

Supporting research for a nursing assessment process



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Assessment is a deliberate, systematic and interactive process that underpins every aspect of nursing care (Heaven & Maguire, 1996). It is the process by which the nurse and patient together identify needs and concerns and is seen as the cornerstone of individualised care. It is the only way that the uniqueness of each patient can be recognised and considered in the care process (Holt, 1995). The process of assessment requires the nurse to make accurate and relevant observations, to gather, validate and organise data and to make judgements to determine care and treatment needs. A nursing assessment should have physical, psychological, emotional, spiritual and cultural dimensions and it is vital that these are explored with the patient being assessed. When carrying out the assessment the nurse must at all times consider the patient as a unique individual, thereby supporting the notion of a holistic individual approach to nursing (Roper, Logan & Tierney, 1996).

When the nurse uses Roper, Logan and Tierney's model she concentrates on the activities of daily living, basing the assessment on the patient's usual abilities and routine. When the nurse ascertains what the patient usually does in relation to the activities of living a comparison can then be made based on what the patient is like now. When carrying out the assessment the nurse must at all times consider the patient as a unique individual thereby supporting the notion of a holistic individual approach to nursing (Roper, Logan & Tierney 1996).

Nicol et al (2003) suggest that the assessment is crucial to the whole nursing process. When the data has been collected and analysed this will allow the nurse with the patient (if appropriate) to identify problems and strengths of

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the patient. Assessment can take place anywhere, for example, in the hospital, in the patient's home or in the workplace. Heath (2000) suggests that assessment is regarded as the data collection phase that allows the nurse to make judgements about the patient's health situation, needs and wishes. Assessment also helps to establish priorities and allows the planning of care.

Holland et al (2003) suggest that frameworks like the Roper, Logan and Tierney model are essential tools to be utilised in the nursing process. The structuring of patient assessments is vital to monitor the success of care and to detect the emergence of any new problems. The structure of a patient's assessment depends not only on the speciality and care setting but also on the purpose of the assessment. Different conceptual or nursing models such as Roper et al (2000) provide frameworks for a systematic approach to assessment such as Roper's Activities of Daily Living, implying that there is a perceived value in the coexistence of a variety of perspectives. However, Chalmers et al (1990) claims 'the nursing model may have been positively unhelpful to knowledge building in nursing by inhibiting alternative, more fruitful lines of theory development.' There remains much debate about the effectiveness of such models for assessment in practice, with some arguing that individualised care can be compromised by fitting patients into a rigid or complex structure (Tierney, 1998; Kearney, 2001). Nurses therefore need to take a pragmatic approach and utilise assessment frameworks that are useful and appropriate to their particular area of practice. This is particularly relevant in today's rapidly changing healthcare climate where nurses are taking on increasingly advanced roles, working across boundaries and

setting up new services to meet patients needs (Department of Health, 1996). A different type of assessment would be required for an acutely ill patient where early recognition of potential or actual deterioration is absolutely essential (Ahern & Philpot, 2002).

The district nurse who visited the patient following his discharge from hospital carried out a thorough nursing assessment which was based on the Roper, Logan and Tierney Activities of Daily Living Nursing Model (2000). A single assessment form based on Roper, Logan and Tierney's Activities of Daily Living was used. The form consisted of both questionnaire type and checklist type questions. Whilst the checklist questions offered limited options for answers the questionnaire type questions required more specific answers.

The patient was a fifty-four year old male, recently divorced and living alone in a ground floor flat. What follows is a summary of his health needs based on his assessment document.

Communication

At this present time has no problems with communication. Makes needs known. Will need to be reviewed.

Maintaining a safe environment

Has no problems maintaining his own environment and is able to recognise potentially dangerous situations.

Respiratory

Manages own airway. No difficulty breathing. Currently no need for intervention.

Cardiovascular

No problems identified.

Neurological

Has lived with MS for the last 10 years.

Endocrine

No problems identified.

Pain

Intense stabbing pain and burning sensations. Has suffered from chronic pain for the last 8 months due to worsening symptoms of MS. Currently prescribed Zomorph for pain relief by GP.

Nutrition/Fluid Assessment

Appetite has become poor over the last few months but is independent with regards to feeding himself.

Continence

Has no problems getting to the toilet. However, patient often constipated and at other times unable to tell when stool is about to be passed.

General/Oral Hygiene

Lives in flat with specially adapted bathroom facilities. Requires no assistance.

Mental Wellbeing

Experiences anxiety and depression. Currently taking Citalopram for depression.

Death and Dying

Would like to be resuscitated in the event of emergency.

Expressing Sexuality

Recently divorced and not in a relationship.

Sleeping

About 8 hours sleep per night. Falls asleep naturally but wakes frequently during the night.

The assessment process highlighted a number of issues regarding the current health state of the patient such as a reduction in his appetite and continued constipation. It also highlighted the chronic pain the patient had to endure daily. Additionally, it came to light that the patient had previously been diagnosed as suffering from depression following a relationship breakdown and had been prescribed anti-depressants (Citalopram) which he had been taking for some time on a regular basis. It was possible the patient was suffering from depression as a result of the relationship breakdown or maybe as a consequence of the persistent pain endured. Pain can cause long term distress and impact severely on quality of life. Self help may play an important role in pain control. Multiple Sclerosis sufferers who remain active and maintain positive attitudes report a reduction in the impact of pain on the quality of their lives (Benz, 1996). According to Dougherty and Lister

(2008) some of the problems identified during the assessment process may be linked to the medical condition whilst others will be specific to the individual, their psychology and their social and cultural status.

Nursing diagnosis involves making a 'decisive statement concerning the clients needs' (George, 1995: 21). With this statement being somewhat dated there has been little change in the way nursing diagnosis is defined. Some of the nursing diagnosis of this patient are based on NANDA (2009-2011) and are as follows with the major referrals that were made to other MDT members that needed to be involved to give optimal care to the patient.

Diagnoses

Chronic pain due to Trigeminal Neuralgia. A common condition among individuals with Multiple Sclerosis. Referred to Multiple Sclerosis specialist nurse and GP to be reassessed for management of pain and to draw up new treatment regime.

Loss of appetite associated with patient's anxiety and depression which tends to suppress most biological functions such as eating and drinking. Referred patient to Multiple Sclerosis specialist nurse to help stress the importance of diet in the treatment of Multiple Sclerosis and to help draw up diet designed to possibly alleviate some Multiple Sclerosis symptoms.

Contenance problems due to neuropathic nerve damage as a result of patient's Multiple Sclerosis. Referred to Multiple Sclerosis specialist nurse to advise patient about incorporating bowel management strategies into daily routine.

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Anxiety and depression probably due to the accumulation of a variety of factors. Some are related to patient's psychological reaction to his Multiple Sclerosis whilst Multiple Sclerosis related nerve damage could also be a trigger. Recent divorce also made patient more susceptible to depression and emotional changes. Referred patient for counselling as per NICE MS Guidelines (2003). Also referred to GP in order to discuss alternative treatment regime.

Sleep disturbance due to anxiety, pain. Referred; councillor to allow the patient to discuss any anxieties, any problems they are currently experiencing and offer coping strategies.

Social isolation due to increased pain when mobilising, subsequent reduced mobility.

The assessment tool was adapted from Roper, Logan and Tierney's activities of daily living nursing model. This model is useful in the assessment process as it allows the systematic identification of actual or potential problems that the patient may experience and allows the clear identification of nursing needs.

The Roper, Logan and Tierney model says little overtly about the principles that should guide nursing intervention and therefore could be argued detracts from its utility (Aggleton & Chalmers, 2000). The assessment form used to assess the nursing needs of the patient contained somewhat of an empty approach. It enables nurse to assess but does not give guidance on the type of things to look for, it guides planning yet provides little

information regarding the form that care plans should take. It suggests <https://assignbuster.com/supporting-research-for-a-nursing-assessment-process/>

interventions yet fails to specify what may be appropriate interventions in certain circumstances, it calls for evaluation without specifying the standards against which comparisons should be made (Aggleton & Chalmers, 2000).

With this it could be argued that in order to get the best out of an assessment a further set of ideas about people and the factors that can cause health related problems to arise are needed.

Throughout the initial assessment with the patient many issues arose that needed further investigation and assessment, but the main issue that appeared to be affecting the patient's ability to carry out activities of daily living was the pain that he had to endure on a daily basis. For the purpose of this assignment a focus will be put on the assessment of his pain. It will also provide a critical evaluation of how the assessment was carried out, looking at the pain assessment tool that was used in order to assess his pain, and finally evaluating the reliability and validity of the assessment tool.

During the assessment of the patient's health needs the main issue that was highlighted was pain that he was currently experiencing and how this impacted on his carrying out simple everyday tasks and how he had become increasingly isolated. Pain is a personal experience and the only way in which health professional can judge the patient's level of pain is to firstly rely on the patient's perception of their pain and secondly observe their resultant behaviour (Jenson, 1999). Although no specific assessment tool was used to document the patient's pain score, the structure that the assessment took could suggest that it was based on the Numerical Pain Rating Scale (NRS).

The patient was asked to rate his pain on a scale of ' 0-10' and this was then documented in his nursing notes. Higginson (1998) notes that taking <https://assignbuster.com/supporting-research-for-a-nursing-assessment-process/>

assessment directly from the patient is considered the most valid way of collecting information regarding their current quality of life and by encouraging the patient to take an active role in his pain assessment could be one step to help him and make him feel part of his own pain management process.

The NRS consists of both written and verbal forms, the written forms are described as either a vertical or horizontal line with '0' being no pain and '10' indicating severe pain (Doherty & Lister, 2008). When reviewing the patient's pain and the issues surrounding it, not having an assessment tool available to document these issues on proved extremely difficult and a time consuming process as each issue needed to be documented in the patient's notes. As a consequence subsequent visits proved difficult as the results would not be readily accessible, the results may be misinterpreted and could prove to be a time consuming process.

Higginson (1998) suggests that it is important to make an assessment of each pain separately, since the pain may need to be managed in a different manner and one analgesic will rarely be sufficient. Bearing this in mind it could be argued that by not reviewing each pain experienced by the patient, from pain experienced on mobilising through to pain experienced from trigeminal neuralgia, the assessment of his pain and in the interventions given to him would be insufficient and may lead to a further deterioration in his condition. By comparison if an assessment tool such as the McGill's pain questionnaire (MPQ) were available, this could have been addressed as this tool was developed to capture the multi-dimensional nature of pain and specifically measures several features of pain (Doherty & Lister, 2008).
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The NRS provides a figure to say if the pain experienced has increased or decreased and by how much, the information documented also serves as a regular re-assessment and evaluation tool throughout a patient's illness (Aggleton & Chalmers, 2000). The initial measurement of the pain experienced can also be used as a baseline on which to assess future interventions. Jensen (1999) states that in general a pain test should be reasonably simple to undertake, and is directed at a level that most patients would understand and should also be accurate and reliable. An instrument is said to be reliable if the test scores provided by the same individual on two separate occasions are similar (Doherty & Lister, 2008). Furthermore, the simplicity of this assessment tool should not detract from its validity and reliability (Jensen, 1999).

In conclusion, by understanding that every individual's experience of pain varies it could be argued that a more reliable tool to use in our patient's case would have been the MPQ. This would have enabled the nurse gain a more in-depth analysis of the pain experienced by the patient and would have greatly enhanced the effectiveness of the overall assessment.