An illustration of how Clinical Pocket References cover the Future Nurse Standards of Proficiency

NMC standard

Part 1: Procedures for assessing people's needs for person-centred care

1 Use evidence-based, best practice approaches to take a history, observe, recognise and accurately assess people of all ages:

Evidence based practice is covered in Fundamental care pages 12-14

		PAGES	PAGES	PAGES
1.1	**Mental health and wellbeing status**			
1.1.1	Signs of mental and emotional distress or vulnerability	58	27–9	27-45
1.1.2	Cognitive health status and wellbeing	28–9, 51-9 57-9	27-9 33–4	42ff
1.1.3	Signs of cognitive distress and impairment	55–6 57–9	27–9 33–4	42ff
1.1.4	Behavioural distress based needs	55–6	95	27, 28 35ff
1.1.5	Signs of mental and emotional distress including agitation, aggression and challenging behaviour	55–6 59	27	27-28 33ff
1.1.6	Signs of self-harm and/or suicidal ideation	58	27–9, 95	27
1.2	**Physical health and wellbeing**			
1.2.1	Symptoms and signs of physical ill health	4–73	M 21–2 24	17, 63, 67 68, 70 77, 87
1.2.2	Symptoms and signs of physical distress	30	24	17, 63, 67 68, 70, 77, 87
1.2.3	Symptoms and signs of and sepsis.	4–6, 7 24–5	70, 96 100–1	18,33

Teachers may download the complete document mapping against Annexes A & B. Please visit:
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Clinical Pocket Reference resources cover essential underpinning knowledge for practice required by registered nurses. Each resource appears in practical, pocket-sized format, and is fully referenced.

Our core resources, all recently updated, are:

Clinical Pocket Reference for Nurses 4e
Fundamental Care 2E
Practical Medicines Management 2E
Nursing Care of Children and Young People

Why Clinical Pocket References?

Universities can provide each student with a common level of knowledge by equipping each individual with Clinical Pocket References.

In an increasingly digital world of Future Nurse training, these unique resources can play an essential role in providing tangible, rapid access to core knowledge, whatever the practice setting.

Each resource is fully referenced to enable further learning and self-directed research, and complements existing digital and print resources: textbooks, journals, websites and digital services.

Reference: Nursing and Midwifery Council (2018) Future Nurse: Standards of Proficiency for Registered Nurses: https://www.nmc.org.uk/standards/ standards-for-nurses/standards-of-proficiency-for-registered-nurses/

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Sample pages highlighting key features across all resources

Ways that tutors and assessors use these resources...

- Whole class teaching (eg in scenario simulations or preparation for placement) – consistency across the cohort.
- Clinical skills teaching in conjunction with knowledge from the appropriate resource – perfect for blended learning or discussion via Zoom or Teams
- Great for quizzes to reinforce knowledge. And for revision.
- References: all content is referenced learners can use for research,
- Add to reading lists for all Adult Nursing students

5: Communication

5.1 Person-centred communication

The way in which you communicate with the person is person-centred care and to developing a therapeutic re Your approach to the person and your interpersonal ski influence the experience of care that the person receiv

(1) Code (NMC, 2018) outlines the responsibility of nurses to communication, including 'listen to people and respo preferences and concerns' (p.6) and 'communicate clea emphasizing the importance of verbal and non-verbal

You will be communicating with the person and their family, the immediate nursing team, and wider health and social care teams. Effective communication is based on trust, respect, care, compassion, empathy and dignity.

The purpose of communication is multidimensional. You may need to:

- introduce yourself and develop a rapport with the person
- collect relevant information as part of assessment

(2)
- listen and 'be there' for a person who may be anxious about their diagnosis
- discuss the options available for the person and to facilitate the sharing of decision-making
- advise on health promotion
- be an advocate for a person who is finding it difficult to express their needs.

Communication barriers

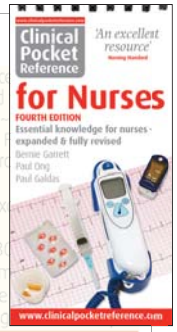
Different barriers to communication may impact on your ability to be present with the person and to communicate effectively.

(3)

The person	Nurse	Environment
• Hard of hearing • Limited vision • Poor physical or mental health • Pain • Anxiety • Difficulty expressing themselves (aphasia) due to stroke or brain injury • Cognitive impairment impacting on memory and communication	• Trying to listen to more than one person at the same with divided attention • Preoccupied with own issue, e.g. lack confidence or concern over safety • Time – competing demands and priorities • Anxiety • Lack of self-awareness	• Noise, e.g. monitor going off, loud television • Lighting • Lack of privacy

Learning to communicate effectively is a skill that must be developed and takes practice. There are different types of communication; understanding this can help you to develop your own communication skills.

(1) References NMC Code
(2) Key person-centred professional approach to care
(3) Useful discussion points for practice



(4) 3.6 Urinalysis

Urinalysis tests the characteristics and composition of a r specimen of urine to establish a preliminary diagnosis a further investigations. The kidneys process approximatel day, but only about 1.5% of this leaves the body as urin has a slight odour, which can alter as a result of disease diabetes mellitus acetone may cause a sweet smell.

Urine electrolytes reflect the ability of the kidney to reabsorb electrolytes.

- sodium: 100–260 mEq/24 hr
- calcium: 100-
- potassium: 39–90 mg/24 hr
- protein: <100

Abnormal results may be caused by a range of disea than renal disorders, e.g. raised calcium due to prolo

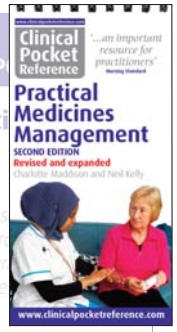
(5)

Test	Normal	Outside normal
Colour	Amber–yellow	Red: haematuria (urethral/bladder trauma, renal calculi, obstruction, tumour, renal failure, cystitis)
Clarity	Clear	Cloudy: debris, bacterial sediment (urinary tract infection (UTI))
pH	4.6–8.0 (average 6.0)	Alkaline on standing or with UTI may indicate bladder stone formation; increased acidity with renal tubular acidosis
Specific gravity	1.002–1.030 g/ml	Indicates the kidneys' ability to concentrate or dilute urine in the presence of abnormal substances, e.g. glucose: <1.002 indicates dilute urine and >1.030 concentrated urine; 1.035 is usually contaminated
Protein	0.8 mg/dl	Proteinuria may occur with high-protein diet and exercise (prolonged); seen in renal disease
Nitrites	0	Nitrites occur when urinary bacteria reduce urinary nitrates to nitrites. A highly sensitive test. A negative result does not rule out UTI
Sugar	0	Glycosuria occurs after a high intake of sugar or with diabetes mellitus
Ketones	0	Ketonuria from starvation and diabetic ketoacidosis
RBCs	0–4	Injury to kidney tissue (*refer to Colour, above*)
WBCs	0–5	UTI
Casts	0	UTI, renal disease
hCG	<25 mIU/ml	In women, >25 mIU/mL indicates pregnancy

Public Health England advises against dipstick testing for UTIs in catheterized patients and those over 65. Many will have asymptomatic bacteriuria that gives a positive result but does not require treatment with antibiotics.

(6) **Sources/bibliography:** Garrett BM (2017) *Fluids and Electrolytes: Essentials for Healthcare Practice*, Abingdon: Routledge; Public Health England (2007, 2019) *Urinary tract infection: diagnostic tools for primary care*: www.gov.uk/government/publications/urinary-tract-infection-diagnosis; Wians, FH Jr (2019) *Normal Laboratory Values. Merck Manual Professional version*: www.merckmanuals.com/professional/appendixes/normal-laboratory-values/normal-laboratory-values.

(4) Essential daily nursing knowledge
(5) Accessible layout ensures rapid reference to information
(6) Fully referenced for checking and further study



12. Adverse drug reactions and in reporting

12.1 Adverse drug reactions (ADRs)

An appreciably harmful or unpleasant reaction, intervention related to the use of a medicinal predicts hazard from future administration and w or specific treatment, or alteration of the dosa withdrawal of the product.

(Edwards & Aronson 2000, p. 125)

(7)

Recognizing and reporting ADRs is an important responsibility of the practitioner. Particular attention should be paid to:

- drugs with limited experience of use (intensively monitored), labelled with a black triangle ▼ in the BNF
- herbal remedies and established drugs where the ADR is serious (see Levels of ADR in Section 12.2 below)
- any ADR in children.

Recognizing ADRs

An ADR should be considered when there is:

- exacerbation of an existing condition
- development of a new problem/symptom.

Pay particular attention when a new drug is administered or a dose is changed.

(8) Patients are the best source of information about new symptoms

(9) that occur when a new drug is prescribed or OTC medication taken. It is essential that they are encouraged to share this information. In addition, healthcare staff should consider instances of the following:

- GI symptoms
  - nausea
  - diarrhoea
  - vomiting
  - dyspepsia
  - constipation
  - dry mouth
- CNS symptoms
  - fatigue
  - drowsiness
  - dizziness
  - headache
  - jitteriness
  - insomnia
- changed urine frequency
- altered taste, dry mouth
- changes in sleep pattern
- changes in clinical observations (including weight and blood glucose levels)
- changes in biochemical and haematological laboratory results.

(7) Referenced content
(8) Table and bullet points for clarity
(9) Practice points for discussion on essential knowledge and patient safety