

GNM 1st Funda Unit-2

UNIT-2

AKANSHA INSTITUTE OF

NURSING.

GNM 1ST YEAR

FUNDAMENTAL OF

NURSING

Restraints :- These are protective

device employed to prevent client

safety reduce from harming self and others, to immobilize a body part, to restrict the activity and to promote a feeling of security in a client who needs control

Types of Restraints

- Ankle and wrist
- Elbow and knee
- Mitt
- Body jacket
- Mummy
- Safety belt

Environmental controls

o) Siderrails

o) Seclusions or quiet room.

Hazards of Restraints :->

- o Tissue damage under restraint due to constant friction.
- o Damage to other parts of the body.
- o Development of pressure sore.
- o Ischemia or nerve damage.
- o Wrist drop.
- o strangling death.

General Instruction

Explain the need for application and type of restraints

Assistant should be given.

Allow freedom to move.

Circulation must not be occluded

Pad with bony prominences.

- Do not apply linen restraint with a regular knot.
- Never use restraints over an IV set.
- While removing, remove one restraint at a time.
- Ensure that there are no wrinkles in restraints.

Side Rails

These are safety measure that comes under the category of environment control.

Objectives

- To prevent the client getting out of the bed.
- To prevent the client from falling out of the bed.
- To observe the client.
- To prevent any type of injury.

Use of side rails : →

Altered level of consciousness

the elderly client, children.

Clean Environment

- unit cleaning
- physical setup
- noise free environment
- Aseptic Technique
- fumigation.

Nursing Process

It is defined as systematic method of assessing the health status, diagnosing, health care needs, formulating a plan of care.

Purposes of Nursing Process :-

- To help the patient in maintaining health.
- To protect client from illness.
- To identify client health status.
- To determine priorities.
- To deliver specific nursing interventions

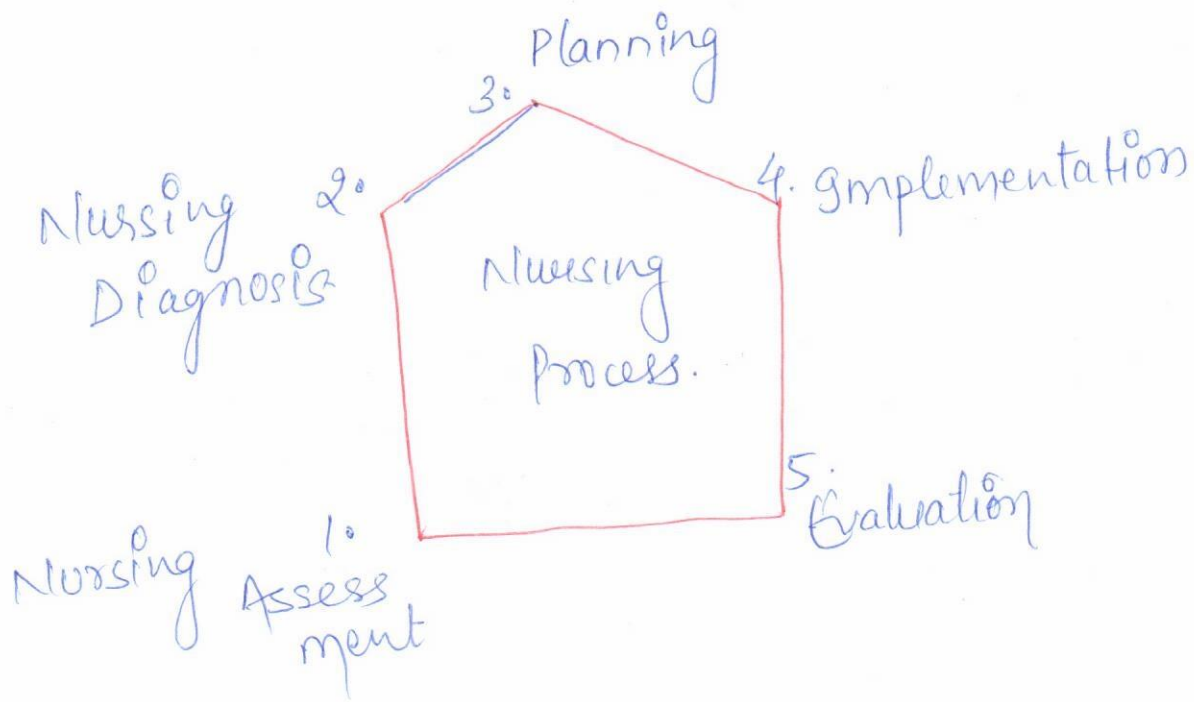
- To promote recovery from illness
- To promote return to a state of maximum functioning.

Characteristics of
Nursing process

- Problem oriented
- cyclic and dynamic
- Interpersonal.
- Goal oriented
- Systemic and planned
- Emphasis on feedback

Nursing process

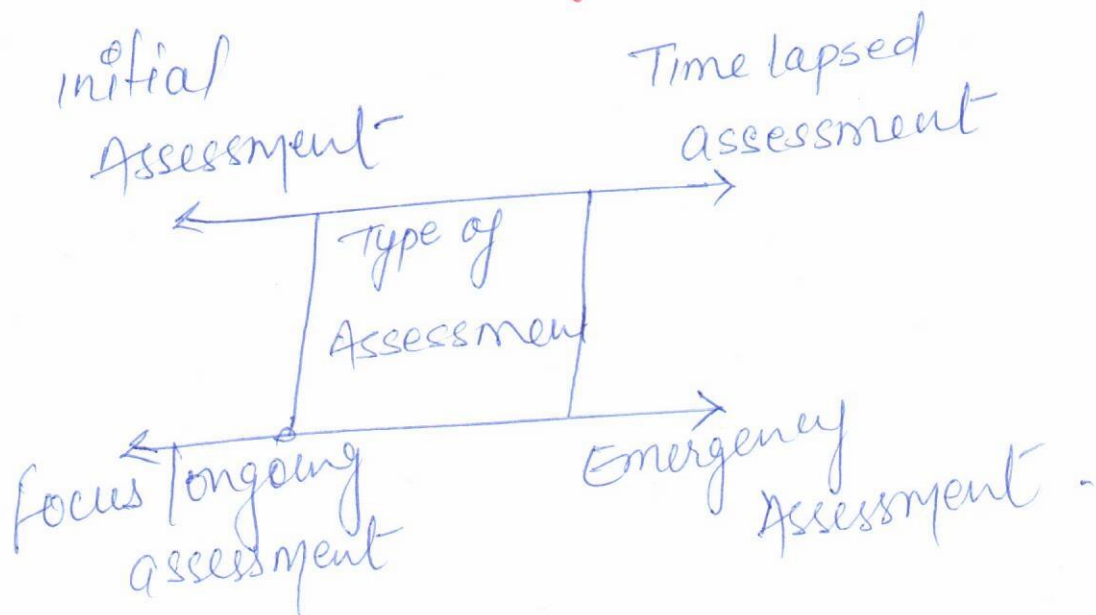
Nursing process help the nurse to organise and deliver effective nursing care. It include.



Nursing Assessment

Definition - Assessment refers to the collection and interpretation of clinical information. It focuses on gathering the data about a client's state of wellness, functional ability.

Type of Assessment



Initial Assessment :- It is the assessment ⁴ done within specified time after admission to a health care agency.

Focus Assessment :- This is daily assessment done by nursing personnel of admitted client.

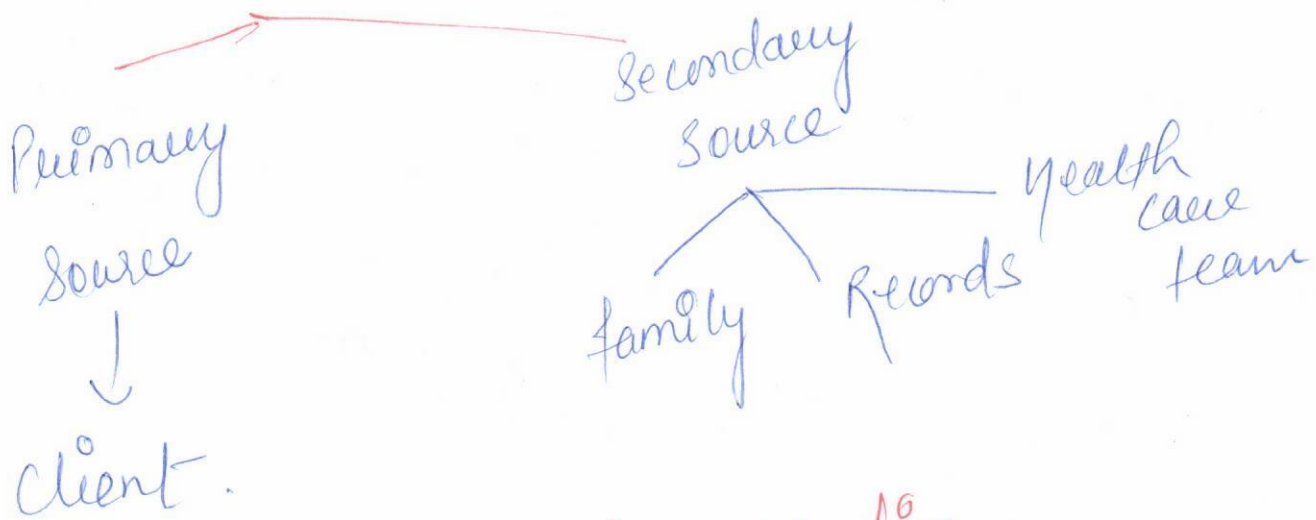
Emergency Assessment :- → Emergency assessment is done if client has suddenly physiologic or Psychologic crisis.

Time lapsed Assessment :- → This assessment is done several months/years after initial assessment.

Component of Assessment

- 1) Collecting Data.
- 2) Organising Data.
- 3) Validating Data.
- 4) Recording Data.

Source of data



Methods of data collection

- o) observation
- o) interviewing
- o) laboratory data,
- o) physical examination.

Nursing Diagnosis

Defined as actual or potential health problem which nurse by virtue of their education and experience are capable and licensed to treat.

NIANDA → North American Nursing Diagnosis Association.

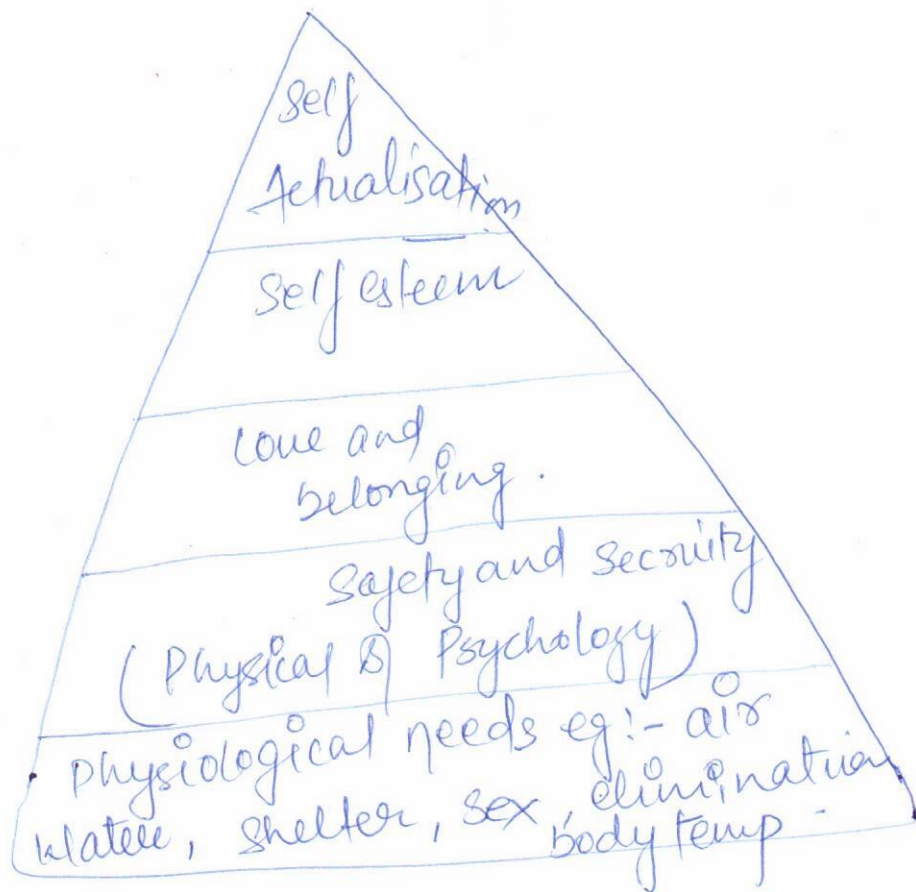
Medical Diagnosis

- 1) It focus on identifying disease
- 2) Treatable by physicians within scope of medical practices.
- 3) It deal with the actual pathophysiological changes within the body.

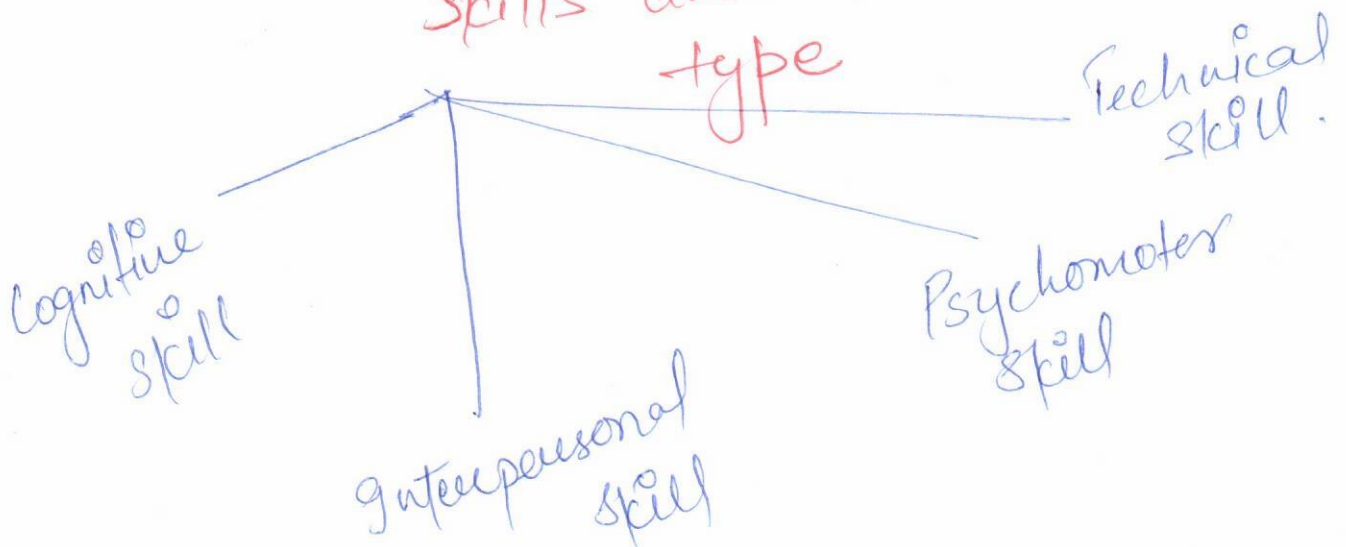
Nursing Diagnosis 5.

- 1) It focuses on identifying human response.
- 2) Treatable by nurses within the scope of nursing practice.
- 3) It deal with the patient perception of his own health state.
- 4) Nursing diagnosis relates to the nurse independent functions.
eg! - ineffective airway clearance.

Maslow's Hierarchy of Needs



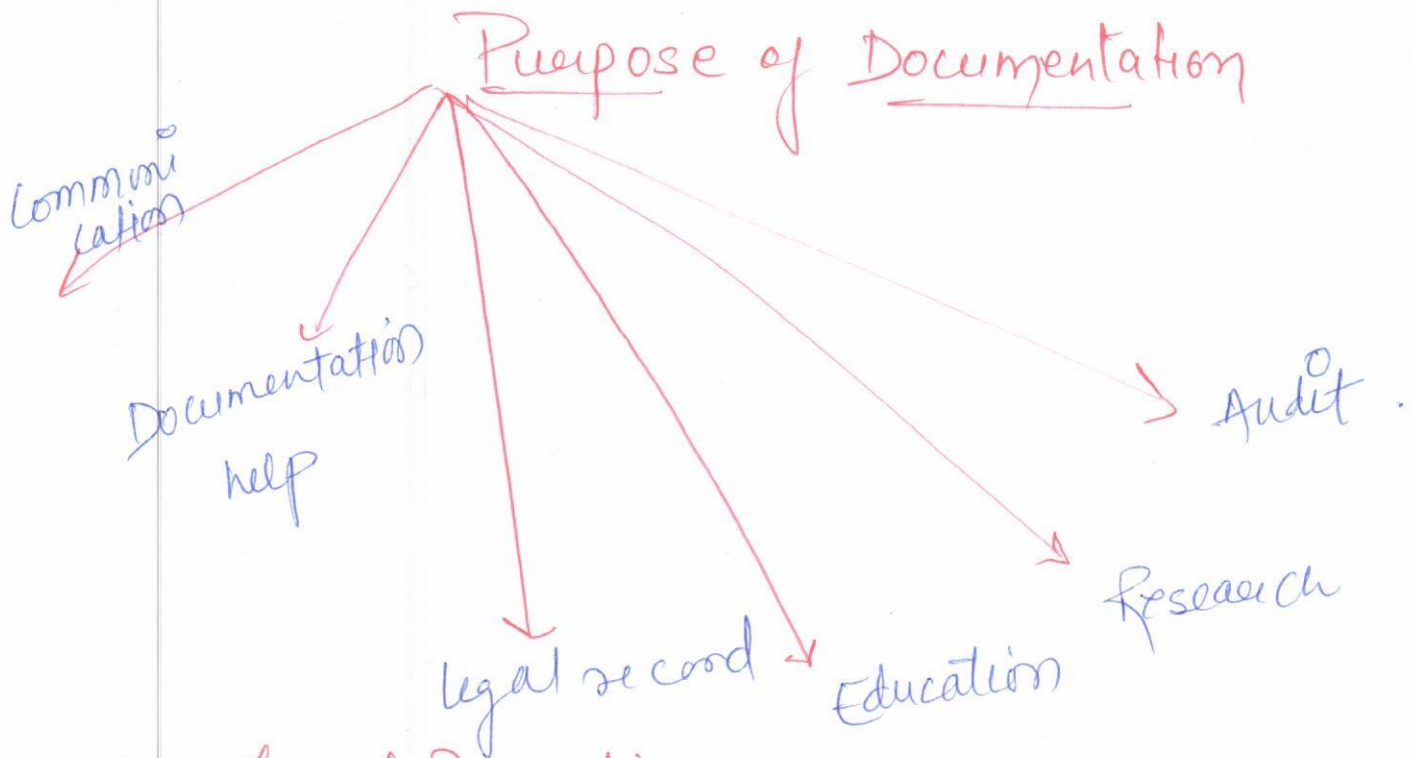
Skills and its type



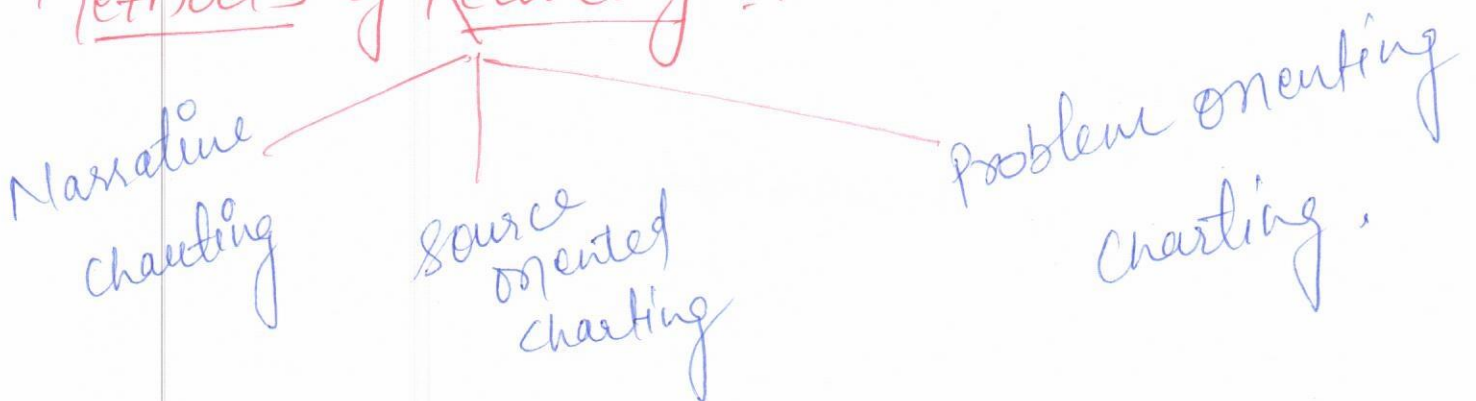
Documentation

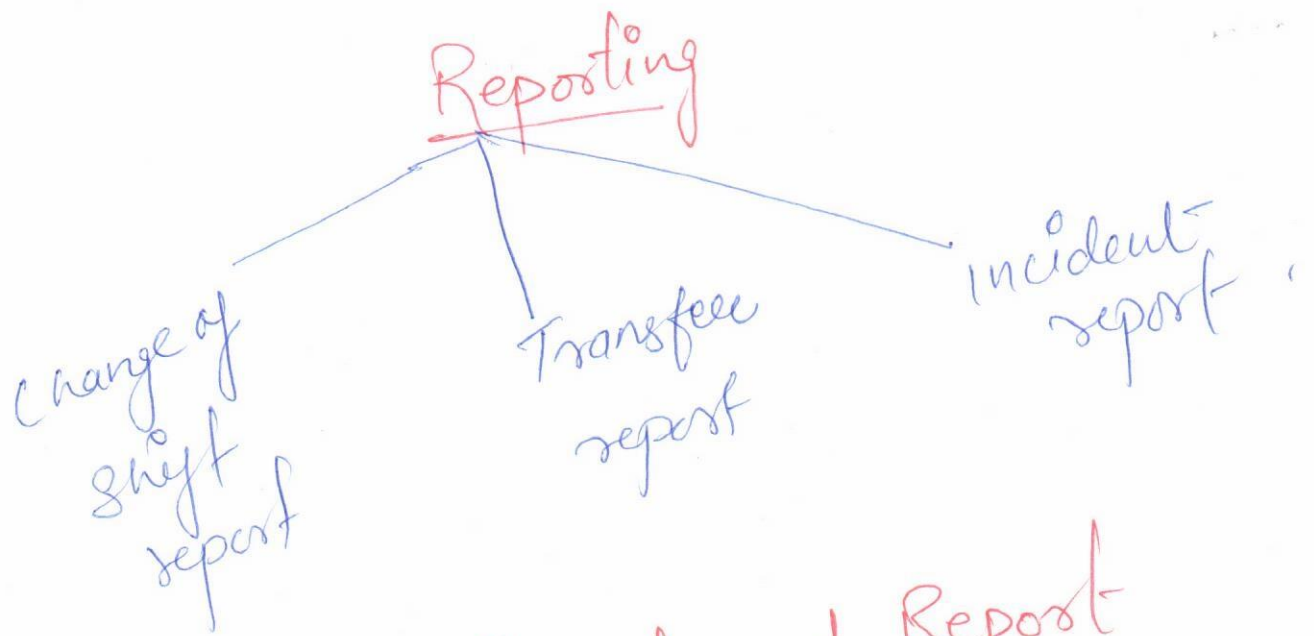
Record :- Record is a clinical, scientific administrative legal document related to the nursing care given to individual, family, community.

Report :- are oral or written exchange of information shared between nurses or a number of persons.



Methods of Recording :-





Importance of Records and Report

- Decision making
- Planning client care
- communication
- Legal documentation
- Education
- Research
- Auditing
- Quality Assurance
- vital statistics
- financial billing
- Accrediting and licensing.