

**Conference/Workshop, Naming Nursing in an Information Age**  
**Bodelwyddan Castle, 21<sup>st</sup> October 2005.**

**Presentation on behalf of North Wales Nursing Terminology Group**

The history of the group is that following the attendance of a number of us at the 'Naming Nursing' Conference in 2003, Dave Lloyd suggested meeting as a group to try to take things forward. Initially it was staff of the School of Nursing, Midwifery and Health Studies at the University of Wales, Bangor but then we involved the North Wales NHS Trusts and are now trying to get members from the LHB's. We call ourselves the Nursing Terminology Group-because initially our main interest was nursing terminology.

When eNWI was formed we became founder members and are now seen as the North Wales Regional Branch.

We have a range of interests, Educational, Informatics-technical, e-learning, bi-lingualism, clinical, managerial and at an early meeting we decided as a group to ask the questions- 'What are we here for?' and 'What should we be doing?' Not sterile umbilicus watching but trying to focus on what we could do to try to develop an agenda. During that first session I drew a diagram on the white board as a 'first stab' at illustrating it. Everyone present let me do so, as I obviously get great pleasure out of it especially when my medication levels are low.

At subsequent meetings we added, took away and refined the original diagram to the one I shall be presenting today. We don't pretend it's complete or that it cannot be refined further. Someone at an early stage called it a 'Conceptual Model'-an 'ideas model or plan' and that is what we now call it. Hopefully we're not too pompous. It's a Conceptual Model based on Nursing. We mean Nursing, Midwifery and Health Visiting.

We started with EPR-Electronic Patient Record as that was the main focus of thinking at the time. We quickly decided that like the legendary Irishman when asked the way replied-I wouldn't start from here- so we didn't.

We started with the patient and the general approach to individualised nursing care.

The 1st generation of Nursing Process was four stage: APIE-Assessment, Planning, Implementation, Evaluation. In the USA it rapidly moved to five stage: ADPIE with addition of Diagnosis. Many British texts use five stages: Assessment, Identifying Problems, Defining expected outcomes, Prescribing interventions, Evaluation.

As a group we have six, does it matter?

**Nursing Assessment.** Here the nurse uses the various models of assessment and models of nursing. No need to rehearse the models here, but our view is that models of assessment are useful in framing the way the nursing assessment is undertaken. Should we have the same models for patients with Psychiatric problems as for clients who are expecting a baby?

The Assessment is for a purpose, it leads to Diagnosis by the application of clinical reasoning. We're talking **Nursing diagnosis** here. **Example:** Two patients both in their 20's and both with the medical diagnosis of C5/6 # dislocations and Tetraplegia. One was admitted to a specialised unit after 24hours, one after three weeks, both had the following nursing diagnoses (among others). Please don't let the Americanisms get in the way (the nursing diagnoses have been translated to English by the Chelsea and Westminster Hospital, I just don't have the latest version): pain, post-trauma syndrome, powerlessness, disturbed sensory perception, sexual dysfunction, risk for impaired skin integrity, disturbed sleep pattern, ineffective thermoregulation, urinary retention, bathing/hygiene self care deficit, dressing/grooming self care deficit, feeding self care deficit, impaired physical mobility, impaired bed mobility, impaired gas exchange, risk for fluid imbalance, risk for constipation, bowel incontinence, fear, ineffective airway clearance disturbed body image, (among others).

The patient with delayed admission had 8 pressure sores and flexion contractures of both elbows with sores in the skin creases and also had a tracheostomy. So he had the additional nursing diagnoses of: impaired tissue integrity, impaired swallowing, risk for infection and impaired verbal communication.

Each of those diagnoses requires nursing action.

Nursing Assessment is not a once and for all matter-it will need to be revisited.

I would argue (and here I'm not sure if I reflect the views of my colleagues) that the only person with the skills necessary to undertake a nursing assessment is a Registered Nurse.

Next **Objectives**-Identify the expected outcome-what do the nurses together with the patient want to achieve to resolve, control or ameliorate the diagnoses. We do this with the patient and if possible/desirable from the patient's point of view his/her nearest/dearest. It involves clinical decision-making and clinical reasoning skills.

Next: **Select the interventions** that will achieve the objectives that have been agreed. Again this involves clinical reasoning skills. These interventions could be as part of a Care Pathway- but is there some tension here as 'Care Pathways' tend to be based on Medical Diagnoses-

do all such patients have the same nursing diagnoses and therefore nursing needs?

**Implement** Undertake the interventions appropriately, to an agreed standard. Modify the interventions based on the patient's reaction/acceptability

**Evaluate** –the effect of the interventions/implementation on the diagnosis. Has it been effective-has the desired result been achieved. How do you measure? What tools do we, as nurses have to do the measuring?

This gives us the information by which we can begin to understand if the nursing care has been effective, (clinical/nursing effectiveness) and to develop the research capacity of nursing to find out what works and then we will truly have developed Evidence Based Practice.

Inside this circle we've identified that every piece requires clinical decision making skills and that there might be an opportunity to develop/research Decision support systems to assist in this.

We would say that if we were going to do this then we need to standardise the professional nursing language that we use. This is not the language we use with the patients but that which we use inter-professionally. The language we use with patients will be a reflection of all kinds of factors and modified to meet the needs of the individual. It's entirely legitimate to use standardised languages and examples of their use exist in Europe and the USA. It's necessary because if we don't clarify the terms how do we know that the nurse in Carmarthen is talking about the same patient condition (nursing diagnosis) that she is treating as her counterpart in Anglesey? And further how can we then say what the interventions lead to if we don't have the problem unambiguously defined?

If the patient changes nursing teams, the receiving nurse must have the information about the diagnoses, planned outcomes, and the interventions and these expressed in terms we all know and agree.

The model shows some of the nursing languages used or being developed, NANDA, NIC, NOC, and SNOMED CT.

In Wales we must be conscious that patients/clients and professionals operate bi-lingually and the use of standardised languages needs to take this into account. There is no reason why Standardised Nursing Languages cannot be translated, it's happened for other so-called minority languages.

We also feel that there is a rich vein to be mined (you can tell I was brought up in the South Wales valleys) in the development of synonyms, using the word in the two senses of ‘a word or phrase that means exactly or nearly the same as another in the same language’ - *shut and close* and ‘a word denoting the same thing as another but suitable to a different context.’ –*serpent for snake*. We would want to explore how patients and others use synonyms to describe their situations. These could be cross mapped to nursing terminology.

If you consider everything in and around the outer circle we would argue that this should comprise the Minimum Data Set for Nursing. If that information is collected for each patient then we have a tool for care, for teaching, for research, for EBP and at different levels of aggregation a tool for managing the service.

As a former manager I would have welcomed evidence that showed that patients with ‘stroke’ are not all the same in terms of their need for nursing interventions, or in my specialty someone with a tetraplegia can be different in terms of the need for nursing from another patient with the same medical diagnosis. I would have been in a much better position to regularly revisit my resource needs, the skill mix requirements and begin to build from practice a picture of nursing epidemiology. For example what specific nursing diagnoses do patients with a particular medical diagnosis mostly present with?

We also recognise that models of assessment can have other disciplinary input and thus give an Unified Assessment for input into the EPR. It could be argued quite reasonably that the Unified Assessment is what you start with but our view is that it has to lead to a nursing assessment using a suitable model otherwise the other aspects of care cannot be addressed.

In Wales we have an unique opportunity to get agreement on the NMDS. It’s not too late, we’re small enough to work on it collaboratively and get the result we need. Of course what we’ve outlined can work with paper but we would see it being developed electronically. When we as a profession can agree what we need, we can ask someone to build it for us rather than have to accept what particular vendors want us to have. It would be a comprehensive Care Management System.

This model has a number of challenges, for practitioners, for managers, for Educators and for Informing Health Care. And we’ve left the boxes open for you to complete in your groups this afternoon. We did as a

NWNT Group start to fill the boxes in ourselves but felt that it was important to share it with you and therefore get a better answer. That's it that is all I want to say regarding the model. Let it be a warning to you, this is what comes of being unable to stop writing on walls. Thank you very much.

Rodney Hughes  
21<sup>st</sup> October 2005