

GENERAL PRINCIPLES FOR ALL GUIDELINES

INTRODUCTION

These general principles are applicable to all nursing practice guidelines and are intended as guidance for practitioners who need to be familiar with them.

The Nursing and Midwifery Council (NMC) states in “The Code of Professional Conduct” (NMC, 2004):

“To practise competently, you must possess the knowledge, skills and abilities required for lawful, safe and effective practice without direct supervision. You must acknowledge the limits of your professional competence and only undertake practice and accept responsibilities for those activities in which you are competent (para. 6.2).”

This is the underpinning principle behind nursing practice and forms the foundation for all nursing actions. In addition, local Trust policies should be referred to, as appropriate e.g. hand hygiene, guidance on cleaning and decontamination, waste management and consent to treatment.

These nursing practice guidelines consider the seven basic principles that underpin all aspects of care, namely:

- assessment;
- explanation;
- consent;
- preparation;
- privacy;
- evaluation;
- documentation.

These principles should be taken into consideration before undertaking any procedure, using the Code of Professional Conduct (NMC 2004) for further guidance.

The NMC (2004) also states:

“You must recognise and respect the role of patients and clients as partners in their care and the contribution they can make to it. This involves identifying their preferences regarding care and respecting these within the limits of professional practice, existing legislation, resources and the goals of the therapeutic relationship (para. 2.1).”

	PRINCIPLE	RATIONALE
1.	<p>ASSESSMENT</p> <p>Assess the patient prior to the procedure in order to establish any factors that could affect the patient or the type of procedure undertaken. It is also important that assessment remains on-going throughout the procedure as well as afterwards.</p> <p>The following factors may need to be assessed:</p> <ul style="list-style-type: none"> • pain; • anxiety level; • level of understanding; • physical condition; • mobility; • sensory difficulties; • potential contra-indications and/or complications; • specific preparations necessary for the procedure; • allergies; • medication. 	<p>Assessment is a key feature which will enable you to select the appropriate procedure, help the patient to adopt a comfortable position and influence the observations undertaken for the patient and the care required. The assessment needs to include whether or not an aseptic non-touch technique is required (Rowley, 2001).</p> <p>Some medication may require different or additional pre or post procedure care, e.g. warfarin.</p>
2.	<p>EXPLANATION</p> <p>Following the assessment of the patient's needs, give an explanation of the procedure, in accordance with the patient's level of understanding at the time.</p>	<p>Clear explanations have been shown to reduce pain, anxiety and the side-effects of treatment (Byrne, 1993; Wilson-Barnett, 1994; Poroch, 1995; Maguire, Walsh and Little, 2004).</p>

	PRINCIPLE	RATIONALE
3.	<p>CONSENT</p> <p>Obtain the consent of the patient in accordance with Trust policy prior to undertaking the procedure.</p> <p>It is the responsibility of the nurse undertaking the procedure to obtain informed consent for procedures which they will perform. This needs to be obtained and documented in accordance with the local consent policy which requires that the nurse is competent at obtaining consent.</p>	<p>To perform a procedure without the patient's consent (which may be implied, verbal or written, depending on the particular procedure) could be considered trespass (Dimond, 2005).</p> <p>For consent to be valid, it must be given by a legally competent person, given voluntarily and be informed (NMC, 2004 para.3.3.).</p>
4.	<p>PREPARATION</p> <p>Prepare the environment and equipment required, considering the procedure to be undertaken and relevant ward activities.</p> <p>Ensure that the patient is ready for the procedure by giving a further brief explanation and the opportunity to ask further questions. Prepare the patient for the procedure. Where appropriate, record baseline observations of vital signs.</p> <p>Position the patient appropriately for the procedure, taking into account the general condition of the patient. Ensure the patient is as comfortable as possible both during and following the procedure.</p> <p>Undertake or assist with the procedure ensuring the patient receives reassurance throughout and appropriate feedback afterwards.</p>	<p>Timing linked to activities of the ward or unit may minimise interruptions, distractions and the risk of cross infection.</p> <p>Although this aspect should be covered earlier, at times patients say "yes, I understand" but, in fact, do not. A second brief explanation can ensure understanding and informed consent.</p> <p>To enable comparison with post-procedure observations, early detection of a change in condition or possible complications.</p> <p>Facilitates the procedure whilst endeavouring to minimise discomfort for the patient.</p> <p>To reduce the anxiety of the patient by giving information (Byrne, 1993, Wilson-Barnett, 1994, Poroch 1995).</p>

	PRINCIPLE	RATIONALE
5.	<p>PRIVACY</p> <p>Ensure that privacy and dignity are maintained at all times, both visually and audibly (wherever possible).</p> <p>Consider the need for a chaperone when undertaking intimate examinations or procedures, referring to local guidelines if available.</p>	<p>To minimise embarrassment, maintain confidentiality and preserve the patient's dignity.</p> <p>To protect the patient and the nurse from any misunderstanding of intentions.</p>
6.	<p>EVALUATION</p> <p>Establish the effectiveness of the procedure for the patient and consider alternative interventions, if appropriate.</p>	<p>In order to ascertain the need to reassess and re-plan nursing care if necessary.</p>
7.	<p>DOCUMENTATION</p> <p>Document the procedure undertaken, outcome and vital signs where indicated (NMC, 2004) and modify the nursing care plan appropriately.</p> <p>Provide the patient with further information and ongoing support, where appropriate.</p>	<p>To maintain accurate records, ensuring continuity and effectiveness of care.</p> <p>To enable the patient to make informed choices (NMC, 2004 Para 3.3).</p>

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ELEMENTS FOR ASSESSMENT OF CLINICAL COMPETENCE

KNOWLEDGE

Have a working knowledge of the NMC Code of Conduct

Have a good understanding of the patient's nursing and medical history

Explain the importance of the seven basic principles that underpin all aspects of patient care.

SKILLS

Demonstrate effective interpersonal skills

Was effective preparation for the procedure in evidence?

Was it implemented effectively?

Was care documented in a clear and concise manner?

ATTITUDES

Was there evidence of a professional and empathetic approach to the patient?

Were courtesy, dignity and privacy demonstrated throughout the procedure?