

CAREFUL NURSING NEWS

Additional Strategies

Splitting tablets: Often times, different strengths of the same drug may cost the same amount (ex. a 30 day supply of metoprolol tartrate 50 mg may cost the same as a 30 day supply of metoprolol tartrate 25 mg). If this is the case, patients can request a prescription for their medication in a dosage form that is double their needed dose and administer half of a tablet per dose. Before this is considered, the medication in question must be able to safely be split (i.e. not extended release) and the patient must be evaluated and deemed to be capable of performing this task without risk of overdosing themselves.

Alternative therapy recommendations: Despite our best efforts, it may be concluded that the price of a medication a patient is on simply cannot be afforded. In this case, alternative therapies should be recommended to the prescriber. Searching discount programs for other medications in the same drug class as the medication prescribed for the patient can be a good starting point.



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CAREFUL NURSING PROFESSIONAL PRACTICE MODEL THEME FOR JANUARY/FEBRUARY 2016 ISSUE— ‘WATCHING-ASSESSMENT-RECOGNITION’

Saint Clare’s Health System Nursing has adopted Careful Nursing as the Professional Practice Model for nursing practice. Careful Nursing has three philosophical assumptions and four concepts: therapeutic milieu, practice competence and excellence, nursing management and influence in health systems, and professional authority. This issue of the *Careful Nursing News* will focus on ‘WATCHING-ASSESSMENT-RECOGNITION’ which is one of the eight dimensions of the Practice Competence and Excellence Concept. Meehan (2012) explains this theme of the newsletter as, “A composite of nurses’ constant visual and perceptive attentiveness to patients and alertness to their bio-physical and psycho-spiritual condition and needs in order to be aware as immediately as possible of any changes in their conditions or levels of responsiveness to medical treatments, collaborative problems and nursing interventions. It provides the foundation for clinical reasoning and decision making.” (p. 2911).

The Careful Nursing professional practice model has FOUR Nursing Concepts (Dimensions) and 19 accompanying Key Practice (Concepts) Dimensions.

- I. Therapeutic Milieu
 - a. Caritas
 - b. Inherent human dignity
 - c. Nurses’ care for selves and one another
 - d. Intellectual engagement

- e. Contagious Calmness
 - f. Safe and restorative physical environment
- II. Practice Competence and Excellence
 - a. Great tenderness in all things
 - b. Perfect’ skill fostering safety and comfort
 - c. **Watching-assessment-recognition**
 - d. Clinical reasoning and decision-making
 - e. Patients’ engagement in self-care
 - f. Nursing diagnoses-outcomes-interventions
 - g. Family, friends, community supportive participation in care
 - h. Health education
- III. Management of Practice and Influence in Health System
 - a. Support of nursing practice
 - b. Trustworthy collaboration
 - c. Participative-authoritative management
- IV. Professional Authority
 - a. Professional self-confidence
 - b. Professional Visibility

Meehan, T. (2012). The Careful Nursing philosophy and professional practice model. *Journal of Clinical Nursing*, 21, 2905–2916, doi: 10.1111/j.1365-2702.2012.04214.x

CAREFUL NURSING PHILOSOPHY AND PROFESSIONAL PRACTICE MODEL®: PRACTICE COMPETENCE AND EXCELLENCE: ‘WATCHING-ASSESSMENT-RECOGNITION’

New Year greetings to all! Over this year we will consider the six remaining concepts of the practice competence and excellence dimension. To begin, let us refresh in our minds the overall structure, principles, dimensions and concepts of Careful Nursing, shown in Figure 1.

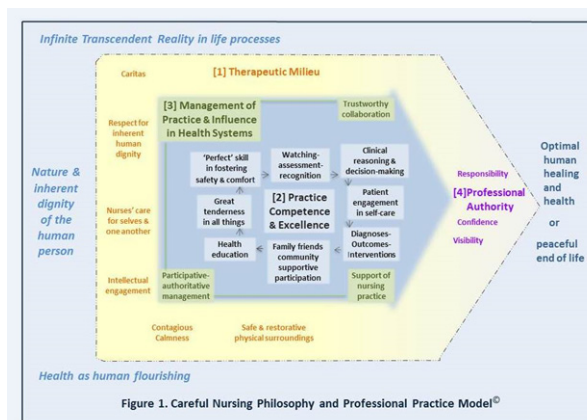


Figure 1. Careful Nursing Philosophy and Professional Practice Model®

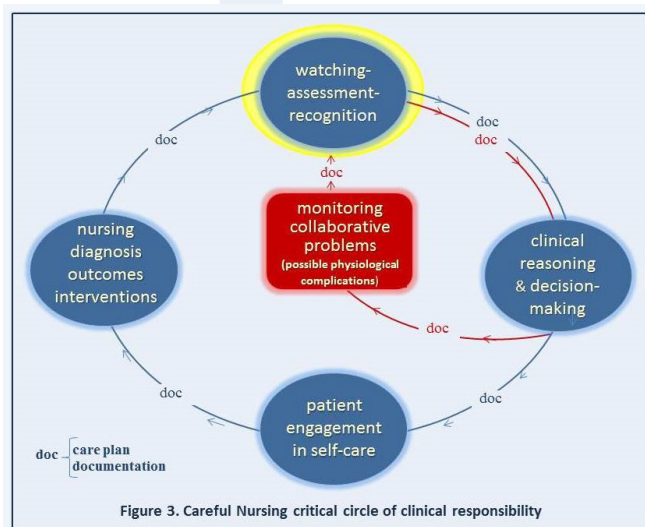


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Now let us zero in on a subgroup of concepts of the practice competence and excellence dimension; concepts which are central to patient safety, shown in Figure 2.



These concepts can be thought of as the Careful Nursing critical circle of clinical responsibility, shown in Figure 3. The first concept which is highlighted, watching-assessment-recognition, will be our focus for this issue of *Careful Nursing News* (CNN).



In the next issue we will consider clinical reasoning and decision-making and the associated concept of monitoring collaborative problems, that is, possible physiological complications which could be life-threatening for patients. In the two following issues we will focus respectively on patients' engagement in self-care and nursing diagnoses-outcomes-interventions.

Watching-assessment-recognition

This is a threefold concept in which its three interrelated qualities give rise to nurses' knowledge of patients' bio-physical/psycho-spiritual condition. Its qualities are distinctive but folded into the one another to form one concept. It is a function of our all-important nurse-patient relationship. That is, the depth and meaning of the knowledge we obtain from performing the concept is dependent on the focus, attentiveness and depth of experience we bring to our relationships with patients. Its purpose is to identify and prioritize the immediate and longer term care of patients.

Usually it is patients' bio-physical condition and immediate care that is our main concern. But patients' psycho-spiritual condition and long term care is also of central concern. Discharge planning for hospitalized patients is expected to begin at the time of hospital admission. From a Careful Nursing perspective, discharge and long term care planning relates to how we can best help patients to flourish as unitary human persons, even if they are disabled, have a chronic illness or live in difficult social conditions which are hard to resolve.

An example of a patient's immediate care is shown in Figure 4. The nurses' focus is on the blood transfusion they are administering to the patient. It is evident that they are gathering their knowledge about it and the patient's response through watching-assessment-recognition in the context of their nurse-patient relationship. Likewise it is evident, somewhat imperceptibly, that they are also gathering knowledge related to the patient's psycho-spiritual experience of the event.



We are familiar with concepts similar to watching-assessment-recognition and discussions about them in the literature, for example, observation, surveillance, or simply assessment. But these concepts do not fully represent the detail, depth and richness of this important nursing responsibility of attending to and knowing from moment to moment the condition of patients.



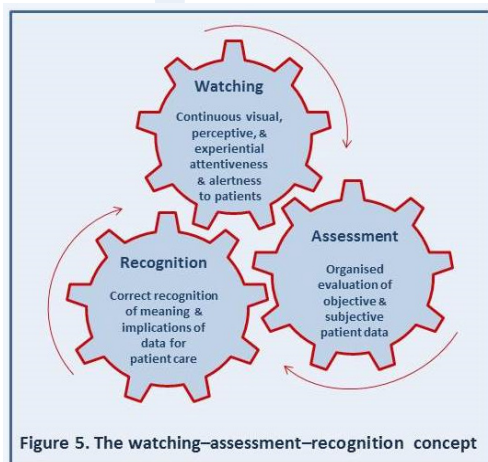
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Background of the concept

With its three qualities, watching-assessment-recognition reflects its 19th century source and also the clinical insight of a contemporary doctoral student. Early in their hospital experience the 19th century nurses recognized the importance of watching patients as attentively and continuously as possible. When they arrived at the Crimean War hospitals they had something of a disagreement with Nightingale about night watching. Nightingale thought that nurses should not be on the wards after 8:00pm. But, they knew from long experience that very sick patients required watching and assessment through the night. They solved the problem by asking the doctors to write an order for a patient they were particularly concerned about; that he was to be watched by a nurse during the night. Later Nightingale came to recognize the importance of night watching.

Earlier in the development of Careful Nursing this concept was called watching and assessment and defined as such (Meehan, 2012). However, in subsequent discussion at a doctoral student seminar a participant observed that watching and assessment went only so far and that it was necessary to recognize what the watching and assessment data meant. Although this had been implicit in the historical documents, it had not been drawn out in the content analysis. In addition, reflection on nurses' relatively common intuitive experiences of deterioration in patients' condition (Brier et al., 2014) indicated that this experiential phenomenon should be allowed for in the definition. et al

Revised definition. Accordingly, the concept name was changed to watching-assessment-recognition and its definition was revised as: a composite of nurses' constant visual, perceptive and experiential attentiveness to patients and alertness to their bio-physical/psycho-spiritual condition and needs in order to recognize as immediately as possible any changes in their conditions or their levels of responsiveness to medical treatments, collaborative problems and nursing interventions. The concept provides the foundation for clinical reasoning and decision-making. We can use the diagram shown in Figure 5 to visualize and think about how we experience the interrelated qualities of watching-assessment-recognition as one concept.



Importance of the concept

Watching-assessment-recognition can be considered the concept most central to patient safety. It lies at the root of one of the nursing profession's primary responsibilities, the protection of sick, injured and vulnerable people from harm. In any acute care setting this nursing responsibility is the most sensitive 'first alert' or 'early warning' of potential or actual deterioration in patients' condition. Failure to carry out this responsibility well can lead to 'failure to rescue' patients from critical illness or death (Garvey, 2015, p. 145).

It is the most sensitive indicator because nurses are with patients 24/7 and have patients' objective and subjective data available to them continually. In a community or clinic setting where nurses are with patients only for intermittent visits their objective and subjective interactions with patients in the context of the unitary (holistic) nurse-patient relationship still provides them with the most sensitive range of patient data.

The watching-assessment-recognition concept is also considered the first step in the nursing process and, as Herdman and Kamitsuru (2014) stress, if we do not perform it well we lose control over the nursing process as a whole. In other words, we lose control over our practice.

Documentation. Watching-assessment-recognition leads immediately to the critically important process of nursing documentation of patients' condition, also shown above in Figure 4. Because nurses' knowledge of patients' condition is central to patient safety, its clear and precise documentation is vital to communication among nurses and other health professionals. Whether such documentation is written, semi-electronic or electronic, it must also show clearly the distinctive nursing contribution to patient care. It illustrates the focus of nursing practice in nursing diagnoses and interventions and provides data for measuring nursing-specific patient outcomes, and can provide data for calculating nursing costs.

Importantly, documentation of knowledge gained from watching-assessment-recognition provides the data for clinical reasoning and decision-making, monitoring collaborative problems (Carpenito, 2014), making nursing diagnoses, setting and measuring nursing outcomes, and selecting and implementing nursing interventions in immediate and long-term care-planning (which we will discuss in subsequent issues of CNN).

The concept's qualities

Watching has long been a central aspect of nursing practice for the purpose of guarding vulnerable people from harm; for keeping them safe. It is an activity that occurs continuously over time. Historically, watching/guarding is linked to the use of the term ward to describe the area in a hospital where patients reside. The terms "guarding of" and "warding of" vulnerable people were once used synonymously ("Ward", 2016; "Watch", (2016). Wards were controlled and managed by nurses because they had the primary responsibility for guarding patients.



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Although in the United States the term hospital ward has been mainly replaced by hospital unit, the term hospital ward continues to be used internationally in other English-speaking countries. Using or recalling the term ward can serve to embed its historical meaning of guarding in our consciousness. A search in the nursing literature of the current use of the term guarding indicates it is used mainly to refer to protecting against known but subtle threats to patients' safety; to watch for such threats in order to ward them off, so to speak.

Watching can be specific and objective, for example, a patient's physical position, drainage through a tube or information on an electronic monitor. Or, it can be broad and subjective. For example, on entering a patient room; whether for one, two or more patients; a watchful nurse will pause, often imperceptibly, and attentively scan the patient, or patients, to gain an overall impression of their condition. The nurse is functioning as a unitary person; the nurse's gaze and perception registers in her or his mind an overall impression of a pattern of characteristics and the status of each patient as a unitary being. This may be a first impression of a patient. Or it may be an impression compared with a previous impression.

This unitary (holistic) process is often called intuition. Because this is a subtle subjective experience of a patient's condition, it may not be easily put into words. Rather, a nurse can say only that "something is not right" (Brier et al., 2014, p. 835). But, this experience can serve as a basis for on-going comparison with successive experiences of a patient's condition; to determine whether still "something is not right". At the same time such an initial experience must be taken very seriously and nurses' watching intensified. It could be a vital 'first alert' to a patient's deterioration. The literature suggests that nurses can be slow to recognise and respond to cues to patients' deterioration (Hart et al., 2014; Considine et al., 2015).

Assessment, it is widely agreed, is a structured, evidence-based process used to gather objective and subjective patient data in an organized way. Logically, nursing assessment should be guided broadly by a nursing knowledge framework, for example, a nursing theory or conceptual model or a philosophy and professional practice model such as Careful Nursing.

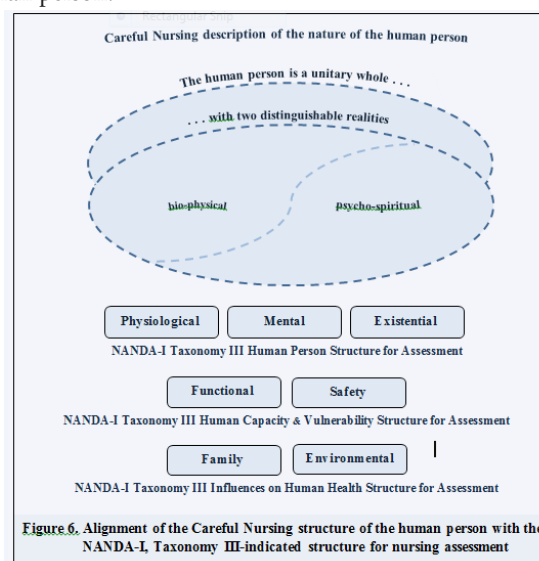
Generally, attempts to introduce an assessment structure which follows a nursing framework or theory have not been successful in healthcare organizations. Likewise, use of Gordon's well known functional health patterns as a structure for nursing assessment has not been widely followed. For example, the Gordon-based NANDA-I Taxonomy II structure begins with a focus on health promotion and nutrition (Herdman, 2014). These concerns are not usually of immediate importance to the care and safety of patients admitted to such healthcare organizations.

Because most nurses practice in healthcare organizations, their specific assessment structure is usually determined by the organization's Department of Nursing. Traditionally, these structures have focused to a considerable extent on physical assessment of vital signs and body systems from

a medical perspective. But, arguing from the critical standpoint of patient safety, Considine and Currey (2014) propose that these structures do not give nurses sufficient guidance for the order in which data is to be collected and prioritized. They recommend instead the primary survey approach to patient assessment because it focuses on evidence-based patient safety concerns. This approach prioritizes assessment of respiratory rate (not oxygen saturation) cardiovascular circulation and neurological status because changes in these data have been shown to be the best predictors of physiological status and any deterioration in patients' condition.

A problem and solution for Careful Nursing. For Careful Nursing the problem of how to structure nursing assessment so that it prioritizes patient safety and follows the Careful Nursing philosophical principles is of major concern. As indicated in Figure 1. above, the practice competence and excellence dimension of the Careful Nursing professional practice model incorporates the use of the standardized nursing languages of NANDA-I nursing diagnoses (Herdman & Kamitsuru, 2014), the nursing outcomes (Moorhead et al., 2012) and nursing interventions (Bulechek et al., 2013). The nursing diagnosis structure presupposes the nursing assessment structure to be used. However, because the NANDA-I diagnosis Taxonomy II structure does not prioritize patient safety, it creates conflict for many nurses in clinical practice. In addition, it does not fit well with the Careful Nursing philosophical principles.

Fortunately, a solution is on the horizon. A newly proposed NANDA-I Taxonomy III structure developed by von Krogh (Herdman, 2014), is currently being considered to replace the Taxonomy II structure. The new structure would prioritize patient safety in a way similar to that suggested by Considine and Currey (2014). Further its structure, outlined by Herdman, (2014, pp. 79-80) would be viewed as broadly consistent with the Careful Nursing description of the nature of the human person, as shown in Figure 6. The mental and existential domains of Taxonomy III would be aligned to the Careful Nursing distinguishable psycho-spiritual reality of the human person.



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On a philosophical level, this would mean that the Careful Nursing philosophical principles would be substituted for the atheist philosophical principles of existentialism. The related nursing diagnoses would be addressed from a Careful Nursing philosophical perspective rather than an existentialist philosophical perspective. The Taxonomy III structure is currently undergoing international review, but its adoption cannot come soon enough for emphasizing patient safety and for Careful Nursing.

In Careful Nursing, as indicated in Figure 6, bio-physiological assessment of the body and five outward senses is of major importance. Although Aquinas's philosophy emphasizes the unitary nature of the human person and unitary human interactions and relationships, it also places great emphasis on the importance of the human body and the functioning of its five outward senses as a distinguishable reality (see CNN 2013, 4/4, pp.2-7). Likewise, psycho-spiritual assessment and the role of values in human relations are considered central to human healing and the development of health as human flourishing.

Recognition. The meaning of recognition, as we are concerned with it here, is identification of something through the perception of sameness to something previously known or encountered. This meaning stems from its original meaning "to know again, or recall to mind" (Recognition, 2016). In relation to nursing watching and assessment, recognition is an act of identifying correctly the meaning of perceptions and experiences of patients and patient assessment data, based on knowledge and previous experience.

This quality highlights for us that our level of knowledge and intellectual engagement are major factors in enabling recognition. In relation to patient safety, this applies to rapid recognition of patients' condition and any deterioration that occurs. In relation to preparing to make nursing diagnoses, it means having a good knowledge of the defining characteristics and related factors of a range of nursing diagnoses, especially those which are similar to one another but must be differentiated.

There can also be a sort of inverse use of this quality in a situation where we are seeing and, or, experiencing something not encountered before. In terms of patient safety this can flag the need to act quickly to get other opinions. In terms of preparing to make nursing diagnoses it could be the beginning of working toward developing a new diagnosis. In both cases it could also mean that our knowledge bases requires further development.

This quality has many practical implications, not least for nurse education. It has practical staffing implications for nurses and nurse managers. It highlights the probable threats to patient care which result from moving nurses to different practice areas to 'cover a shift' when there is a shortage of nurses. It can go some way toward explaining why nurses generally are uncomfortable with being suddenly transferred to a practice area where they have little or no previous experience with the types of problems patients are experiencing. It also has implication for the use of bank or agency nurses.

The qualities as one concept

The statement of this concept, watching-assessment-recognition, and the overview above indicate that its qualities are each important in themselves. They warrant separate attention, attention they might not receive fully when they are thought of under one term such as observation, surveillance, or simply assessment. But they are also clearly folded into one another in our practice, just as this concept is folded into the other concepts of the practice competence and excellence dimension. Indeed, all the concepts of the nursing process are folded into one another.

Conclusion

The concept of watching-assessment-recognition is of key importance in our professional practice because it lies at the root of one of our primary professional responsibilities; to protect sick, injured and vulnerable people from harm. Thus, its three qualities warrant our separate and on-going attention, as does the concept as a whole.

What do you think? Perhaps you will send some feedback on this exploration of watching-assessment-recognition to the editor of *Careful Nursing News* sueweaver@primehealthcare.com or send a message in the 'Contact' section of the Careful Nursing website: <http://www.carefulnursing.ie> We look forward to hearing from you.

References

- Brier, J., Carolyn, M., Haverly, M., Januario, M.E., Padula, C., Tal, A. & Triosh, H. (2014). Knowing 'something is not right' is beyond intuition: development of a clinical algorithm to enhance surveillance and assist nurses to organise and communicate clinical findings. *Journal of Clinical Nursing*, 24, 832-843.
- Bulechek, G.M., Butcher, H.K., Dochterman, J.M. & Wagner, C. (Eds.). (2013). *Nursing Interventions Classification (NIC)* (6th ed.). St Louis/London: Mosby/Elsevier.
- Carpenito L. J. (2012). *Nursing Diagnosis Application to Clinical Practice* (5th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Considine, J. & Currey, J. (2014). Ensuring a proactive, evidence-based, patient safety approach to patient assessment. *Journal of Clinical Nursing*, 24, 300-307.
- Considine, J., Trotter, C. & Currey, J. (2015). Nurses' documentation of physiological observations in three acute care settings. *Journal of Clinical Nursing*, 25, 134-143.
- Garvey, P. K. (2015). Failure to rescue: The nurse's impact. *MEDSURG Nursing*, 24, 145-149.
- Hart, P.L., Spiva, L.A., la Baio, P., Huff, B., Whitfield, D., Law, T., Wells, T. & Mendoza, I.G. (2014). Medical-surgical nurses' perceived self-



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confidence and leadership abilities as first responders in acute patient deterioration events. *Journal of Clinical Nursing*, 23, 2769–2778.

Herdman, T. H. (2014). Introduction to the NANDA-I Taxonomy. In Herdman, T. H. & Kamitsuru, S. (Eds.), *Nursing Diagnoses Definitions and Classifications 2015-2017* (52-90). Oxford: Wiley Blackwell.

Herdman, T. H. & Kamitsuru, S. (Eds.). (2014). *Nursing Diagnoses Definitions and Classifications 2015-2017*. Oxford: Wiley Blackwell.

Meehan, T. C. (2012). The Careful Nursing philosophy and professional practice model. *Journal of Clinical Nursing*, 21, 2905–2916.

Moorhead, S., Johnson, M., Maas, M.L. & Swanson, E. (2012) *Nursing Outcomes Classification (NOC)* (5th ed.). St. Louis/London: Mosby/Elsevier.

Recognition. (2016). *Oxford English Dictionary* Retrieved from <http://www.oxforddictionaries.com/definition/english/recognition>

Ward. (2016). *Oxford English Dictionary* Retrieved from <http://www.oxforddictionaries.com/definition/english/ward>

Watch. (2016). *Oxford English Dictionary* Retrieved from <http://www.oxforddictionaries.com/definition/english/watch>

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KUDOS

Congratulations to **Robyn Bogert, RN, CNOR**, OR staff nurse who passed the CNOR exam. *CNOR is a definition not an acronym. CNOR certification is defined as: "the documented validation of the professional achievement of identified standards of practice by an individual registered nurse providing care for patients before, during and after surgery."* <http://cc-institute.org/cnor/about>

Congratulations Sarah Granda, **MSN, RN, CIC**, Infection Control Coordinator, who successfully fulfilled the educational practice and written examination requirements and is now Board Certified in Infection Prevention and Control.

WELCOME TO SAINT CLARE'S:

Kathleen M. Craig, BSN, RN-BC – Pediatrics/Special Care Nursery

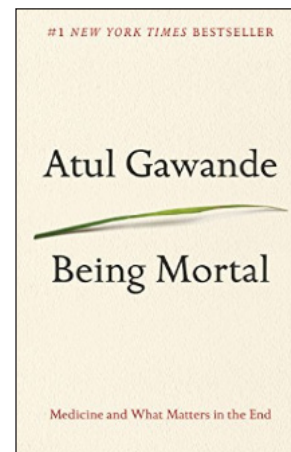
Eileen Hassa, BSN, RN – Emergency Department

Stephanie Martinez, RN – Labor and Delivery

Paul Saulys, RN – Emergency Department

MUST READ

Being Mortal: Medicine and what matters in the end by Atul Gawande illustrates how modern day medicine approaches mortality and how we view end of life care. How do we define Mortality? One such definition states, "A living human being subject to death; perishable." More than just being mortal, I feel this book teaches us about being human as well. We approach aging and death as a battle that must be overcome. Gawande (2014) explains, "We've been wrong about what our job is in medicine. We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being." Well-being is about reasons one wishes to be alive. Sickness and old age make being mortal a struggle.



It's a sobering fact that in the late 18th-century those 65 and older made up less than two percent of the US population. Today, they comprise 14 percent. In 30 years, there will be just as many people over 80 years old, as there will be under 5 years old (Wilwol, 2015). Those statistics are staggering, but Gawande takes the focus off of the statistics we thrust upon the elderly and looks at the soul. He explains that direct patient and family involvement is vital when determining the course of action against failing health or terminal disease. Medical care and hospice care is not about treating or doing nothing, but rather it is about the priorities and purposes of a mortal's life. Gawande passionately conveys that people understand that they are aging and dying each day. They do not fear death itself, but rather they fear what happens short of death, those last few months, weeks, or days when they experience the uncomfortable and consuming demands the process puts on the body and soul; the period of time when they become dependent on medical technology and devoid of spirit and energy.

The most meaningful experiences in my career and as a human being has been to do for others what medicine can no longer do. We are all mortals, not divine, and aging and death is inevitable. **"We should not fear death, but rather an unlive life. You don't have to live forever. You just have to live."** (Babbitt, 1975)

