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КАФЕДРА ПРОПЕДЕВТИКИ ВНУТРЕННИХ БОЛЕЗНЕЙ

М. В. Шолкова, Э. А. Доценко, Т. П. Новикова

НАБЛЮДЕНИЕ ЗА ПАЦИЕНТОМ. УХОД ЗА ПАЦИЕНТАМИ С ДЕФИЦИТОМ САМООБСЛУЖИВАНИЯ

FOLLOW UP OF PATIENTS. PATIENT CARE FOR INDIVIDUALS WITH SELF-CARE DEFICIENCY

Учебно-методическое пособие

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Р е ц е н з е н т ы: канд. мед. наук, доц. каф. терапии Белорусской медицинской академии последипломного образования И. И. Семененков; каф. пропедевтики внутренних болезней Витебского государственного ордена Дружбы народов медицинского университета

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Изложены современные представления о принципах оценки состояния пациента, основы ухода за пациентами с дефицитом самообслуживания.

Предназначено для студентов 1-го курса медицинского факультета иностранных учащихся, обучающихся на английском языке по специальности «Лечебное дело».

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MOTIVATIONAL CHARACTERISTICS OF SUBJECT

Theme of Lesson: Supervision of the patient. Main objective data and characterizing the current state of the patient. Principles of care for patients with self-care deficiencies.

General Time of Lesson: for 1-st year students the general medicine faculty is 3 hours.

Goals of Lesson: introduce the students with the stages of nursing, principles of following up on the patient's status, methods of assessment and kinds of registration of the patient's current condition, to study the main principles of care for the patients who display self-care deficiencies.

Tasks of Lesson:

1. Introduce the students with the stages and principles of nursing observation after the patient's condition.
2. To study the methods of patient examination, principles of objective and subjective data.
3. To study the principles of observation the patient's status under various pathological processes and conditions.
4. To study the rules of registration of the patient's current data into patient's card.
5. To study the main needs of the patients with self-care deficiencies.
6. To learn the principles of care for the patients with self-care deficiencies.

Requirements for initial level of knowledge:

In preparation for seminar, students should get acquired with the recommended reading materials and any additional literature about the steps of nursing care, principles of supervising patients, subjective and objective data of patient's condition, and the principles of patient care with self-care deficiencies.

Control Questions

Medical Psychology:

1. What communication tools are the most important for the medical personnel?
2. What models of interpersonal communication exist between medical personnel and patient?
3. What is the subjective conception of illness? How does it determine the patient's behavior?

Control Questions on the theme of lesson:

1. State the steps of nursing care, and the goals of each step.
2. In what ways can medical personnel gather information of the patient's state?
3. Characteristics of objective and subjective data of the patient's state.
4. Types of consciousness exhibited by patient.
5. Types of patient's position.

6. Characteristics of patient's general condition.
7. Objective data of all systems during patient's examination.
8. Characteristics of vital important levels of patient's state.
9. Rules of checking of the data of patient's condition.
10. Rules of registration of medical data.
11. Determinants of patients with self-care deficiencies; the main needs of such patients.
12. Principles of care for patients with self-care deficiencies.

TYPES OF HUMAN NEEDS

In 1943, American psychologist A. Maslow theorized the hierarchy of human needs, which reflect on their behavior. He suggested that the highest level of human needs only becomes realized after the actualization of the subsequent level (fig. 1).

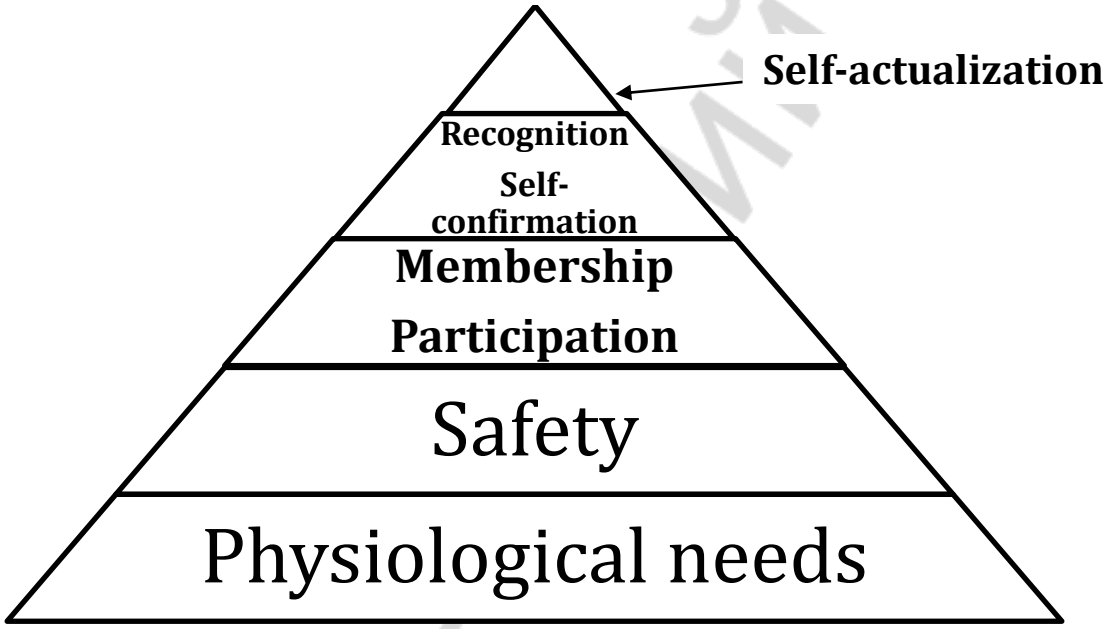

Fig. 1. Maslow's hierarchy of needs

1. Physiological needs (food, shelter, sleep, etc).
2. Need for safety (clothing, blood, stability, protection, etc).
3. Social needs (understanding, assimilation, love, family, etc).
4. Self Esteem needs (respect, accomplishment, etc).
5. Self Actualization (morality, realizing one's potential, etc)

Virginia Henderson, American hospital nurse, one of the founders of nursing care as profession formulated the main human needs in the book «Main Principles of Patient Care» (1966):

1. Normal respiration.

2. Adequate intake of food and water.
3. Discharge the products of vital function (urination, bowel movements).
4. Remain active and support needed position.
5. Rest and sleep.
6. Be able to dress and undress oneself, to choose the clothes.
7. Regulate body temperature in normal ranges through proper dressing and changing the environment.
8. Look after personal hygiene and appearance.
9. Take care of your safety and of those around you.
10. Support relationships with friends, express your emotions and opinions.
11. Maintain spiritual morals within the religion you practice.
12. Take part in favorite activities.
13. Take part in games and sports.
14. Take part in self-actualizing activities that allow for normal progression of growth.

Human needs by V. Henderson are not depicted in Maslow's hierarchy of needs. (tabl.)

Table

Connecting Maslow's and Henderson's needs

Maslow's Hierarchy of Needs	Henderson's Human Needs
1.Physiological Needs	1. Breathing 2. Food 3. Life sustaining products 4. Exercise 5. Sleep
2.Need for Safety	6. Clothing 7. Body temperature regulation 8. Take care of personal hygiene 9. Take care of one's safety
3.Social Needs	10. Interact with others 11. Maintain spirtual morals
4 and 5. Needs for Esteem and Self-realization	12. Take part in favorite activities 13. Rest 14. Take part in self actualizing activities

A healthy person does not experience hardships with their abilities to live a successful life. However, in old age or when affected by an illness a person cannot accomplish the same things in life unless provided some aid.

NURSING PROCESS

The first terminology of «nursing process» appeared in medical literature in 1950's. Currently, nursing process is a key term in the sphere of nursing. Under the idea of nursing process one can understand the systematic,

educational, goal-oriented affect of any medical nurse. The essence of nursing process concludes that the patient care is determined by the proper medical care chosen and how it is implemented. Nursing process is always dynamic and a repeating process due to the fact that the patient's needs change, either partially or fully, under the factors of time, illness, treatment, and affected by both family members and medical personnel.

The goal of nursing process is to execute the maximum level of care for the patient's physical, social and emotional comfort. It is achieved by providing aid and the restoration of independence in the patient. The organizing structure of nursing process is expressed by the following:

1. Nursing examination of the patient. The goal of this step is to obtain accurate information regarding the patient's current status.
2. Nursing diagnostics. The goal is to prioritize the problems and needs of patient.
3. Planned treatment and care plan. The goal is to provide short term and long term treatment on the basis of nursing manipulation and intervention.
4. Realization of the treatment plan. The goal is for the successful implementation of treatment plan, and it excludes nursing error.
5. Rating the effectiveness of the executed treatment. The goal is to accurately rate the patient's reaction on the carried out nursing manipulations, as well as estimate the execution of care plan that was outlined in goal 3.

The first step in the nursing process most of the time determines the subsequent steps, in order to decide which manipulation and care plan should be implemented the patient's status must be properly documented.

METHODS OF RATING THE PATIENT'S STATUS

Information regarding the patient's status may be received with the use of various methods:

– by taking patient questionnaire along with information given by relatives.

– by monitoring patient's external appearance, behavior and communication.

– by examination the patient's body systems (cardiovascular system, respiratory system, digestive system, etc. As well as taking vital signs like blood pressure, temperature and pulse).

– by analyzing lab work (CBC, biochemical blood panel, urine analysis, sputum sample, etc).

– by analyzing instrumental data done by MRI, ultrasound, ECG, XRAY, etc.

There are 2 types of medical information: subjective and objective. Subjective information is information taken from the patient during the questionnaire. The patient informs us how he is feeling, what are his general

complaints, how he perceives physical and psychological discomfort. For example, headache, insomnia, weakness or dyspnea- these are examples of subjective information.

Subjective information may be received:

– from patient's words;
– from the relatives;
– from other medical personnel or social workers.

Without a doubt, the patient himself, is the best source of the information that regards to how he feels, however there are times when the patient may not be able to communicate such information (comatose status or mentally impaired, or verbal impairment), in such cases the relatives of the patient will be responsible to provide the information. If there were other medical personnel taking care of patient prior to current care, then they will be responsible for providing the patient's information.

Subjective information contains key points:

1. They cannot be measured accurately. The difference between strong and moderate pain is solely dependant on the patient.
2. They are not always accurate. For example, the patient may be certain that his heart is causing him pain, he regularly takes nitroglycerin, however upon investigation during examination it is determined that the source of his pain was related to pathology of his spine.
3. They are not always productive. If you ask the questions in a random order, the patient's answers might be different, especially when it regards to older patients, patients with mental regression and very impressionable patients. They will give information that doesn't align. The patient might forget what caused him pain yesterday, or have a different interpretation of what is actually causing his pain. For example, sometimes during angina pectoris the patient may not be able to differentiate the type of pain he is experiencing, i.e. if the pain is heavy-pressing or squeazing. If we were to ask, «Do you experience pain in the area of your heart?», the patient will answer no. However, if we were to ask, «Do you notice any unpleasant feelings in your chest? », the patient may answer, «Yes, every now and then I feel tightness here» and will point to his chest. Often times, people who are not in the sphere of medicine only interpret cardiac pain at the level of the left nipple and do not associate cardiac pain in the thoracic region at all.

Objective information is the presented data collected by medical personnel. Such information includes: body mass, height, skin color, heart rate, blood pressure, respiratory rate, etc. There are two ways objective information may be obtained:

– from medical documents;
– during medical examination of the patient.

There are various medical documents containing important medical information such as epicrisis, any results from laboratory findings, doctor or

nurse notes left in patient’s medical card. However, no other document other than laboratory-diagnostic results will provide the most accurate and reliable information on the patient’s current status.

The importance of objective information:

– Ability to reproduce. For example, we can measure aterial pulse in a patient multiple times and it will only have miniscule changes with every measurement.

– Results not influenced by emotions. The objective information is independent from patient's emotional status or medical personnel's mood. For example, leukocyte count or ESR (erythrocyte sedimentation rate) does not change under emotional influence.

– Measurability. Majority of objective information may be measured and has universal units.

– Objective information may be a fixed result of physical or laboratory-instrumental findings. In medicine today there are instruments that collect vital signs at specific intervals and input them into the patient's electronic file. Such instruments are used in the intensive care unit (ICU), and is depicted in fig. 2.

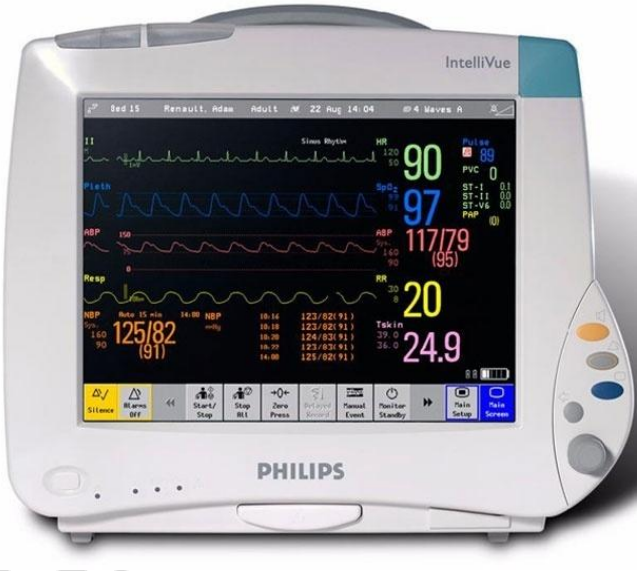

Fig. 2. Patient monitor

This apparatus can measure heart rate, respiratory rate, arterial blood pressure, ECG (electrocardiogram), and an other vital signs. If the patient's vitals are below or higher than the standard norms then the machine calls for a nurse. Subjective and objective information may confirm one another: for example, if the patient complains on his heart, the instrumental data will confirm that his pulse is in tachycardia rhythm or is arrhythmic.

PATIENT QUESTIONNAIRE

Retrieval of nurse information from patient, as a rule, comes after the doctor's examination of the patient, and it also differs from the doctor's not just in the depth of information but also schematically. A nurse collects patient information differently than a doctor: a doctor's aim is to diagnose and to implement a treatment plan, whereas a nurse's aim is to uncover what is causing the patient pain, eradicate the problem and increase the quality of life while under her care.

Nurse examination always starts with dialogue between nurse and patient. The medical nurse should control the conversation in a way so that the patient is willing to share the information and acknowledges the friendliness. The aim of the conversation- is not just to collect the complaints, but also to achieve a positive outlook by the patient towards the treatment plan and explain what to expect during the indicated tests that are to be performed. The conversation should be a positive one, without being rushed or tension, and the patient should feel comfortable to ask any and all questions that he has.

It is crucial that the patient states his name to start the conversation to confirm with whom the nurse is speaking, but the nurse must provide a private place to speak with the patient, free from others. First, the nurse must confirm the passport information (surname, name, father's name, living address, profession). This information may also give an overall understanding of what kind of person is before you as a nurse. Then, the conversation is aimed at thoroughly understanding what the patient's complaints are. To achieve this, the following questions must be asked:

1. What are your worries/concerns? What brought you here (to the hospital, doctor's office, clinic)?
2. How intense is the pain you are expereincing (dyspnea, cough, etc)? What is the character of the pain? What does the pain remind you of?
3. When did this pain start? Do you rememeber what caused the pain?
4. What provokes your symptoms? Under what circumstances do your symptoms start?
5. Does anything relieve the symptoms?
6. Do you experience any other symptoms that cause worries?

During the questioning, do not assume the patient will easily remember what concerns him/her, and it is important to keep the aim of the conversation fixed on getting answers to the questions. Likewise, the patient will not answer directly on your question, but the answer will be in the answer, so you must construct your answers based off of the words of the patient. For example, it is better to write «the patient complains of the absence of stool for the duration of 5 days», rather than «patient complains on constipation». It is also very important to clearly understand just how intense the symptoms and pain are, and the extent of their influence on the rest of patient's day.

An important segment of the patient questionnaire is the patient history. It is important to gather all information regarding past illnesses or traumas that the patient experienced (special attention to past tuberculosis infections, viral hepatitis), as well as if there are chronic conditions (diabetes mellitus, arterial hypertension, ischemic heart disease) and any allergies on medications. The patient's living conditions must be accounted for in the planned nursing treatment plan, such information includes the relationships with relatives, any bad habits patient might have (drinking, smoking) and patient's overall relationship to his/her own health.

OBJECTIVE EXAMINATION

The retrieval of objective information starts the moment the nurse starts the conversation with the patient, she records the start time of the dialogue, the level of patient's consciousness and awareness, the color of skin and mucous membranes, condition of the hair and nails, position in bed etc. It is necessary to pay close attention at the patient's speech (absence of slurring, stutters, long pauses for they can show higher neural affection), patient's vision and hearing. Other aspects of the patient that should be noticed is the condition of clothing (washed or dirty), personal hygiene (do they look after themselves) for these could all be clues for underlying issues regarding the patient's ability to care for oneself (for example, urine incontinence) or the condition of the home.

From the initial moment the nurse has contact with the patient it is her duty to rate the mental status of the patient. Clear mental status is noted when the patient orientates himself to the conversation being held, shows comprehension towards the information that the nurse is communicating and adequately responds to questions. If you believe the patient to have disturbed mental status, he/she will display slowness in responses, may give irrelevant answers or might possibly be in a comatose condition. Comatose is a condition where the patient's central nervous system is functioning very poorly, there will also be noted absence of consciousness and reactions to stimulus.

There are 3 types of positions that the patient can be in; active, passive or forced poses. Active position is when the patient may change his/her position upon his own needs. Passive position is the body placement by patient due to intoxication or weakness. If a patient due to symptoms repositions himself periodically in effort to feel relief then it is considered to be forced position. For the patient to feel relief he is required to take whatever position that provides relief. For example, during the abdominal pain the patient can lie down on his side and feel relief.

The quality of the skin and mucous membranes is very important and is of clinical significance. Any changes to the coloring or structural integrity may be key indicators of some illnesses. *Hyperemia* (redness) of the skin may develop in patients with streptococcal angina, arterial hypertension, and under strenuous

physical labor or while alcohol intoxication. *Pallor* (whitish hue) of the skin occurs during hypotension, hypoxia and from various intoxications. *Cyanosis* (bluish hue) of the skin occurs if there is a oxygen exchange pathology and can also be signs of cardiovascular or respiratory diseases. *Jaundice* (yellowing) of the skin and mucosal membranes only occurs in increased hemolysis or liver pathology.

Other important characteristics of the skin that should be accounted for is how moist the skin is (dry or wet), the elasticity (elastic or loose), if any rashes are present, the nail beds should be examined for color and integrity, hair (color, integrity and whether or not it is falling out), and special attention to any rashes or itching.

The general condition of the patient can be rated as positive condition, minimally critical and very critical.

Positive condition of the patient does not require extra medical help, if the patient is sick he is still capable to execute daily tasks and the disease does not interfere with his abilities. For example, the patient may have arterial hypertension, however when taking medication his blood pressure is within normal ranges and in turn does not affect daily life.

Minimally critical condition of the patient is seen when the disease is in exacerbated phase and has marked affect on the patient's ability to fulfill daily tasks. For example, if a patient who already has arterial hypertensions is going through a hypertensive crisis, he will experience visual disturbances, severe headache and his blood pressure will be above the normal ranges; despite these concerning symptoms his life is not being threatened.

When a patient is in very critical condition, he is considered to be in a life-threatening stage, for example when there is acute ischemic affection of the brain vessels. If not immediately treated and perfusion to the brain is returned the patient is at high risk for hypoxia and irreversible brain damage.

The medical nurse must record the height and body weight of the patient in order to properly measure them. These measurements are very important to the doctor, likewise for the nurse in order to execute proper care. In order for the doctor to prescribe any medication the weight of the patient must be known for proper dosage. The nurse must also take body temperature and must fill in the result into the medical card.

CARDIOVASCULAR SYSTEM

The objective information that the nurse collects during examination is the following: pulse quality, arterial blood pressure, the presence or absence of interstitial edema, and water balance.

When measuring arterial pulse, the characteristics taken into account are the symmetry of the pulse (are they the same on both arms), rhythm, the rate of

the pulse (the norm is 60–90 BPM), the filling (is it a full pulse, medium or faint), and its tension. Arterial blood pressure is measured 10 minutes after rest on both arms, the normal systolic pressure is between 100–140 mmHg, and diastolic pressure can fall anywhere between 60–90 mmHg.

Edema usually occurs due to increased permeability of the interstitial tissues. In cardiovascular diseases edema is typically spread on the lower extremities. To rate the degree of edema we must examine the patient's lower leg and foot. Under various types of edema the skin may appear stretched, and if we apply pressure with our fingertips there will be an indentation left on the skin for a few minutes. The fluid may also be collected in the abdomen (ascites) and may appear in the pleural cavity (hydrothorax).

To assess the water balance it is necessary to count the intake of fluids (includes all beverages, liquid foods, intravenous fluids), as well as the fluid output (urine, loose stools, any open wounds, etc).

Respiratory System. When assessing the condition of respiratory system the nurse needs to characterize the following: respiratory rate (normal range is 14–20 BPM), rhythm, type of breathing (abdomen, thoracic or combined), and whether dyspnea is present or not. If patient is experiencing respiratory insufficiency the color of skin (cyanosis) and rate of respiration will be changed, the nurse must note these and document them. During inpatient treatment the patient will be hooked up to a pulseoximeter that measures the oxygen saturation in the body. The normal SpO_2 saturation is between the ranges of 96–99 %, if the patient is experiencing hypoxia then the oxygen saturation will fall under 96 %. The nurse must also pay attention to the characteristic of the cough (if present), and assess whether or not it is wet, dry, bloody or mucoid cough.

Gastrointestinal System. The nurse must document a thorough examination of the GI system of patient which includes: the eating habits, the characteristic of appetite, the quality of stool, and how frequent patient experiences bowel movements. Nurse must examine the tongue (clean or fur), smell from the mouthe, the abdomen (groqth in volume, symmetry).

Urinary System. The nurse will assess the rate of urine output, the color, characteristic and volume of urine output. If patient has incontinence or frequent urination this will also be an important indicator as to the help the nurse will be providing.

Muscular-skeletal system. Another inquiry the nurse must address is if the patient is experiencing any skeletal problems that involve joints, and if so then the degree of the discomfort must be rated (does the patient have difficulty moving due to the joint pain, what special means are used: walking-stick, crutch, wheel-chair). When assessing the joints the following is taken into consideration: presence of deformation, presence of swelling, hyperemia, pain, and mobility. Frequently when a patient has skeletal or joint problems, they are incapable of taking full independent care of themselves.

Nervous System. When the nervous system is affected the patient may complain on headaches, dizziness, episodes of losing consciousness, muscle spasms, memory problems and sleep disturbances. If the patient had a cerebral stroke they may have subsequent mobility disturbances, speech impairment and memory loss. It is the nurse's duty to prevent bedsores if patient has any kind of paralysis.

Reproductive System. When inquiring on male or female reproductive systems the questions should be tactful. For women, it is important to know the regularity of menstruation, amount of pregnancies and births. It is crucial also to know how much blood loss a woman experiences during menstruation, because if the bleeding is severe and long then it can lead to anemia.

Once the nurse has finished the general examination, any additional questions of the patient must be answered. It is necessary to introduce the patient with the regime and rules of hospital.

VITAL SIGNS

Vital signs- are signs that reveal the condition of the patient, the functioning of all general body systems. They must be assessed during every patient examination, and if under extreme situations that are life threatening, urgent medical attention should be carried out. Vital signs consist of the following:

– Heart rate (normal 60–90 beats per minute);
– Arterial blood pressure (normal 100–140/60–90 mmhg);
– Respiration rate (normal 14–20 breaths per minute);
– Body temperature (normal is 36–36,9 degrees Celsius).

If any of these vital signs do not fall in the normal ranges then the nurse must contact the doctor in charge.

DOCUMENTING THE MEDICAL INFORMATION

The collected information must regularly be checked for assessment of accuracy and reliability. The medical nurse must be sure:

– that the information is complete;
– the subjective and objective information compliment each other;
– no information was skipped.

It is mandatory that the information is complete and double checked before the next step of nursing care is followed through. Any diagnoses or treatment plans can only be implemented once all of the chief complaints are collected and the full physical examination is done, because it is between these steps, where mistakes are often made.

Checking the information:

– Some of the collected information may require a second examination, for example pulse may be counted several times.

– Additional questions may be asked by the nurse to confirm the information that was collected. For example, if the patient is holding his hand behind his head, the nurse might make a conclusion that the patient is experiencing headaches. However upon asking the patient if he is having headaches, it might turn out that he was just holding his head because he is upset over the diagnosis.

– The collected medical information must also be double checked by another medical personnel. For example, if the nurse has doubts about the accuracy of the blood pressure measurement because it seems too low, she may ask a colleague to recheck the blood pressure to either confirm or disprove the concern.

– Cross evaluation of subjective and objective information should be carried out. For example, if a patient with edema says that his water intake is low, but on his bedside table there are several empty water bottles, the nurse must confirm the actual volume of fluids he ingested, and then do an assessment on the water balance in the body.

The collected patient information may be documented straight into the patient's medical card. There are two types of medical cards: out-patient (ambulatory) and clinical medical cards. They differ in structure and in volume of information. The ambulatory medical card records information over several years, whereas clinical cards may only record a week or several months worth of information. In the clinical card the patient is examined daily (several times throughout the day), whereas the ambulatory medical card may have breaks in time where patient did not come in to see the doctor. Both versions of medical cards may be in paper form or electronic format.

Rules of documenting medical information:

The documentation of medical information must be accurate, grammatically correct and should implement the proper medical abbreviations. For every entry into the medical history, the date and time must be stated, as well as the nurse's or doctor's full name and specialty. The documentation should be precise and interpretations of the information should be avoided, only the facts should be present in the medical card. In the medical card such adjectives such as «norm», «normal» should be avoided and the information should be as accurate as possible. For example, the following should be inputted «the body temperature is 36,7 degrees Celsius» instead of writing «body temperature is in norm». All of the collected information should be fixed and stated clearly.

MEDICAL ASSISTANCE FOR PATIENTS WITH SELF-CARE DEFICIENCY

During the conversations and examinations of the patient with the nurse, it is crucial to know if the patient has any limitations and how the nurse can offer assistance. Whether or not the patient requires assistance, it should be a mutual agreement between medical personnel and the patient. Only under extreme circumstances when the patient has cognitive disturbances the medical personnel may make such executive decisions on the patient's behalf. Also, under such circumstances the relatives and the doctor in charge must be aware and in agreement of the treatment plan.

Aims of nursing care for patients with self-care deficiency:

1. Providing physical and psychological comfort
2. Increasing the quality of life
3. Decreasing the disease manifestations
4. Finding and satisfaction of breaking needs

The nursing care of patients with limitations consists of the following:

1. Implementation of physical and emotional safety (stress free environment, comfortable conditions)
2. Airing out the patient room (increasing the oxygen and prophylaxis of upper respiratory tract infections)
3. Controlling the condition of the patient increases the chances of preventing exacerbations of illness
4. Controlling the urine and stool allows nurse to see the condition of the GI and urinary system, and take appropriate measures if something is not normal.
5. The nurse maintains the personal hygiene of such patients (daily cleansings, bathing, care for eyes, mouth, nose, external ear canal, nail care and external care of reproductive organs)
6. Special prophylactic care is implemented to avoid bedsores (assessment of risk and development of bedsores, examination of skin, repositioning the patient every 2 hours, and providing therapeutic massage for blood circulation)
7. Changing the bedding and clothing of patient
8. Feeding the patient
9. Educating the patient and the relatives on the care
10. Providing a positive atmosphere in efforts of reducing stress
11. Organizing patient's interests
12. Providing rehabilitation measures (physical exercises, massage, etc) to ensure the improvement of patient's quality of life and treatment.

If the patient requires any of these needs, the nurse will implement proper care and inform relatives on how to create the best environment for treatment and rehabilitation.

If the patient has any respiratory problems he may complain on cough, dyspnea, and pain in the chest. The ways a nurse may assist a patient in this circumstance may be adjusting patient's position, opening up a window to allow air to circulate, educating of patient on respiratory gymnastics, using supportive inhalers and controlling the amount and type of sputum that the patient discharges.

If the patient has GI related disorders they may experience lack of appetite or absolute refusal of food, nausea, vomiting, pain in the stomach or abdomen, etc. The duty of the nurse is to educate the patient and family about the appropriate diet for the patient, create a menu for the patient, properly feed the patient and take care of the mouth after vomiting, and in extreme cases implementing a naso-gastric feeding tube.

The patient may also complain on urinary or bowel problems such as constipation, diarrhea, incontinence, absence of urine, pain upon urination or defecating, abdominal bloating or discomfort. The nurse will follow up with proper educational material on how to maintain normal GI regularity, may put the patient into adult diapers, put urine catheter, and maintain hygiene of reproductive areas.

If the patient has limited mobility for various reasons (pain, joint affections, nerve problems) then there will be subsequent decrease of activity in the patient to the extent that he might not be able to use the restroom without assistance. For bedridden patients, they have an increased risk of acquiring bedsores and they frequently have constipation. The measures the nurse can take to aid such patients is to try to save the functioning mobility of patient (giving crutches or wheelchair to aid in movement), helping the patient adapt to the new physical limitations, and educate the patient on physical therapy and methods of prophylaxis of bedsores and constipation.

Likewise, the patient may have sleep disturbances that manifest as inability to fall asleep and poor quality of sleep for various reasons such as nocturnal dyspnea, pain in various positions, uncomfortable sleeping conditions, anxiety etc. The nurse's job is to provide a comfortable environment for the patient to sleep by controlling how much caffeine is taken and when the last meal was for example, and under doctor's orders may administer sleeping aids.

The patient may present poor body temperature regulation; such cases might be hypothermia or respiratory infections. Patient may complain on sweating and weakness. The care of this patient is tailored to controlling the temperature of the body, pulse, blood pressure and either cooling/warming of the patient along with changing the linens/clothing of patient's.

When hygiene of the patient is suffering due to limitations, and he is unable to dress himself it is the job of the nurse to help fulfill these needs. Patients with limited mobility are at a higher risk of contracting skin infections and bedsores, so their hygiene is of high importance. The nurse will assist in bathing, using the restroom, dressing the patient, etc.

In some cases the patient may also become a safety hazard to him or to others or live in life threatening environments at home. For example, a smoker brings harm to himself and to surrounding people, or a patient experiencing a panic attack is afraid of things in reality or they might be hallucinating then the patient becomes unstable and might pose as a threat to him or others. The nurse in this instance must provide a safe place for the patient, inform the patient on the potential risks, educate the consequences of bad habits, teach some methods of self control and ways to manage stress/anxiety.

It is not uncommon for a patient to have social problems that isolate them from others and lose interest in things that before have provided pleasure. The nurse should be tactful in such cases and mindful, making sure to assess if the patient experiences a deficit of social stimulus at home, or doesn't have moral support at home, it is important that the nurse implements these in the treatment plan for patient. The hospital also has many outlets for psychological or religious support that are available for the patient at any time.

SELF CONTROL TESTS

1. Nursing process is:

a) the daily schedule of a nurse;
b) treatment plan that nurse executes;
c) process of caring after patients with limitations;
d) all of the above.

2. All of the following are steps of nursing process EXCEPT:

a) nursing diagnostics;
b) nursing examination;
c) nursing treatment;
d) planning;
e) realization of planned care;
f) assessment of effectiveness.

3. Aim of nursing process is (are)

a) treating the patient
b) providing environment for patient's rehabilitation
c) providing a high level of care for patient that is parallel to nursing code
d) providing a maximum level of physical, social and emotional comfort

4. Information regarding patient's condition can NOT be received:

a) from the patient;
b) from the relatives;
c) from other medical personnel;
d) from medical documents;
e) from medical book;
f) from examining the patient.

5. Types of medical information are:

a) subjective;
b) objective;
c) unidentifiable;
d) laboratory;
e) all are true.

6. Which of the following is NOT a vital sign:

a) heart rate;
b) arterial blood pressure ;
c) respiratory rate;
d) body temperature;
e) erythrocyte sedimentation rate.

7. Methods of checking collected medical information are:

a) repeating some tests;
b) confirming information with patient;
c) cross checking subjective and objective information;
d) confirmation from colleague;
e) all are true.

8. Human needs as stated by A. Maslow include:

a) physiological, psychological, need for respect and self actualization;
b) physiological, social, need for safety, and need for self actualization;
c) physiological, social, need for recognition and need for self actualization.

9. Number of human needs as stated by V. Henderson:

a) 5; b) 6; c) 10; d) 14; e) 16.

10. Goals of nursing care for patients with limitations:

a) providing and supportive physical and psychological comfort;
b) increasing quality of life;
c) decreasing chances of disease exacerbations;
d) decreasing the chances of disease;
e) finding and addressing the limitations of patient;
f) all are true.

Answers: 1 – a; 2 – c; 3 – d; 4 – e; 5 – a, b; 6 – d; 7 – e; 8 – b; 9 – d, 10 – f.

RESOURCES

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