Clinical Nursing Skills at a Glance

Edited by
Sarah Curr
Carol Fordham-Clarke

WILEY Blackwell

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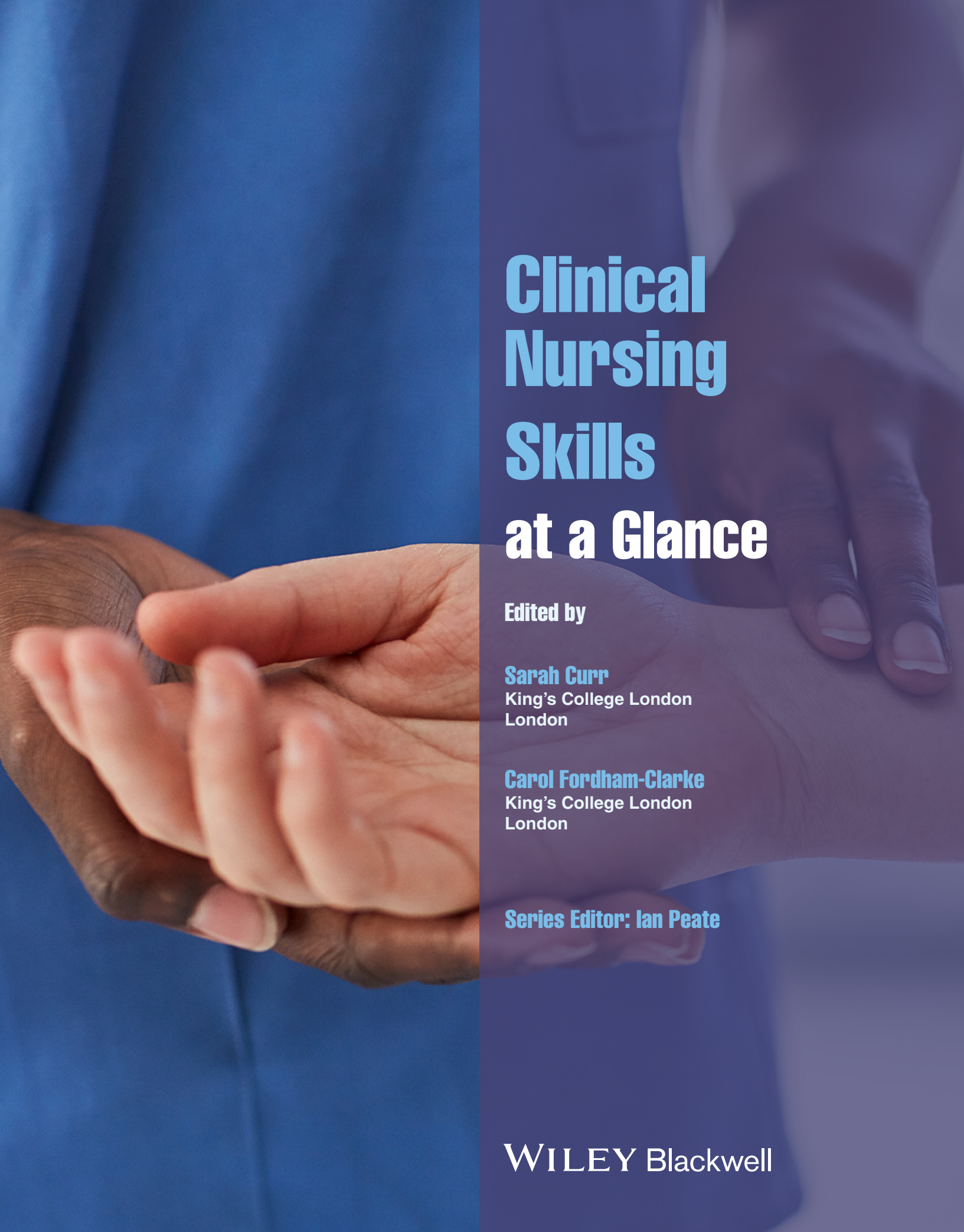

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Edited by

Sarah Curr
King's College London
London

Carol Fordham-Clarke
King's College London
London

Series Editor: Ian Peate

WILEY Blackwell

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Contents

List of contributors

Tiago Horta Reis da Silva MSc, MBA, MScTCM, PGDipSFC, PGDipHE, PGCertHE, BSc (HONS) (Nurs), BSc (HONS) (TCM), RN, FHEA, MBAcC
Lecturer in Nursing Education, Florence Nightingale Faculty of Nursing, Midwifery and Palliative Care, King's College London
London, United Kingdom

Rhiannon Eley RN, MSc, DTN, PGCert Clin.Ed, FHEA
Sister, Urgent Care Centre, Princess Grace Hospital, London, UK
PhD Candidate, King's College London, London, UK

Joanna De Souza RN, MSc, PATHE, RNT, AKC
Senior Lecturer, Florence Nightingale Faculty of Nursing, Midwifery and Palliative Care.
King's College London
London, UK

Dr Alison Gallagher FHEA
Senior Lecturer, Programme Director MSc Advanced Clinical Practice
School of Nursing, Midwifery and Social Work,
Canterbury Christ Church University
Chatham, UK

Kate Brown MSc, PGDipHE, BA(hons), RGN
Faculty Director for Simulation and Clinical Skills
Canterbury Christ Church University
Canterbury, United Kingdom

Karen Fawkes MSc, BSc, PGCE, FHEA, RGN
Teaching Fellow, Florence Nightingale Faculty of Nursing, Midwifery and Palliative Care, King's College London
London, United Kingdom

Lucy Tyler, RN, BSc, MSc, FHEA
Senior Lecturer in Adult Nursing
School of life and health sciences
University of Roehampton
London, United Kingdom

Helen B McInnes RN MSc
Nurse Specialist – Cancer Information, Dimbleby Cancer Care, Guy's Cancer Centre
Guy's and St Thomas' NHS Foundation Trust
London, UK

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About the companion website

This book is accompanied by a companion website.

www.wiley.com/go/clinicalnursingskills

This website includes:

- Scenarios
- MCQs

Part 1

Chapter

1 Introduction: the setup of this book and how to use it

This book is separated into 12 key sections with each section related to a system of the body. The exceptions to this are Chapter 2 (Principles of Skills) and Chapter 3 (Mandatory Skills). The principles of skills highlight key considerations for your healthcare practice, with the mandatory skills focusing on key skills required prior to entering the clinical environment to ensure safe practice. As such, these sections are intended to be read first.

Within this book each page is presented in an easy-to-follow double-page spread. This double page provides written content and tables, figures, and photos, which add a visual context and support.

The United Kingdom (UK) National Health Service Knowledge and Skills Framework (KSF) (NHS Employers 2019) was key in the development of this book due to its focus on the necessary knowledge and skills required to enable quality care provision. As such, each chapter provides both knowledge and skill, thereby ensuring an evidence-based approach to each skill. Each chapter has a brief background section where knowledge is provided with guidance for the procedure. The skill is then outlined in the sections on influencing factors, equipment and procedure. Each chapter also has a red flags section for specific signs and concerns to look for as well as actions to take.

The skills in this book have the potential to be used for all healthcare professionals but there is a recognition that much of these skills will be undertaken by the nursing workforce. As such this book provides skills that align with the UK Nursing & Midwifery's Council (NMC) *Standards of Proficiency for Registered Nurses* (2018). Throughout the book, and weaved across each chapter, are the core platforms:

- Being an accountable professional.
- Promoting health and ill health.
- Assessing need and planning care.
- Providing and evaluating care.
- Leading and managing care and working in teams.
- Improving safety and quality of care.
- Coordinating care.

We feel that whist skills have changed to incorporate the complex care delivery now required, these skills reflect commonly performed procedures in practice as well as those highlighted within the annex of the above publication (NMC 2018). We would also like to emphasise that all these skills require training and an assessment of competence and that this book is intended as a learning adjunct to clinical practice. Prior to performing each skill, you must have been assessed and deemed competent, thus having the necessary knowledge and skills to undertake the procedure.

Do use this book to inform your clinical practice, always ensuring that you use it whist following local and national policies and guidance. The purpose of this book is to provide a quick visual approach to essential healthcare skills and as such should be supplemented by material providing detailed theory underpinning the skills. However the knowledge gained within these chapters can be further consolidated within our online complementary package, which is available in www.wiley.com/go/clinicalnursingskills. This will test your knowledge through quizzes and case studies to ensure further preparedness for practice. Enjoy!

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Principles of skills

Part 2

Chapters

2 Care planning and the nursing process

Figure 2.1 The nursing process.

Figure 2.2 Henderson's needs theory.

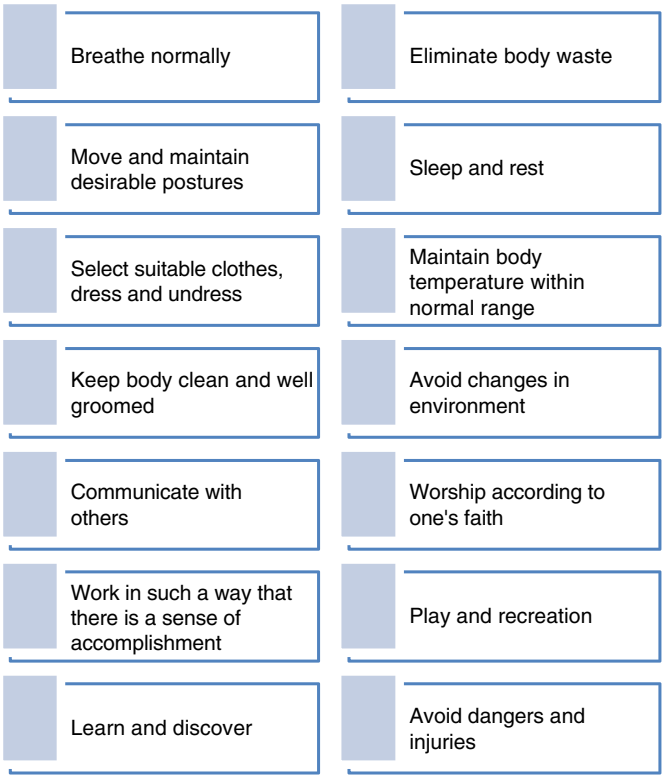

Figure 2.3 Orem's theory of self-care deficit.

Figure 2.4 Activities of daily living.

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Background

Care planning has been a core component of health and social care for many years and was first introduced as part of the nursing process by Ida Jean Orlando (1961). This four-stage process focused on the initial assessment, care planning, implementation, and then evaluation of the care delivery (Orlando 1961). This is intended as an ongoing, circular, activity (Figure 2.1) until care is no longer required and the patient is discharged from the service.

Since its introduction, the nursing process has evolved, with diagnosis being added by Gebbie and Lavin in 1973. The term diagnosis in nursing has long been debated due to its medical undertones, with Levine coining the term "trophicognosis" (Levine 1965) to replace diagnosis. This is because the term means the art and knowledge of nursing (Levine 1965) and refers to the use of information from the assessment and our pre-existing knowledge, which allows us to judge the need and thus create an individualised care plan.

Whichever the term used, the provision of individualised care is key to ensuring that high-quality care that places the patient at the centre is delivered. This also involves recognising that care planning, where possible, should involve the patient and the healthcare professional working together to plan care and set goals that are both desirable and achievable (NHSE 2016).

Influencing Factors

- When patients cannot be involved in the care planning, such as in an emergency or with unconscious patients, ensure that you act in their best interests. This will involve establishing if there is an advanced care plan or "living will". You will also need to establish if legal power of attorney has been granted to an individual and to ensure that person is involved in the process.
- Care planning may well differ across settings, but regardless of the setting there will be an opportunity to document the care plan, either digitally or written. This must be done to ensure continuity of care and a timely evaluation.

Professional Approach

- When assessing patients, ensure that they are fully informed by explaining the rationale of the assessment and how it will ensure care delivery that meets their individual needs.
- While you may be undertaking an individual assessment, planning care will most likely involve other members of the multidisciplinary team (MDT). Ensure that all members of the MDT are involved that are required, undertaking referrals where necessary.

Equipment

- Appropriate assessment paperwork.
- Patient's notes.
- Care planning paperwork.

Procedure – Assessment

This will involve using the relevant assessment documents within your clinical area. The questions asked may reflect Henderson's needs theory (Henderson 1966) (Figure 2.2), Orem's theory of self-care deficit (Orem 2001) (Figure 2.3), or Roper, Logan & Tierney's Activities of Daily Living model (Roper et al. 1980) (Figure 2.4). All these models focus on the fact that nursing care is provided while the patient cannot self-care or meet their daily needs.

Procedure – Diagnosis

- The diagnosis involves considering what has been observed and what information has been given during the initial assessment to identify the problem.
- The diagnosis focuses on key characteristics that enable the nursing diagnosis to be made.
- It is the diagnosis, or diagnoses, that inform the care plan.

Procedure – Care Planning

- More than one care plan may well need to be created to ensure that the patient's individualised needs are met.
- Care plan charts will most likely be available in your clinical area but the key elements to consider are:
  - What is the issue to be addressed?
  - What interventions will resolve this issue?
  - When would be it be appropriate to evaluate care?

Procedure – Implementation

- This is your ongoing care for the patient.
- Essentially by performing a thorough assessment, diagnosis and care plan, appropriate, necessary, person-centred care should be delivered.

Procedure – Evaluation

- This is when you review the care plan and determine if the initial issue has now resolved, remained the same, or worsened.
- Essentially the evaluation will then lead to an assessment and continuation of the process.

Red Flag

- If the patient becomes unresponsive during initial assessment the BLS (Basic Life Support) algorithm and the A–E (airway, breathing, circulation, disability, exposure) assessment should be used.
- A holistic assessment may take time as well as several discussions, depending on the patient's condition and priorities of care.

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3 Communication – fundamentals

Table 3.1 Examples of paraphrasing.

	Patient	Healthcare worker
Summarising	"I'm the bread winner, I'm not sure what will happen to my family."	"You are worried about how your family with cope financially."
Interpreting	"I'm waiting on the results. I've been waiting a while."	"You're worried about when you're getting your results."

Table 3.2 Clarification questions.

"So, what you're saying is. . .?"
"Am I correct in understanding that. . .?"
"So what you mean by that is. . .?"
"What I'm hearing is. . ., is that correct?"
"I'm not quite sure I follow, could you give me more details?"

Table 3.3 SOLER – a tool to build rapport Identified by Egan (2014).

S	**Sit** at a comfortable angle and distance
O	Maintain an **open** posture, i.e. uncrossing legs and arms
L	**Lean** forward appropriately to show engagement
E	Maintain **eye** contact. The healthcare professional must be aware of when this might not be culturally appropriate
R	Maintain a relaxed posture. This will help with building rapport and trust.

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Background

Communication is undertaken with every social interaction and effective communication is affected by how the message is sent and how it is received (Gates et al. 2003). Communication is recognised by the Nursing & Midwifery Council as an essential skill (2018) and involves written, verbal, and non-verbal communication, with patients/clients/service users, relatives, carers, and other members of the immediate and wider multi-professional team.

Influencing Factors

How we communicate depends on the client group we are communicating with and can change when:

- Communicating with people from different cultures.
- Communicating with people who speak different languages.
- Communicating with those with learning disabilities.
- Communicating with children.
- Communicating with those with dementia and/or delirium and other neurological impairments.
- There is a lack of time – it will be apparent by your body language if you feel that you do not have time for the interaction. This can be mitigated by providing a more suitable time for the conversation.

Professional Approach

In nursing how we communicate will impact upon the therapeutic relationship and trust built between the professional and the patient. How we communicate should be considered at the beginning of each episode of care and must be open, honest and non-judgemental. There are numerous factors that we must consider:

- The environment – where is the best place for this conversation?
- Physical discomfort, e.g. pain – consider giving analgesia before the conversation.
- Psychological discomfort, e.g. anxiety – adjusting body language, volume, articulation, pitch, emphasis and rate (VAPER) (Nelson-Jones 2014) of verbal communication can help here.
- Emotional discomfort, e.g. grief.
- Physical impairments, e.g. sight or hearing impairment– consider proximity, visual aids.
- Jargon – avoid professional language the patient may be unfamiliar with as this will create an additional barrier.

Procedure: Verbal Communication

Verbal communication can be face-to-face, over the telephone, or through other media forms, e.g. Facetime, Skype:

- Listening – this is a key aspect of verbal communication as it shows we are attentive and interested in the message being conveyed. It also demonstrates that we receive the message, understand it, support the person we are communicating with, and thus validate the message being delivered.
- Active listening involves paraphrasing, where the key points are repeated back to show that the correct message is being received (Table 3.1).
- Active listening can also involve the use of paralanguage such as: "mmh", "yes", "uh-huh", to show that you are listening.
- Verbal communication may initially start with closed questions, such as "Were you inside or outside?", which can be used at the outset, and open questions, such as "How did you feel when that happened?", to build rapport and engagement.
- Open questions are then used to gain more detailed information and insight into how the person is feeling.
- When communicating verbally there are other factors to consider. VAPER can help us to reflect on our communication in the moment and adjust accordingly (Nelson-Jones 2014).
- If you are not fully following the message it is acceptable to ask for clarification. Table 3.2 provides examples of clarification questions.

Procedure: Non-verbal Communication

- Non-verbal communication involves body language, our gestures, and dress (e.g. uniform), and can also be impacted by our height, gender, and scent, which some may find intimidating.
- As healthcare professionals work in closer proximity than is socially comfortable we need to be aware of our non-verbal communication and utilise this method of communication to demonstrate our care and compassion.
- Egan's acronym SOLER (Egan 2014) can be a useful tool to use initially to build rapport (Table 3.3).
- Communication is often split into three Cs, represented as 55/38/7 (Mehrabian 1972): 55% of communication occurs through body language, 33% through tone of voice, and 7% through the actual words said. Although this is often contested, it is certainly worth considering when engaged in communication.
- In some instances, therapeutic use of silence is also required, allowing the person time to express their message.

Written Communication

- Written communication can be used where there is an impairment impacting on the verbal message being received.
- It can also be used when professionals need to communicate with each other, i.e. via emails or in multidisciplinary notes.
- Written communication needs to be clear, concise, and legible. The key points need to be emphasised, jargon must be avoided, and the patient needs to be comfortable with, and able to use, this method.

Red Flags

- New dysphasia or dysarthria.
- New or sudden onset of confusion.
- Decrease in level of consciousness.
- Changes in behaviour following injury.

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