St. Pölten

Supporting and advancing practice:

Evidence based implementation of SNLs

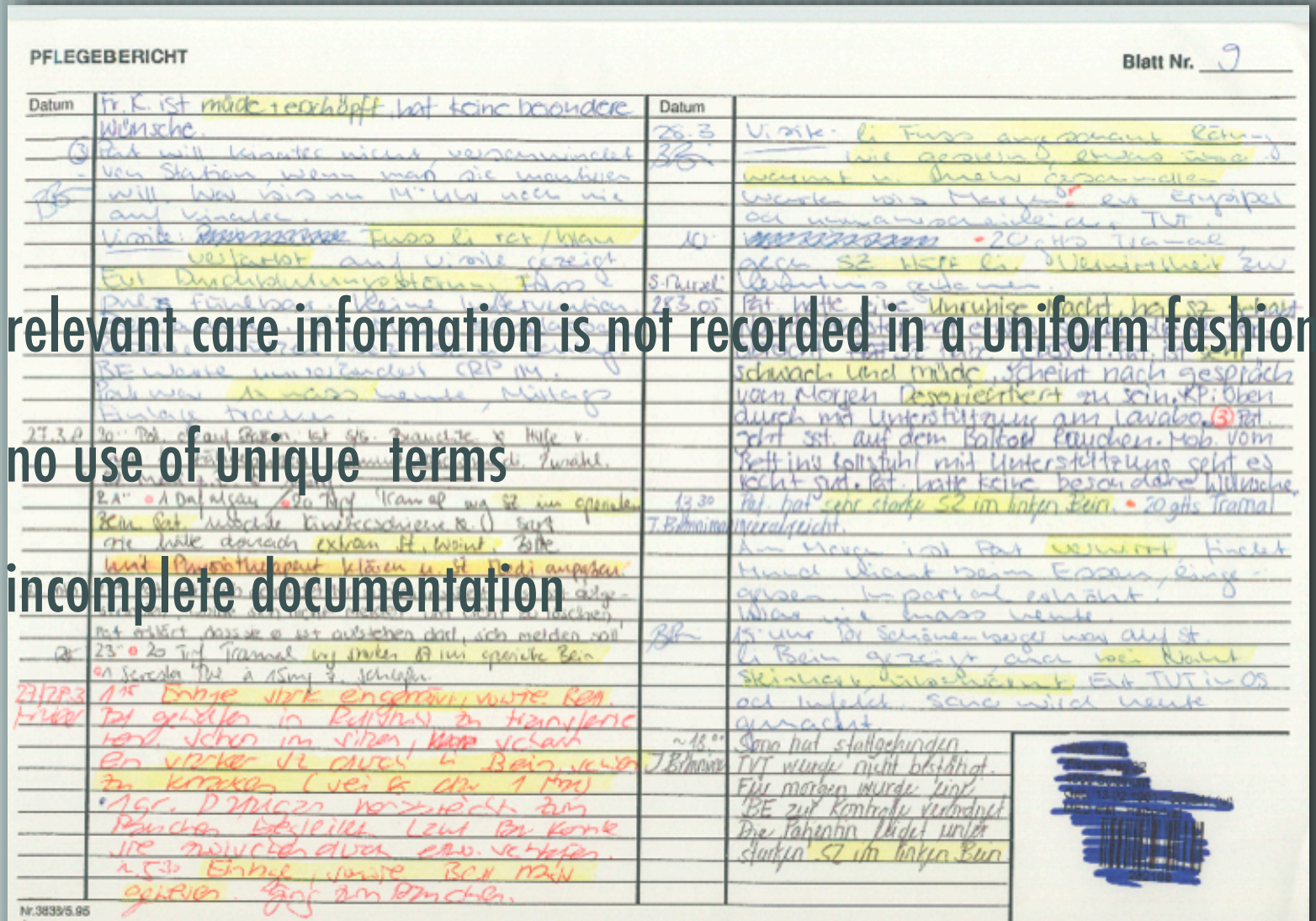
Aim of the project

- to introduce an electronic patient record with SNLs including decision support
- to maintain that nursing documentation fulfills quality criteria in structure, process and outcomes

Project plan

1. Practice analyses
2. Theoretical background
3. Goals
4. Interventions
5. Criteria for examination

1. Practice analysis

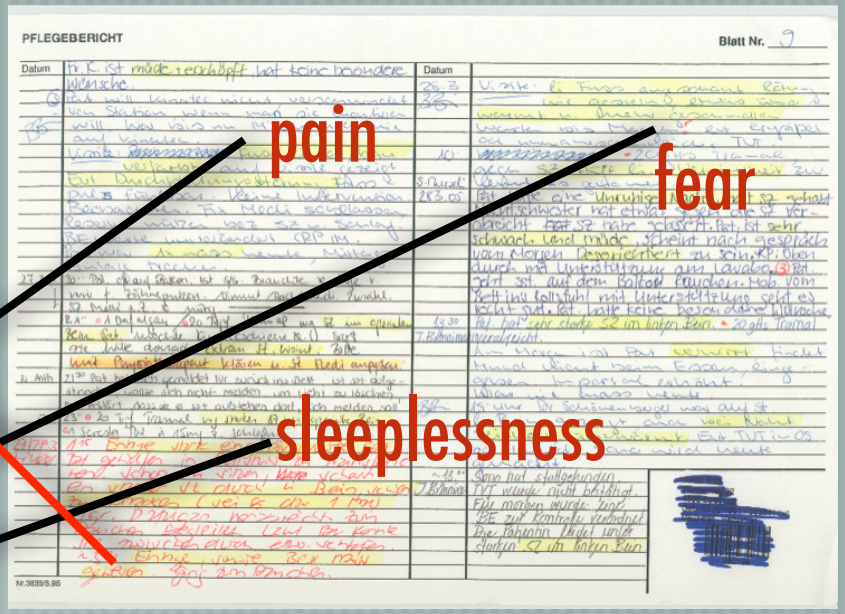


relevant care information is not recorded in a uniform fashion

no use of unique terms

incomplete documentation

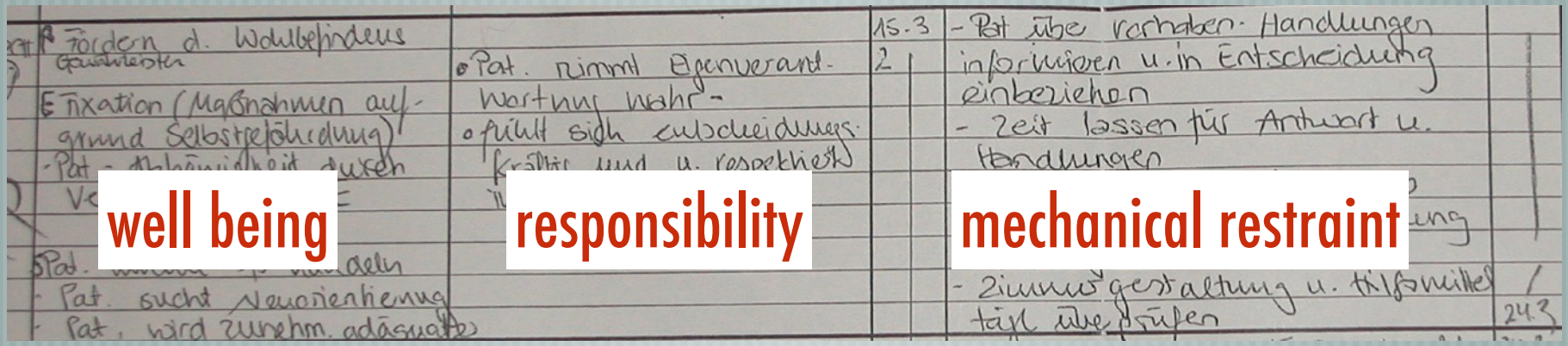
no connection between the documented problems, the problems in the nursing plan, the goals and the nursing interventions



problem

goals

nursing interventions



1. Practice analysis showed

- Nurses have difficulties linking patient data
- data were unclear, narrative, not specific, difficult to interpret and research
- redundant data
- missing interoperability
- no continuity of nursing care = no quality in the nursing process
- high expense of resources (time/ persons/costs)
- nurses' loss of motivation (double work, no consequent standards)
  - (Hayrinen & Saranto, 2010; Keenan et al., 2013; Müller-Staub et al., 2009, Paans et al., 2010; Wang, 2011)

Project plan

1. Practice Analysis
2. Theoretical background
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2. Theoretical background

- defining quality criteria for documentation about structure, process and outcomes
- Standardized Nursing Language = A must to develop a Nursing Process-Clinical Decision Support System (CDSS)

2. Quality criteria are:

- using a uniform language (nursing classifications NANDA, NIC, NOC)
- connecting all documented data that relate with each other
- = these data are the basis for the nursing diagnoses
- and supporting care continuity through the whole care process (stated in the documentation)

Project plan

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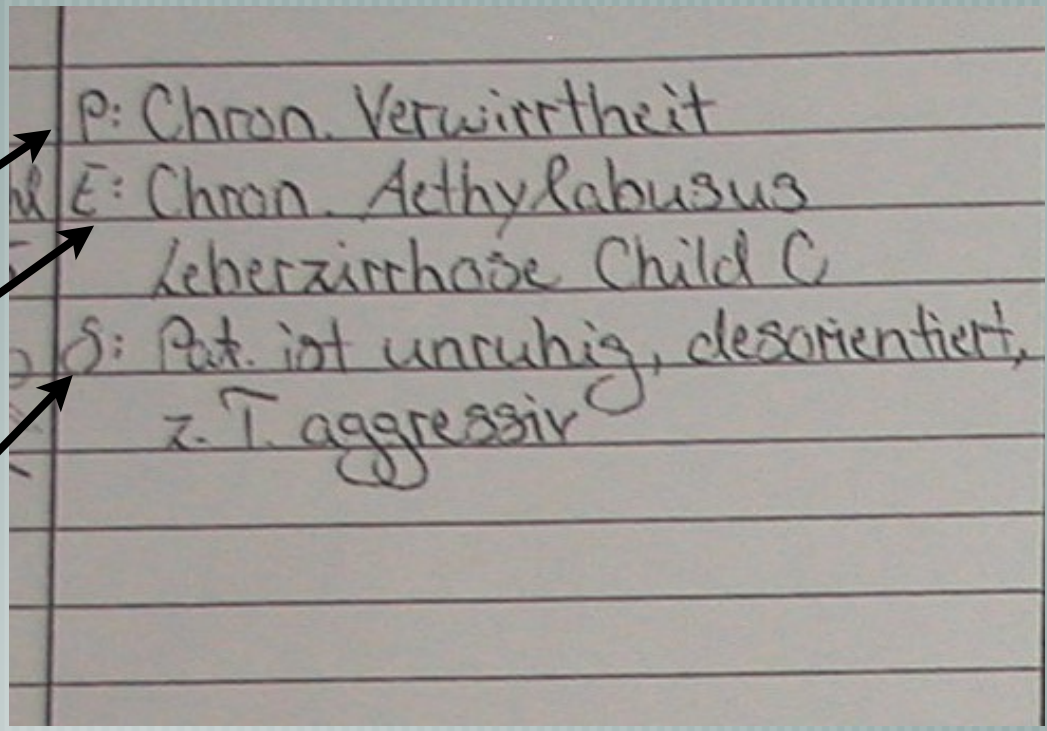
3. Project goals were:

- Currently used documentation systems remain but are adjusted
- Nursing diagnoses (ND) are used in all routine work
- Nursing interventions are connected to the ND
- Nursing outcomes are measurable

3. Criteria for ND

- the nursing diagnoses
  - PES format is used
    - P = Problem
    - E = Etiology
    - S = Symptom
- Nursing diagnoses are numbered



3. Project goals

- Linkages exist between the nursing goals/patient outcomes and the nursing diagnoses
- Aims are patient focused
- The nursing goals are achievable through the planned nursing interventions

3. Criteria for interventions

- The nursing interventions are numbered and formulated concretely
- The nursing intervention correspondents with the etiology of the nursing diagnosis
- The nursing interventions are documented/confirmed after implementation

3. Criteria for outcomes

- The improvement is measurably formulated
  - in the functional status
  - the knowledge state
  - the coping strategies
  - the self care
- Connection between
  - Outcome <–> nursing intervention
  - Outcome <–> nursing diagnoses

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4. Interventions

a. creating a standard assessment tool
b. training with real patient cases in practice
c. making marks in the nursing report notes and care plan
d. numbering the signs and symptoms in the nursing report
e. establishing and using a CDSS in the electronic patient record

a. Standardized assessment tool

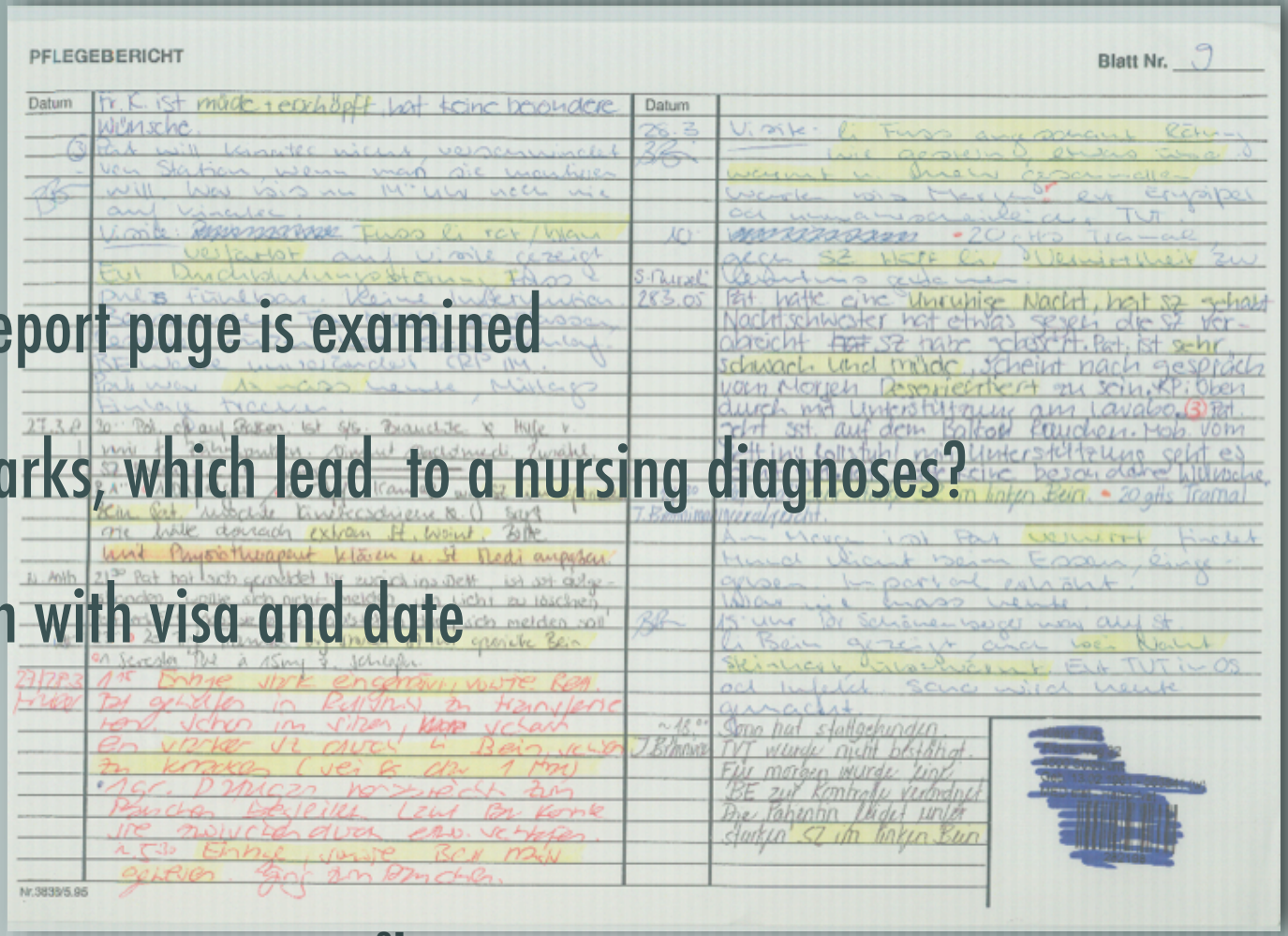
- Assessment items according to Gordon:
  - The reasons for entering the hospital
  - Health problems and resources of the patient
  - Fears or sorrows, concerns to the hospital stay, expectations and wishes
  - Handling the momentary situation / disease experience
  - etc.

b. Training: real patient

- 2 hours: Introduction into the Advanced Nursing Process for all Registered Nurses (theoretical basis)
- Case meetings (1x per month) on real patients on the wards
  - Advanced Nursing Process: - assessments, clinical reasoning
  - diagnostic process = critical thinking

c. Marking in the report

- Each care report page is examined
- Are there marks, which lead to a nursing diagnoses?
- Confirmation with visa and date



d. Numbering report + plan

- make a connection between the report and the care plan
- the number in the report refers to the corresponding nursing diagnoses
  - Is the ND still actual?
  - Can the nursing intervention be stopped ?
  - Are the interventions successful?

e. Use of a CDSS Systems

- CDSS = Clinical Decision Support System
- Definition: A CDSS is an interactive software which is designed to assist physicians, nurses and other health professionals with decision making tasks, such as
- automatically determining diagnoses of patient data.

e. Use of a CDSS Systems

"...software designed to directly aid in clinical decision making in which characteristics of individual patients are matched to a computerized knowledge base to generate patient-specific recommendations"

(Hunt, Haynes, Hanna, & Smith, 1998, pp 1339+1340).

e. Use of a CDSS System

- The nurse enters assessment data in free text:
  - 71 old female, reduced condition. Tells being very exhausted and tired. Her husband died a year ago of lung cancer, and her daughter of breast cancer this year. This is very burdensome, she feels sad. She has lack of strength to make her household.
  - Misses power to climb stairs, has no air to breathe. Loss of appetite, has lost more than 7 KG of body weight. Can't sleep

e. Use of a CDSS Systems

- The CDS-system analyses cues of ND:

71 old female, reduced condition. Tells being very exhausted and tired. She has lack of strength to make her household, no power to climb stairs, has no air to breathe. Her husband died a year ago of lung cancer, and her daughter of breast cancer this year. This is very burdensome, she feels sad. Loss of appetite, has lost more than 7 KG of body weight. Can't sleep

Standardpflegeplanung

Assessment notes:

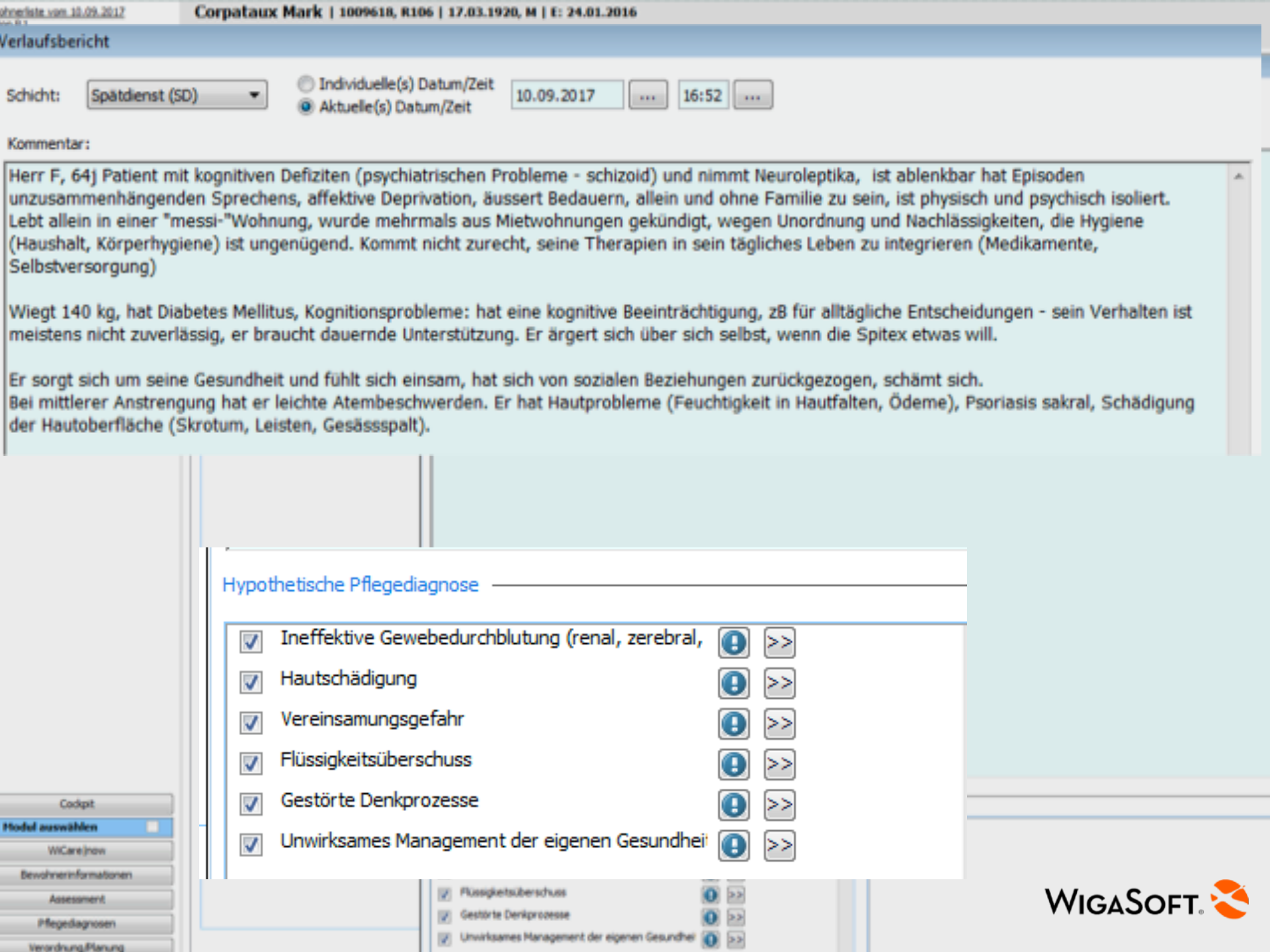
Reduced condition.
Tells being very exhausted and tired.
Her husband died an year ago of lung cancer, and her daughter of breast cancer this year.
This is very burdensome, she feels sad. She has lack of strength to make her household.
Misses power to climb stairs, has no air to breathe.
Loss of appetite, has lost more than 7 KG of body weight. Can't sleep

- Fatigue
- Activity Intolerance
- Ineffective Breathing
- Grieving
- Risk for Imbalanced Nutrition
- Disturbed Sleep Pattern

Erfasst am 18.11.2009 10:07 durch

Analysieren...

Visieren...


Corpataux Mark | 1009618, R106 | 17.03.1920, M | E: 24.01.2016
Verlaufsbericht
Schicht:
Spätdienst (SD)
Individuelle(s) Datum/Zeit
Aktuelle(s) Datum/Zeit
10.09.2017
16:52
Kommentar:
Herr F, 64j Patient mit kognitiven Defiziten (psychiatrischen Probleme - schizoid) und nimmt Neuroleptika, ist ablenkbar hat Episoden unzusammenhängenden Sprechens, affektive Deprivation, äussert Bedauern, allein und ohne Familie zu sein, ist physisch und psychisch isoliert. Lebt allein in einer "messi-"Wohnung, wurde mehrmals aus Mietwohnungen gekündigt, wegen Unordnung und Nachlässigkeiten, die Hygiene (Haushalt, Körperhygiene) ist ungenügend. Kommt nicht zurecht, seine Therapien in sein tägliches Leben zu integrieren (Medikamente, Selbstversorgung)
Wiegt 140 kg, hat Diabetes Mellitus, Kognitionsprobleme: hat eine kognitive Beeinträchtigung, zB für alltägliche Entscheidungen - sein Verhalten ist meistens nicht zuverlässig, er braucht dauernde Unterstützung. Er ärgert sich über sich selbst, wenn die Spitex etwas will.
Er sorgt sich um seine Gesundheit und fühlt sich einsam, hat sich von sozialen Beziehungen zurückgezogen, schämt sich.
Bei mittlerer Anstrengung hat er leichte Atembeschwerden. Er hat Hautprobleme (Feuchtigkeit in Hautfalten, Ödeme), Psoriasis sakral, Schädigung der Hautoberfläche (Skrotum, Leisten, Gesässspalt).
Hypothetische Pflegediagnose
Ineffektive Gewebedurchblutung (renal, zerebral,
Hautschädigung
Vereinsamungsgefahr
Flüssigkeitsüberschuss
Gestörte Denkprozesse
Unwirksames Management der eigenen Gesundhei
Cockpit
Modul auswählen
WiCare|now
Bewohnerinformationen
Assessment
Pflegediagnosen
Verordnung/Planung
WIGASOFT

Project plan

1. Practice Analysis
2. Theoretical background
3. Goals
4. Interventions
5. Criteria for evaluation

5. Criteria for evaluation

- Rules for Nursing Diagnoses
- Context conditions
- Critical areas
- Criteria

Rules for Nursing Diagnoses

- When should we make a diagnostic statement?
  - if there are relevant nursing information about the patient
  - to reach nursing goals, which could only be reached by nursing activities
  - when nurses are responsible for the outcomes

Context conditions

- The support of the care management is extremely important!
- Nursing diagnoses must have a genuine function in the daily working routine!

Five critical areas:

- Consistent integration in the daily work process (nursing care and interdisciplinary work)
- Integration of the patients
- Personal continuity of care (Bezugspflege)
- Lack of specific knowledge in nurses (continuing refreshers needed)
- Supporting nurses' attitude towards Advanced Nursing Process/SNL

Criteria for reaching project aim

- Standard/criteria (process of diagnoses, how to document)
- Regular training (also on frequent diagnoses), check relevancy and accuracy of ND
- Qualification of staff members
- Evidence-based CDSS Nursing Documentation Systems (according to international NP-CDSS Standard)

Criteria for reaching project aim

What do you think?
Time to discuss

Further questions?

Thank you!