DOWNLOAD PDF PATIENT ASSESSMENT AND CARE PLANNING IN NURSING

Chapter 1 : Nursing assessment and care plan statements.

modern nursing assessment in practice seems to be becoming a tick box exercise, this book assists the student in identifying the importance of the assessment and planning processes and looking beyond the tick box.

Related Introduction This essay deals with the holistic assessment of a patient who was admitted onto the medical ward where I undertook my placement. Firstly, the relevant life history of the patient will be briefly explained. Secondly, the Roper, Logan and Tierney model of nursing that was used to assess the care needs of the patient will be discussed, and then the assessment process will be analysed critically. Identified areas of need â€" breathing and personal cleansing â€" will be discussed in relation to the care given and with reference to psychological, social, and biological factors as well as patho-physiology. Furthermore, the role of inter-professional skills in relation to care planning and delivery will be analysed, and finally the care given to the patient will be evaluated. Throughout this assignment, confidentiality will be maintained to a high standard by following the Nursing and Midwifery Council NMC , Code of Conduct No information regarding the hospital or ward will be mentioned, in accordance with the Data Protection Act The pseudonym Kate will be used to maintain the confidentiality of the patient Kate, a lady aged 84, was admitted to a medical ward through the Accident and Emergency department. She was admitted with asthma and a chest infection. She presented with severe dyspnoea, wheezing, chest tightness and immobility. Kate is a patient known to suffer from chronic chest infections and asthma, with which she was diagnosed when she was young. She takes regular bronchodilators and corticosteroids in the form of inhalers and tablets. Kate lives on her own in a one bedroom flat. She has a daughter who lives one street away and visits her frequently. Her daughter stated that Kate has a very active social life; she enjoys going out for shopping using a shopping trolley. Elkin, Perry and Potter outlined nursing process as a systematic way to planning and delivering care to the patient. It involves four stages: Assessment is the first and most critical step of the nursing process, in which the nurse carries out a holistic assessment by collecting all the data about a patient in order to identify the patients nursing problems Alfaro-Lefevre Holland stated that assessment as an on-going process used to identify needs, preferences and abilities of a patient. Among the physical aspects assessed are vital signs and general observations of the patient. Assessment is extremely important because it provides the scientific basis for a complete nursing care plan Wilkinson Assessment is of benefit to the patient because it allows his or her medical needs to be known, but it can feel intimidating or embarrassing so the nurse needs to develop a good rapport NursingLink Under time pressure this can sometimes be neglected. Are the tools user-friendly? What are they for? Why do we have them? After assessment, care plan is formulated. Barrett, Wilson and Woollands a , defined a care plan as an integrated document that addresses each identified need and risk. Care planning is important because it guides in the on-going provision of nursing care. Good care planning allows healthcare professionals make evidence-based decisions about care based on a comprehensive assessment, and to prove this, if necessary Barrett, Wilson and Woollands a. Care plans can be problematic when they are not filled in correctly or are completed carelessly. This can jeopardise patient care. Every nurse has a professional responsibility to make sure that care plans are filled in to the best of her ability to help herself and her colleagues to continue the process of giving the best care possible necessary Barrett, Wilson and Woollands a. Before assessment takes place, the nurse should explain when and why it will be carried out; allow adequate time; attend to the needs of the patient; consider confidentiality; ensure the environment is conducive; and consider the coping patterns of the patient Jenkins During assessment, the nurse needs to use both verbal and non-verbal communication. Using non-verbal communication means that she should observe the patient, looking at the colour of the skin, the eyes, and taking note of odour and breathing. Kate was allocated a bed within a four-bed female bay. Her daughter was with her at the bedside. Gordon stated that understanding that any admission to hospital can be frightening for patients and allowing them some time to get used to the environment is important for nursing staff. Both Kate and her daughter were asked if it was okay for her daughter to be around while assessment

was carried out, so that she could help with some information, to which both agreed. As Kate was an adult and was judged by the nurses present to understand what she was consenting to, it was acceptable for her to consent to having her daughter present Ebersole and Hess Her confidentiality was not compromised because she agreed to the presence of a family member. Alfaro-Lefevre recommended that nursing assessments take place in a separate room, which respects confidentiality, and that the patient be free to participate in the assessment. Although there was a room available, Kate and her daughter said it was fine for the assessment to take place at the bedside especially that Kate was so restless. The curtains were pulled around the bed, though Sibson argued that it ensures visual privacy only and not a barrier to sound. NMC a acknowledges this, along with the need to speak at an appropriate volume when asking for personal details to maintain confidentiality. In this ward the Roper, Logan and Tierney model of nursing, which is based on the twelve activities of living, is used as a base for assessing patients Alabaster This model is extremely prevalent in the United Kingdom and it is used as a checklist on admission in order to get as much background data about the patient Holland , p. Personal details such as name, age, address, nickname, religion, and housing status were recorded. Information was also recorded about any agency involved, along with next of kin and contact details, and details of the general practitioner. Holland stated that these details should be accurate and legible so that, in case of any concerns about the patient, the next of kin can be contacted easily. The name and age are also vital in order to correctly identify the patient to avoid mistakes. Knowing what type of a job the patient does or the type of the house she lives in helps to indicate how the patient is going to cope after discharge. Holland also insisted that religion should be known in case the patient would like to have some privacy during prayers, and this should be included in the care plan. The second assessment to be done focused on physical assessment and the activities of living. Barrett, Wilson and Woollands suggested that when enquiring about the activities of living, two elements should be addressed: During physical assessment, Kate demonstrated laboured, audible breath sounds and breathlessness. Use of accessory muscles and nose flaring was also noted. She was agitated and anxious. Her vital signs were: Taking and recording observations is very important because it helps to recognise the significance of changes in vital signs. Carpenito-Moyet stated that it is important to take the first observations before any medical intervention, in order to assist in the diagnosis and to help assess the effects of treatment. How did all this affect her ability to provide you with information during the assessment? How gave the information, Kate or the daughter? Did this affect the way the questions were asked? Or the information received? Could Kate answer all the questions? Did the daughter know the answer to all the questions? Among the needs identified, breathing and personal hygiene cleansing , being priority needs, will be explored. Breathing will be discussed first being an underlying problem which Kate presented with before moving on to personal cleansing. In old people, muscles become less efficient, resulting in increasing efforts to breathe, causing a high respiratory rate Mallon She was wheezing, cyanosed, anxious and had shortness of breath. Wilkinson explained that a goal statement is a quantifiable and noticeable criterion that can be used for evaluation. The goal statement in this case would be for Kate to maintain normal breathing, which is normally 12 â€” 18 breaths per minute in adults Mallon , and to increase air intake. The prescription of care for Kate depended on the assessment, which was achieved by monitoring her breathing rate, rhythm, pattern, and saturation levels. These were documented hourly for early identification of any deterioration of condition; it also encouraged early identification of interventions. Readings were compared with initial readings to determine changes and to report any concerns. The other part of the plan was to give psychological care to Kate by involving her in her care and informing her about the progress, in order to reduce anxiety. Barrett, Wilson and Woollands a stated that it is very important to give psychological care to patients who are dyspnoeic because they panic and become anxious. Checking and recording of breathing rate and pattern is very important because it is the only good way to assess whether this patient is improving or deteriorating, and it can be a very helpful method for nurses to evaluate the care of the patient Jamieson Mallon stated that, if the breathing rate is more than 20, it indicates that the body is trying to increase its intake of oxygen to meet unusual demands. This can happen even after doing exercise, not only in people with respiratory problems

Blows Griffin and Potter stated that, respirations are normally quiet, and therefore if they are audible it indicates respiratory disease, wheezing sound indicates bronchiole constriction. With nasal catheter, Kate was able to communicate with the nurses and her daughter what about comfort?. The peak expiratory flow was monitored and recorded to identify the obstructive pattern of breathing that takes place in asthma Hilton, This is another method that is used to assess the effectiveness of the medication inhalers the asthmatic patient is taking, and this test should be carried out 20 minutes after medication has been absorbed. Kate was observed for any blueness in the lips and oral mucosa as this could be a sign of cyanosis. Bronchodilators are given to dilate the bronchioles constricted due to asthma, and corticosteroids reduce inflammation in the airway BNF b. Kate was also started on antibiotics to combat the infection because, on auscultation, the doctor found that the chest was not clear. Kate was being reassured during care, her daughter was encouraged to be visiting her mum regularly because she used to be settled whenever the daughter was around. The call bell was always in reach for to call when in need. Kate was nursed in an upright position using pillows and a profiling bed in order to increase chest capacity and facilitate easy respiratory function by use of gravity Brooker and Nicol, In this position, Kate was comfortable and calm while other vital signs were being checked. Pulse rate and temperature were also being checked and recorded because if raised, they indicate infection in the blood. NMC encouraged teamwork to maintain good quality care. Kate was referred to the respiratory nurse who is specialised in helping patients with breathing problems. Kate was on oxygen since admission; therefore she was taught about importance of healthy breathing and taught her about breathing exercises to help her wean from oxygen. Due to breathlessness and loss of mobility it was difficulty for Kate to maintain her personal hygiene. Hygiene is the practice of cleanliness that is needed to maintain health, for example bathing, mouth washing and hair washing.

Chapter 2 : Clinical Guidelines (Nursing) : Nursing assessment

It covers a range of issues including the nurse's role in assessment, how to make sense of patient information, using assessment tools, nursing diagnosis, care planning principles and nursing models, ethical dilemmas in assessment and decision-making in delivering nursing care.

Ongoing assessment of vital signs are completed as indicated for your patient. It is mandatory to review the ViCTOR graph at least every 2 hours or as patient condition dictates to observe trending of vital signs and to support your clinical decision making process. Less than 6 months use digital thermometer per axilla. Assess any respiratory distress. Palpate brachial pulse preferred in neonates or femoral pulse in infant and radial pulse in older children. To ensure accuracy, count pulse for a full minute. Baseline measurement should be obtained for every patient. Selection of the cuff size is an important consideration. For neonates without previous hospital admissions do a blood pressure on all 4 limbs. Monitor as clinically indicated. Note oxygen requirement and delivery mode. Blood sugar level BSL: A structured physical examination allows the nurse to obtain a complete assessment of the patient. Clinical judgment should be used to decide on the extent of assessment required. Assessment information includes, but is not limited to: Shift Assessment At the commencement of every shift an assessment is completed on every patient and this information is used to develop a plan of care. Initial shift assessment is documented on the patient care plan and further assessments or changes to be documented in the progress notes. Patient assessment commences with assessing the general appearance of the patient. Use observation to identify the general appearance of the patient which includes level of interaction, looks well or unwell, pale or flushed, lethargic or active, agitated or calm, compliant or combative, posture and movement. ECG rate and rhythm if monitored. Observation of vital signs including Pain: For further information please see the Pain Assessment and Measurement clinical guideline Skin: Colour, turgor, lesions, bruising, wounds, pressure injuries. Assess hydration and nutrition status and check feeding type- oral, nasogastric, gastrostomy, jejunal, fasting, and breast fed, type of diet, IV fluids. Assess Bowel and Bladder routine s , incontinence management urine output, bowels, drains and total losses. Review fluid balance activity Blood sugar levels as clinically indicated. Assess for Mood, sleeping habits and outcome, coping strategies, reaction to admission, emotional state, comfort objects, support networks, reaction to admission and psychosocial assessments. In the adolescent patient it is important to consider completing psychosocial assessments as physical, emotional and social well-being are closely interlinked. The HEADSS assessment is a psychosocial screening tool which can assist in building a rapport with the young person while gathering information about their family, peers, school and inner thoughts and feelings. The main goals of the HEADSS assessment are to screen for any specific risk taking behaviours and identify areas for intervention, prevention and health education. For more information see Engaging with and assessing the adolescent patient. It is important to note that you may need to establish a rapport with the young person and may require a few shifts to fully complete the HEADSS assessment. Pertinent social assessment information such as court orders can also be documented in the FYI tab to alert all members of the health care team. Review the history of the patient recorded in the medical record. It may be necessary to ask questions to add additional details to the history. Focused Assessment A detailed nursing assessment of specific body system s relating to the presenting problem or other current concern s required. This may involve one or more body system. Nursing staff should utilise their clinical judgement to determine which elements of a focussed assessment are pertinent for their patient. Neurological System A comprehensive neurological nursing assessment includes neurological observations, growth and development including fine and gross motor skills, sensory function, seizures and any other concerns. Neurological observations Assess Level of Consciousness. RCH uses a modified version of the Glasgow coma scale to assess and interpret the degree of consciousness and is documented on neurological observation chart. For infants, an assessment is made of their cry and vocalization. Arm and leg movements, assess both right and left limb and document any differences. Pupil

size, shape and reaction to light. For neonates and infants check fontanels. Neonates should also be assessed for presence of marks from forceps or vacuum delivery device, or presence of cephalohematoma or caput succedaneum. Importance of Vital signs. Vital sign changes are late signs of brain deterioration. Respiratory pattern provides a clear indication of brain functioning. Note for Cheyne Stokes, rapid, irregular, clustered, gasping or ataxic breathing. Temperature alterations may indicate dysfunction of the hypothalamus or the brain stem. Blood pressure increases with increased intracranial pressure. Head circumference should be measured, over the most prominent bones of the skull e. Does the infant visually fix and follow?

Chapter 3 : What Is A Nursing Care Plan and Why is it Needed?

Nursing assessment, care planning, and education are crucial components to improving patient care After reading this article, you will be able to: State what a hospital must define in writing about an assessment 2. Describe common assessment mistakes that hospitals make 3. List ways to improve the care planning process 4. Nursing assessments The most common problem that hospitals have dealing with nursing assessments is not knowing exactly what the standards say and what is required in an assessment, said Pejakovich, a consultant with The Greeley Company, a division of HCPro, Inc. For example, Joint Commission standard PC. In what settings the assessment will be done The content of the assessment The criteria for more in-depth assessment However, the standard does not require nursing assessments to take place in settings such as same-day surgery, the OR, the emergency department, or a physician office practice. Other common errors hospitals make with this standard, according to Pejakovich, include: Trying to apply an inpatient assessment to an outpatient setting Not defining what information is needed to perform nursing care Collecting information that will not be used in the specific care setting Another assessment standard, PC. The same standards apply to reassessments, as shown in PC. Reassessments are actually often overdone, according to Pejakovich, and they should be done only when they are meaningful, not just to complete routine paperwork. What care is a priority for the patient today? How were you informed of these patient care needs? The easiest way to set up a care planning chart, according to Pejakovich, is to make a table with the following column headings: For specific areas of care, such as obstetrics, you may define what constitutes routine care, but you should leave room for when nonroutine issues occur, she added. All care planning really comes back to standard PC. As long as you say what you do and do what you say, you should be fine here, Pejakovich said. Education In this case, education refers to the education assessment performed on patients, specified in PC. The education assessment should include: Cultural and religious beliefs Desire and motivation to learn Physical or cognitive limitations Barriers to communication But the key piece to PC. One way to keep the educational assessment prominent when it comes to educating a patient is by keeping the educational assessment form near the top of the chart and with the education form, Pejakovich suggested. Weekly Reader Poll How difficult is it for you to maintain a healthy lifestyle with your current workload? I can always find enough time for exercise, sleep and healthy meals. I can manage to get sometime in the week to focus on my health, though it can be a time crunch. I almost never have enough time to look after my health, I have too much work to do.

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Chapter 4 : Assessment and Care Planning â€“ The WritePass Journal : The WritePass Journal

A pocket-sized clinical companion, Manual of Psychiatric Nursing Care Planning, 5th Edition supplies you with the latest diagnostic information available, including the DSM-5, for accurate assessment and diagnosis of patients.

We respect your privacy. In nursing school, there is probably no more hated class assignment than the nursing care plan. The Purpose of the Written Care Plan Care plans provide direction for individualized care of the client. The care plan is a means of communicating and organizing the actions of a constantly changing nursing staff. Care plans help teach documentation. The care plan should specifically outline which observations to make, what nursing actions to carry out, and what instructions the client or family members require. They serve as a guide for assigning staff to care for the client. Care plans serve as a guide for reimbursement. Medicare and Medicaid originally set the plan in action, and other third-party insurers followed suit. The medical record is used by the insurance companies to determine what they will pay in relation to the hospital care received by the client. If nursing care is not documented precisely in the care plan, there is no proof the care was provided. Insurers will not pay for what is not documented. The purpose of students creating care plans is to assist them in pulling information from many different scientific disciplines as they learn to think critically and use the nursing process to problem solve. As a nursing student writes more plans, the skills for thinking and processing information like a professional nurse become more effectively ingrained in their practice. Care Plan Formats The exact format for a nursing care plan varies slightly from place to place. They are generally organized by four categories: As defined by the the North American Nursing Diagnosis Organization-International NANDA-I , nursing diagnoses are clinical judgments about actual or potential individual, family or community experiences or responses to health problems or life processes. A nursing diagnosis is used to define the right plan of care for the client and drives interventions and patient outcomes. Nursing diagnoses also provide a standard nomenclature for use in the Electronic Medical Record EMR , allowing for clear communication among care team members and the collection of data for continuous improvement in patient care. Nursing diagnoses differ from medical diagnoses. A medical diagnosis â€” which refers to a disease process â€” is made by a physician and will be a condition that only a doctor can treat. The goal as established in a nursing care plan â€” in terms of observable client responses â€” is what the nurse hopes to achieve by implementing nursing orders. The terms goal and outcome are often used interchangeably, but in some nursing literature, a goal is thought of as a more general statement while the outcome is more specific. Nursing orders are instructions for the specific activities that will perform to help the patient achieve the health care goal. How detailed the order is depends on the health personnel who will carry out the order. Nursing orders will all contain: The evaluation is extremely important because it determines if the nursing interventions should be terminated, continued or changed. To help students learn and apply their knowledge, educators often add one more category to care plans. The rationale is the scientific reason for selecting a specific nursing action. Students may be required to cite supporting literature for their plan and rationale. Care plans teach nursing students how to think critically, how to care for patients on a more personal level, not as a disease or diagnosis. They help teach how to prioritize care and interventions. Sample Careplans Please browse and bookmark our free sample careplans below. Our careplan library has been utilized by over , visitors.