A needs orientated approach to care

Health & Medicine

Introduction

The aims of this assignment are to provide a needs orientated approach to care using anursingmodel alongside a nursing process in order to create a framework. The nursing model for the purpose of the assignment will be Roper, Logan and Tierney (RLT). A nursing model is used to determine what is important and relevant to providing individualized care (Barrett, Wilson, Woollands 2009). This will be discussed in detail providing evidence of strengths and weaknesses of the model. The nursing process that will be discussed will be APIE which is assess, plan, implement and evaluate. A nursing process is a systematic approach which focuses on each patient as an individual ensuring that the patients holistic needs are taken into consideration. These include physical, social, psychological, cultural and environmental factors. . The nursing process is a problem solving framework for planning and delivering nursing care to patients and their families (Atkinson and Murray 1995). When used collaboratively the nursing model and the nursing process should provide a plan of care that considers the patient holistically rather than just focusing on their medical diagnosis (Moseby's 2009). It will also discuss an example of a care plan done for a fictional patient and evaluate and discuss how the nursing plan and the nursing process have created a plan of care and how effective this was or was not.

Care planning is a highly skilled process used in all healthcare settings which aims to ensure that the best possible care is given to each patient. The Nursing and Midwifery council state that care planning is only to be undertaken by qualified staff or by students under supervision. The

Department ofhealth(2009) says that “ Personalized care planning is about addressing an individual’s full range of needs, taking into account their health, personal, social, economic, educational, mental health, ethinic and cultural background and circumstances” with the aim of returning the patient to their previous state before they became ill and were hospitalized considering all of these needs to provide patient centered care. It recognizes that there are other issues in addition to medical needs that can impact on a person’s total health and well being’. It provides a written record accessible to all health professionals where all nursing interventions can be documented. Care planning is extremely important as it enables all staff involved in the care to have access to relevant information about the patients current medical problems and how this affecting them in relation to the 12 activities of living as well as any previous medical history. Barrett et al (2009) state that taking care of an individuals needs is a professional, legal and ethical requirement. There are many different nursing models all of which have strengths and weaknesses and its up to the nurse to choose the right one for individual patient, the model which is used will vary between different speciailties depending on which is more relevant to the patient and their illness and needs. Although a vast majority of hospitals now use pre-printed care plans it is important to remember that not all the questions on them will be relevant to all patients. An example of this would be that activity of breathing may not have any impact on a healthy young adult be would be a major factor for an elderly man with COPD.

There are four stages to the nursing process which are Assess, plan, implement and evaluate (APIE) but Barrett et al state that there should be

six stages to include systematic nursing diagnosis and recheck (ASPIRE) as although they are included in the nursing process they are not separate stages and could be overlooked.(Barrett et al 2009). It is important that a nursing process is used and it is set out in a logical order, the way in that the nurse would think this helps minimize omissions or mistakes. Roper, Logan and Tierney model of nursing suggests that there are five interrelated concepts which need to be taken into consideration when planning and implementing care which are activities of living, lifep, dependence/independence continuum, factors influencing activities of living and individuality in living (Roper, Logan and Tierney 2008).

Assessment

Assessment is fundamental to gaining all the information required about the patient in order to give the best possible care. “ Assessment is extremely important because it provides the scientific basis for a complete nursing care plan” (Moseby’s 2009). The initial assessment untaken by nurses is to gather information regarding the patients needs but this is only the beginning of assessing as the holistic needs of the patient including physical, physiological, spiritual, social, economic and environmental needs to be taken into consideration in order to deliver appropriate individualized care (Roper, Logan and Tierney 2008). When using the 12 activities of living (ALs) for assessment it gives a list a basic information required but must not just be used as a list as the patient will respond better to questions asked in an informal manner and when just part of the general conversation. RLT (2008) state that although every AL is important some are more important than other and this can vary between patients. It is important for nurses to obtain

appropriate information through both verbal and non-verbal conversation patients are more likely to give correct information but without jumping to conclusions or putting words into their mouths. ‘ Assessment is the cornerstone on which a patients care is planned, implemented and evaluated (RLT 2008). “ Poor or incomplete assessment subsequently leads to poor care planning and implementation of the care plan” (Sutcliffe 1990). Information can be gained from the patient, the patientsfamilyand friends as well as any health records (Peate I, 2010)

During this process of gathering information it is important to find out what the patient can do as well as what they cant. , McCormack, Manley and Garbett (2004) state that gathering the information requires a certain kind of relationship between the nurse and the patient and nurses need to be able to communicate effectively in order to be able to build this relationship. A full assessment needs to consider how the patient was before they became ill or hospitalized in relation to their medical diagnosis as well as how the patient was dealing with it, how they are now, what is the change or difference if any, do they know what is causing the change, what if anything they are doing about it, do they have any resources now or have they have in the past to deal with the problem (barrett et al). RLT (2008) state that there are 5 factors that influence the 12 activities of living which are biological, psychological, sociocultural, environmental and politicoeconomic, these may not all have an effect on each patient but all need to be taken into consideration. The more information gained in the assessment process the easier the other steps will follow. RLT (2008) suggest that assessing is a continuous process and that further information will be obtained through

observations and within the course of nursing the patient. At the end of the initial assessment the nurse should to identify the problems that the patient has.

There are limitations to using a nursing process which are the 12 als are often used as a list as part of a core care plan and are not always individualized Walsh (1998) argues that the 12 activities of living may just be used as a list which could result in vital information being missed which could be detrimental to the patient. The Nursing and Midwifery Council (NMC 2008) states a nurse is personally and professionally accountable for actions and omissions in practice and any decisions made must always be justifiable. There are many benefits to using a nursing process it is patient centered and enables individualized care for each patient. It also gives patients input into their own care and gives them a greater sense of control it is outcome focused using subjective and objective information which helps and encourages evaluation of the care given. It also minimizes any errors and omissions.

When I carried out the assessing stage on mabel I did this using the 12 activities of living as suggested by Roper et al (2008) but this was used too much like a checklist. I didn’t gather enough information in order to be able to do the best plan of care possible for her although I don’t feel this could have been detrimental to the care she received it needed more information than I had. I also found it difficult deciding which information should go where so I endened up repeating information in more than one of the 12 als, Which although this wouldn’t have made a difference to the planning of the care plan there was too much irrelevant information which could mean that

it wasn’t read thoroughly just skimmed over as it would take too much time. As I am inexperienced in doing this I realized when writing the care plan that there were many questions that I didn’t ask so there where many parts that could not be filled in. I also didn’t gather enough objective data for certain parts so I didn’t have any evidence that the care had worked or how effective it had been.

This is where Barrett et al (2009) state that there should be a systematic nursing diagnosis where nurses establish a nursing diagnosis rather than just a medical diagnosis. This is where the holistic needs of a patient are taken into consideration. Although nursing diagnosis differs from a medical diagnosis the two do interlink but a nursing diagnosis considers the physical, psychological and spiritual aspects of the medical diagnosis and problems that may arise from these. Another part of the systematic nursing diagnosis is to provide baselines to state where the patients are at at the present time so that a needs statement can be written in conjunction with the patient in terminology that they can understand(Barrett et al 2009).

Planning

The next stage of the nursing process is planning this is where all the information gained in the assessment part to plan the care of the patient. The planning stage of the process is where achievablegoalsneed to be made through discussion with care givers and the patient or the patients representative. These goals need to contain both subjective goals and objective goals in order for them to be measurable and evaluated. The plan of care is to solve the actual problems the patient has and to prevent potential problems from becoming actual ones. It also aims to help the

patient cope with their illness in a positive way and to make them as comfortable and pain free as possible (RLT 2008). Planning needs to be totally individualized and patient centered they need to feel they have a voice and part of the team. The more information gathered in assessment the easier the plan of care will be. The main objective of a nursing plan is to ‘ provide the information on which systematic, individualized nursing can be based and individualized nursing can be based and implemented by any nurse’ (RLT 2008). Through a detailed individualized plan of care any nurse caring for a particular patient should be able to see exactly what is required of them as all the information will be recorded in the care plan. The NMC (2008) says that nursing interventions need to be specific for that particular patient, based on best evidence, measurable and achievable. There are many different criteria for setting goals just one of these is PRODUCT which stands for, Patient centered, recordable, observable and measurable, directive, understandable and clear, credible and time related. This is just meant as a way of helping nurses to set goals (Barrett et al 2009). When planning care a great emphasis needs to be based on the dependence/independence continuum which will have been established in the assessment phase. The care to be given will encourage the patient to get back to as reasonably possible or as close to where they were on the continuum as they were before they were admitted to hospital. Planning also needs to take into account the resources available to implement the care as they need to ensure that the care they are planning is achievable and will not be compromised by lack of resources or a shortage of nursing staff (Roper et al 2008).

When I did a plan of care for mabel it quickly became evident how inexperienced I was. I didn’t gather enough information in the assessing period to be able to do an effective plan of care. I also didn’t know how achievable the goals where as I wasn’t aware of how long they would take to improve or if they where achievable or not, I also found it difficult determine which problems were interrelated and as a result tried to linkanxietyin with another problem when in fact it was a problem on its own. I was able to write the needs statements effectively that were not long but on a couple of these the influencing factors were missed out which would be necessary when providing holistic care. Planning care for a patient requires a great deal of knowledge in the chosen specialty which is why it must be carried out by a qualified member of staff or a student under supervision.

Implementation

Implementation is the next part of the nursing process and where all the goals which were set in the planning stage are put into motion and the goals can start to be achieved through nursing and medical interventions. The main component of the implementation stage is the delivery of the care to the patient. This is done with nursing staff, the multidisciplinary team members involved in the patients care such asdoctor, dieticians and physiotherapists and the patient themselves in order for the patient to be able to return to how they were previously before they were admitted to hospital. The plan of care will be specific to the particular patient and will focus on the biopsychosocial aspects of the patient (Marriner 1983). Implementation provides great emphasis on individualized care which is why it is important to establish in the previous phases where they are on the

dependence/independence continuum and what they are able to do now and what they were able to do before. Individualised care is associated with how the patient did things before such as how the person carries out the ALs and how often they carry these out. An example of this would be when carrying out the AL of personal cleansing and dressing to individualise the care it would be necessary to have determined in the assessing stage how the patient usually did this and how often it wouldn’t be individualized if in the care plan it was stated that they got a shower every morning if at home they only did this once a week. Core care plans may be used in certain situations this can provide a greater level of care as potential problems can be foreseen if related to a certain problem on the other hand it is also important not to standardize care as patients react differently to different illnesses and treatment. (Faulkner A, 2000). The NMC (2008) state that nurses are required to ‘ Make the care of people your first concern, treating them as individuals and respecting their dignity’. In order to deal with certain problems or situations people often develop coping strategies which can be either adaptive or maladaptive. Adaptive coping strategies are usually helpful to the patient whereas maladaptive ones could be detrimental to their health such assmokingor drinking, the patient may feel this helps them to deal with a present situation but it is actually causing them harm. Patients need to be discouraged from using maladaptive coping strategies this could be done by introducing them to adaptive coping strategies and encouraging them to change their maladaptive ones into adaptive ones. Diamond (2008) states that there are also legal and ethical issues when it comes to implementing care as consent needs to be gained before any care is implemented and if this is not given the care cannot be given this will

obviously have an effect on how effective the care has been when evaluating the care. The Nursing and Midwifery Council (NMC) state in section 3 of the code of conduct ‘ you must obtain consent before you give any treatment or care’ (2002).

During the implementation of Mabel I found that although I was able to implement the care effectively I hadn’t recognized all of the nursing interventions needed to provide holistic care and I wasn’t fully aware of timescales of the planned care. I feel I also needed to research further into Mabel’s problems in order to gain the appropriate knowledge to provide the best care available as this would ensure that are the interventions are evidence based and best practice (NMC 2008).

Barrett et el (2008) state that this is where recheck should take place which would enable the health care provider to establish how effective the plan of care is before the treatment ends this would enable them to re-evaluate the plan of care while the treatment is still ongoing and adjust the goals accordingly.

Evaluation

Evaluation is where the care that has been given can be assessed to evaluate the care given and whether it has worked or not. Chalmers (1986) describe that it is an ongoing and continuous process and also occurs at timed points in a formal setting.

Roper et al (2000) say that evaluating care also provides a basis for ongoing assessment, planning and evaluation.

There are two different parts to evaluation summative evaluation and formative evaluation. Formative evaluation is done with the patient taking into account whether they feel the care given has worked when done with consideration of the dependence/independence continuum information regarding the patients previous place on the dependence/independence continuum can be obtained from the patient, their friends and relatives as well as other health care professionals in the multidisciplinary team involved in the care of the patient. Summative evaluation is when the holistic view of the patient is taken into consideration how they feel about the treatment, whether they felt that the goals were achievable. It so where all the measureable data stated in the baselines and data received after this time are analyzed to show how effective or not the treatment has been.

When evaluating care consideration needs to be given to the influencing factors such as biological factors as the bodies physical ability varies according to age the physical ability of an older person is generally less efficient, therefore therefore the plan of care needs to take this into consideration so that when the evaluation takes place it its hoped to have been effective. A nurse needs to evaluate her patient’s status regularly for some patients this will be just once a day but for others it will be much more frequent depending on their illness and healthcare status. RLT (2008) says that evaluation must be individual to the specific patient and not just a standard goal that is related to a specific problem. If goals haven’t been achieved then it is up to the nursing staff to determine why. Maybe the goals set weren’t measureable or achievable. Parsley and Corrigan (1999) say that if goals haven’t been measureable or achievable then new goals need to be

set. It could also be that the nursing interventions were not successful in which case new interventions should be set.

Through my evaluation of Mabel it was evident that I did not require all the information to do a comprehensive plan of care. Although I did set baselines which meant I could compare data I wasn't experienced enough to set goals to the correct timeframe I also didn't obtain enough measureable information in certain problems to be fully able to assess how effective or ineffective the care had been. Had I had more experience I feel that the evaluation wouldn't be a problem. Evaluation requires checking and rechecking in order to see the effectiveness of the care delivered. It requires knowledge and expertise to be able to effectively evaluate and amend the goals and interventions set as necessary. The whole care planning process took me a long time and I still was not very good at certain aspects of it. When setting goals a lot of detailed information is required in order for the plan of care to be effective so I can now understand why it is necessary for a trained member of staff to carry out the task.

Conclusion

This assignment has shown that when used together the nursing process and the nursing model provide a good basis to providing care. It sets out a systematic approach to providing care. Care needs to be set out in a way that both the nurse and the patient know exactly what is happening as well as any other health care professional in the multidisciplinary team providing care for the patient. It has also shown that involving patients in their care enables them to feel they are part of the team and are more likely to help themselves with their care.

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