessment findings
- Plan of care
- Treatments
- Medications
- Intake and output
- Pain level
- Education
- Telephone orders
- Interaction with patient family members
- Patient complaints
- Discussion with family members
- Admission and discharge notes

Technical Tools

- Computerized documentation systems can improve uniformity, accuracy, and retrievability of data.
- Verbal communication systems – Vocera, pagers
- Lab equipment
- Assessment equipment
- IV pumps
- Pyxis machine
- Simulation mannequins