Patient assessment and medication administration



Marisa L. Bishop

The aim of assessment is to ensure all patients receive consistent and timely nursing care. With the healthcare field our assessment skills are our biggest tool in determining patient care. As nurses, one of the first skills taught is a head to toe assessment. Nurses are taught to inspect, auscultate, palpate, and percuss to determine patient's needs. Structured patient assessment frameworks' impact direct patient care. Accurate patient assessment is imperative to determine the status and needs of the patient and the delivery of appropriate patient care. Nurses must be highly skilled in conducting timely and accurate patient assessments to overcome environmental obstacles and deliver quality and safe patient care (Munroe 2013). Nurses have multiple different types of assessment like emergency, focused, and continuing assessments to be in different settings to better suit the patients.

It is important to perform a history and do a focused physical exam to be sure that there are not any medical risks that would predispose the patient to a medical emergency during the actual procedure. As a healthcare worker nonmaleficence which means non-harming or inflicting the least harm possible to reach a beneficial outcome is the highest concern (Beneficence 2017). Nurses are focused on patient centered-care along with health promotion. Patient-centered care has been associated with a large variety of positive patient outcomes such as adherence to treatment, improved health, and satisfaction. These tasks ensure the best treatments for patients. Nurses must assess patients quickly and thoroughly to note areas where care is required.

Most commonly an assessment is broken down in two types of interviews, one is conducting a health history which includes the collection of subjective data information given by the patient or patients family members and a physical examination of the patient which consists of evidence based data and objective data. Collecting and documenting accurate information is imperative in providing the multi-disciplinary health team the information to facilitate an effective and well-formed care plan, as well establishing a baseline for following assessments (Wilson & Giddens, 2009). The assessment interview builds the foundation of the nurse and patient relationship, building good rapport with the patient will alleviate any stress, anxiety or discomfort the patient may be feeling. The patient will be asked personal questions and times may not understand or may not want to reveal information about their personal life or situations. As a nurse being open and honest, explaining why this type of information is necessary and asking open-ended questions will help prompt the patient to disclose the facts required, advance the process and be fundamental in performing a competent assessment.

Medication administration is an vital skill taught in undergraduate nursing programs. Students learning for this activity includes not only how to calculate and prepare and administer medications, but also includes interventions such as patient and family teaching (Bourbonnais 2014). This task is most extensive than just handing out medications. In order to maintain nonmaleficence, nurses must understand multiple things like: knowledge of the medications being given including how it is given, when, and how many times daily. A big rule to standby are the rights of medication

administration. The standard rights of medication administrations include five basic principles which are right patient, route, time, dose, and drug. There are also more extensive rights that include the previous five basic rights plus right response, reason for giving, documentation, assessment and evaluation, education, expiration, and the right to refuse the medication. Medication administration is driven by orders placed by a physician but guided by the nurses' assessment. It is the nurse's responsibility to know their patient from head to toe and can suggest possible needed treatments that care be ordered by the physician if agreed upon. Collaborative, patient-centered care is the new standard in healthcare and is led by nurses intervention and assessments. Which allows the healthcare team to create a patient specific care plan and tailor treatment to match the patients ever changing needs.

References

Beneficence vs. Nonmaleficence. (n. d.). Retrieved February 19, 2017, from http://missinglink. ucsf.

edu/lm/ethics/Content%20Pages/fast_fact_bene_nonmal. htm

Bourbonnais, F. F., & Caswell, W. (2014). Teaching successful medication administration today: More than just knowing your 'rights'. Nurse Education in Practice, 14(4), 391-5. doi: http://o-dx. doi. org. uafs. iii. com/10. 1016/j. nepr. 2014. 03. 003

Clayton, M. F., Latimer, S., Dunn, T. W., & Haas, L. (2014). Assessing patientcentered communication in a family practice setting: How do we measure it, and whose opinion matters? Patient Education and Counseling, 84(3), 294-302. doi: http://0-dx. doi. org. uafs. iii. com/10. 1016/j. pec. 2011. 05. 027

Munroe, B., Curtis, K., Considine, J., & Buckley, T. (2013). The impact structured patient assessment frameworks have on patient care: An integrative review. *Journal of Clinical Nursing, 22* (21-22), 2991-3005. doi: http://0-dx. doi. org. uafs. iii. com/10. 1111/jocn. 12226