Nursing: 10 things.

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ONE: always document the care you deliver.

Legal Requirements Your documentation must reflect the patient's care status (condition/treatment) and include nursing interventions and outcomes of care.

Documentation must demonstrate accountability of practice. Remember: The Clinical Record provides proof of the quality of care given to a patient and is admissible in court as a legal document. If it isn't documented it didn't happen. The Process Clinical notes must meet the following criteria:

- they must be legible.
- they must be dated, timed and followed by author's signature and designation.
- they must be a clearly identified signature. If your signature looks like a spaghetti vomit, print your name in brackets afterwards.

- each page must be labelled correctly,
- you must use only approved abbreviations as per hospital protocols.
- you must accurately document any information reported to a medical officer that relates specifically to a change in a patient's condition.
- you must include information such as recording arrival date, time and mode of arrival. Obtain a thorough history and nursing assessment. Document any pre-existing conditions including allergies and their reactions. Thorough and appropriate documentation of haemodynamic observations including pain score.

TWO: Listen!

1. Listen to patients.
2. Listen to family.
3. Listen to parents.

And then you can listen to doctors, colleagues and yourself.

THREE: End at the beginning.

Always reassess your patient after giving treatment.

It's all part of the nursing process. You can think of it as A Delicious PIPE

1. **A**ssessment.
2. **D**iagnosis.
3. **P**lanning.
4. **I**mplementation.
5. **P**re-empt.
6. **E**valuation.

I have added an extra step to the process: Pre-empt.
Pre-empt is the space just after you have implemented your nursing actions but before you step back and evaluate their outcome.

Here you look for things that require immediate attention as a result of your implementation or incidental to it.
Pre-empt is a situational awareness of the often-little things that you can do now to stop you needing to plan more complex interventions later.

For example: you have just placed a nasogastric tube into your patient and confirmed its position. Before you evaluate (and document) this action you could make sure the patient is comfortable, has a call bell close at hand, knows what sensations to expect with this tube, that his IV is not about to run through etc.

FOUR: Never abandon essential nursing care.

- Mouth hygiene.
- Pressure injury care and prevention.
- Effective & *proactive* pain management.
- Ensuring adequate food and fluid intake.
- Accurate and relevant nursing observations.
- Assisting with patient's personal hygiene.
- Advocating on behalf of your patient.
- Care of self and colleagues.

FIVE: never ignore your gut feelings.

Is it an impending calamity?
Or is it just last night's beer and vegetable vindaloo?
Either way, ignore it and the outcome might just be the same.

So, called gut feelings are an important part of being a nurse. Gut feelings are a response to a whole lot of subtle stimuli and information coming in about your patient that may have otherwise been missed due to cognitive overload, distraction or lack of appreciation/experience of the situation.
Even though your frontal lobes may have completely missed the cues, other areas of your Nurse psyche are ringing the bells. Or more accurately, stirring the pot.

However, your gut feeling can sometimes be completely wrong. It is a receptor developed with experience. So, once you have them feels, question them critically.

Never ignore your gut feelings. But never rely on them.

SIX: never deviate from safe and ethical nursing practice.

You can find the Nursing and Midwifery Board of Australia's codes for professional conduct, professional boundaries and standards for practice here: https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards.aspx

You may think this is going to be pretty dry reading…. but I recommend printing out the relevant documents and using them as a reflective tool to hold against your own practice from time to time.

They also have a nursing code of ethics (full explanation here) https://www.nursingmidwiferyboard.gov.au/News/2018-03-01-new-codes-of-ethics-in-effect.aspx which is shorter and makes a useful nursing ethical compass.

1. Nurses value quality nursing care for all people.
2. Nurses value respect and kindness for self and others.
3. Nurses value the diversity of people.
4. Nurses value access to quality nursing and health care for all people.
5. Nurses value informed decision-making.
6. Nurses value a culture of safety in nursing and health care.
7. Nurses value ethical management of information.
8. Nurses value a socially, economically and ecologically sustainable environment promoting health and wellbeing.

SEVEN: do not accept a doctors orders without question if you have a problem with them.

Doctors are often under high cognitive loads, working in a place filled with multiple distractions and interruptions. Written or verbal orders can be wrong or inappropriate.

And sometimes…doctors are just plain dumb as stumps. As are we.

EIGHT: work as a team.

There is no “I” in: team.
There are, however *more* than enough “I” s in: I think I’m in imminent deep shit again!

A strong effective nursing team should have the following characteristics:

1. Clearly identified **leader** or leaders (this role may be shared over time)
2. The team will be **collectively oriented** to the environment, risks, tasks and expectations they are working within.
3. The team will have a **shared model** of care. What they need to do, how they will do it and how they will work within the team.
4. The team will practice **inter-performance**. Each individual monitors, participates and backs up the work done by others in the team.
5. The team will practice **closed loop communications**. Making sure information is spread accurately an efficiently within (and without of) the group. And making sure that information is understood and acknowledged. For example, using SBAR or SHARED (Situation, History, Assessment, Risk, Expectations, Documentation).
6. The team will always work to develop mutual respect, trust and a safe interpersonal space.

NINE: filter for suspicions of child, spouse or elder abuse.

My own hospital's Health Child Protection Policy requires all its staff to make a mandatory report to Care and Protection Services should they suspect non-accidental injury, sexual abuse, emotional abuse or neglect in the course of their work.

These incidents happen far more frequently than you would imagine and having suspicion of abuse should be enough to turn the wheels so others more expert in the field can make an assessment.

Know how to pick up on the signs and how to respond effectively within your organisations guidelines.

TEN: care for the caregiver.

You.
Them.

CRITICAL THINKING ALERT:
This article is an opinion piece that may or may not contain evidence based information.
Handle with care.

theNursePath

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