Fundamentals of Nursing
Lecture -1-

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Definition of ;

Fundamental of nursing : the art and science of nursing care.

Nursing: It is a profession that uses specialized knowledge and skills to promote wellness and to provide care for people in both health and illness .

Nursing ; Is Caring

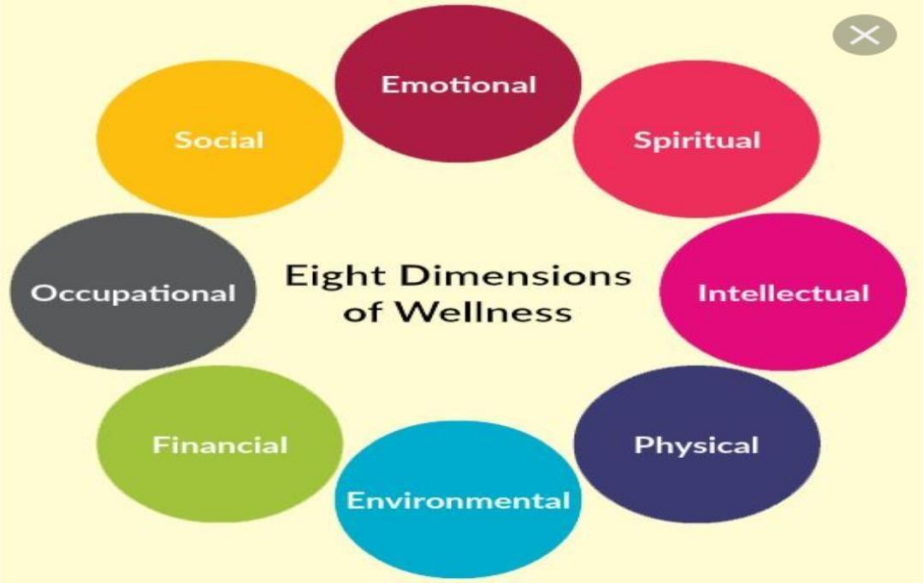
Nursing : Is an Art

Nursing ; Is a Science

Nursing : Is a Profession

Nursing : Is a Holistic

Holistic Health



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- **Nurse:** Is a person who is trained to care for sick or injured people and who usually works in a hospital
- **Health:(WHO)** is a state of complete physical, mental, and social well being, and not merely the absence of disease or infirmity."
- **Hospital:** is a health care institution providing patient treatment with specialized medical and nursing staff and medical equipment.

- **Florence Nightingale (founder of modern nursing, Lady with the Lamp)** .

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AIMS OF NURSING

1. To promote health
2. To prevent illness
3. To restore health
4. To facilitate coping with disability or death

To meet these aims, the nurse uses:

1- knowledge

2- skills

3- critical thinking

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NURSING ROLES IN ALL SETTINGS

1. Caregiver
2. Communicator
3. Coordinator
4. Educator
5. Manager
6. Leader
7- Researcher
8- Advocator
9- Collaborator
10- Counselor
11- Motivator
12- Critical thinker

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Departments or wards of the hospital

- Emergency department Or –ER-
- burn unit
- Dialysis unit
- Surgical unit
- Medical unit
- Operation room
- Orthopedic unit
- Cardiology
- Neurology
- Oncology
- Urology
- Obstetrics and gynecology
- Maternity ward
- ICU
- CCU
- RCU
- HDU
- Outpatient Clinics

Pediatric ward

Admission, Transfer, Discharge, and Referral Process :

Admission involves:

1. Authorization from a physician that the person requires specialized care and treatment.

2. Collection of billing information by the admitting department of the health care agency.

3. Completion of the agency's admission data base by nursing personnel.

4. Documentation of the client's medical history and findings from physical examination.

5. Development of an initial nursing care plan.

6. Initial medical orders for treatment.

7. Medical authorization.

8. The admitting department.

a. Preliminary data collected.

b. Addressograph plate.

9. Initial nursing plan for care.

10. Medical admission responsibilities.

Nursing Admission Activities

1. Preparing the client's room.
2. Welcoming the client.
3. Orienting the client.
4. Safeguarding valuables and clothing.
5. Helping the client undress.
6. Compiling the nursing data base.

Psychosocial Responses on Admission

1. Anxiety and fear.
2. Decisional conflict.
3. Situational low self-esteem.
4. Powerlessness.
5. Social isolation.
6. Risk for ineffective therapeutic regimen management.

TYPE	EXPLANATION	EXAMPLE
Inpatient	Length of stay generally more than 24 hours	Acute pneumonia
Planned (nonurgent)	Scheduled in advance	Elective or required major surgery
Emergency admission	Unplanned; stabilized in emergency department and transferred to nursing care unit	Unrelieved chest pain, major trauma
Direct admission	Unplanned; emergency department bypassed	Acute condition such as prolonged vomiting or diarrhea
Outpatient	Length of stay less than 24 hours; possible return on a regular basis for continued care or treatment	Minor surgery, cancer therapy, physical therapy
Observational	Monitoring required; need for inpatient admission determined within 23 hours	Head injury, unstable vital signs, premature or early labor

Transfer Process

Transfer: discharging a client from one unit or agency; admitting him or her to another without going home in the interim.

Transfers are used when there is a need to:

1. Facilitate more specialized care in a life-threatening situation.

2. Reduce health care costs.

3. Provide less intensive nursing care.

Steps Involved in Transfer

1. Informing client and family about the transfer.

2. Completing a transfer summary.

3. Speaking with a nurse on the transfer unit to coordinate the transfer.

4. Transporting the client and his or her belongings, medications, nursing supplies, and chart to the other unit.

The Discharge Process

Discharge is the termination of care from a health care agency. Planning for discharge actually begins on admission, when information about the patient is collected and documented. The key to successful discharge planning is an exchange of information among the patient, the caregivers, and those responsible for care while the patient is in the acute care setting and after the patient returns home. This coordination of care is usually the nurse's responsibility.

Steps in the Discharge

1. Discharge planning

a. Assessing and identifying health care needs.

b. Setting goals with the patient.

c. Important teaching topics about self-care at home must be covered before discharge.

d. Meeting eligibility requirements for home health care.

2. Obtaining a written medical order.

3. Completing discharge instructions.

4. Notifying the business office.

5. Helping the client leave the agency.

6. Writing a summary of the client's condition at discharge.

7. Requesting that the room be cleaned.

The Referral Process

A referral is the process of sending someone to another person or agency for special services. Referrals generally are made to private practitioners or community agencies.

Home Health Care

Health care provided in the home by an employee of a home health agency

Home care nursing services:

1. Help shorten time spent recovering in hospital.

2. Prevent admissions to extended care facilities.

3. Reduce readmissions to acute care facilities.

Factors contributing to the increased demand for home health care:

1. Outcome of limitations imposed by Medicare and insurance companies on number of hospital and nursing home days for which they reimburse care.

2. Growing number of chronically ill older adults in need of assistance.