

Assessment and care planning: holistic assessment

[Life](#), [Emotions](#)



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 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 (2008). No information regarding the hospital or ward will be mentioned, in accordance with the Data Protection Act 1998. The pseudonym Kate will be used to maintain the confidentiality of the patient.

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.

Assessment of the Patient

Assessment Theory

In this ward, the Roper, Logan and Tierney model of nursing, which reflects on the twelve activities of living, is used as a base for assessing patients (Alabaster 2011). These activities are “ maintaining safeenvironment, communication, breathing, eating and drinking, elimination, personal cleansing and dressing, controlling body temperature, mobility, working and playing, sexuality, sleeping, and dying” Holland (2008, p. 9).

Elkin, Perry and Potter (2007) outlined nursing process as a systematic way to plan and deliver care to the patient. It involves four stages: assessment, planning, implementation and evaluation. 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 (Alfaro-Lefevre 2010). The nurse uses physical assessment skills to obtain baseline data to manage patients’ problems and to help nurses in the evaluation of care. Data can be collected through observation, physical assessment and by interviewing the patient (Rennie 2009). A complete assessment produces both subjective and objective findings (Wilkinson 2006). Holland (2008) defines subjective data as information given by the patient. It is obtained from the health history and relates to sensations or symptoms, for example pain. Subjective data also includes biographical data such as the name of the patient, address, next of

kin, religion etc. Holland defines objective data as observable data, and relates it to signs of the disease. Objective data is obtained from physical examination, for example of blood pressure or urine.

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 2008). The nurse should also introduce herself to help reduce anxiety and gain the patient's confidence. 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. An accurate assessment enables nursing staff to prioritise a patient's needs and to deal with the problem immediately it has been identified (Gordon 2008). Documentation is also very important in this process; all information collected has to be recorded either in the patient's file or electronically (NMC, 2009b).

Carrying out the Assessment

Kate was allocated a bed within a four-bed female bay. Her daughter was with her at the bedside. Gordon (2008) 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. Kate's daughter was asked if she could be present while the assessment was carried out, so that she could help with some information, and she agreed. Alfaro-Lefevre (2008) recommended that nursing assessments take place in a separate room, which respects confidentiality, and that the patient be free

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to participate in the assessment. Although there was a room available, Kate's daughter said it was fine for the assessment to take place at the bedside because her mother was so restless and just wanted to be next to her. The curtains were pulled around the bed, though William and Wilkins argued that it ensures visual privacy only and not a barrier to sound. NMC (2009a) acknowledges this, along with the need to speak at an appropriate volume when asking for personal details to maintain confidentiality.

The assessment form that was used during Kate's assessment addressed personal details and the twelve activities of living. A moving and handling assessment form was also completed because of her immobility. First, 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 (2008) 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 (2009) suggested that when enquiring about the activities of living, two elements should be

addressed: usual and current routines. Additionally, identifying a patient's habits will help in care planning and setting goals. During physical assessment, when objective data was collected, Kate demonstrated laboured and audible breath sounds (wheezing) and breathlessness. Use of accessory muscles and nose flaring was also noted. She was agitated and anxious. Her vital signs were: blood pressure 110/70; pulse 102 beats /min; respirations 26/min; temperature 37.4 degrees Celsius; oxygen saturation 88%; peak flow 100 litres; weight 60kg; and body mass index 21. Taking and recording observations is very important and is the first procedure that student nurses learn to do. These observations are made in order to detect any signs of deterioration or progress in the patient's condition (Field and Smith 2008). Carpenito-Moyet (2006) 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.

Kate's initial assessment was carried out in a professional way, taking account of the patient's particular circumstances, anxieties and wishes. After the baseline observations were taken, the twelve activities of living were analysed and Kate's needs were identified. Among the needs identified, breathing and personal hygiene (cleansing) will be explored.

Identified Care Needs

Breathing

Wilkinson (2006) states that a nursing diagnosis is an account about the patient's current health situation. The normal breathing rate in a fit adult is 16-20 respirations/minute, but can go up to 30 due to pain, anxiety, pyrexia,

sepsis, sleep and old age (Jenkins 2008). In old people, muscles become less efficient, resulting in increasing efforts to breathe, causing a high respiratory rate. On assessment, Kate's problem was breathing that resulted in insufficient intake of air, due to asthma. She was wheezing, cyanosed, anxious and had shortness of breath.

Wilkinson (2006) 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 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, comparing the readings 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 (2012) 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 whether or not the patient is responding to treatment (Jamieson 2007).

Mallon (2010) stated that, if the breathing rate is more than 20, it indicates the need for oxygen. Blows (2001), however, argued that this can happen even after doing exercise, not only in people with respiratory problems.

Griffin and Potter (2006) stated that, respirations are normally quiet, and therefore if they are audible it indicates respiratory disease. Nurses need to be aware of these sounds and what they mean, for example a wheezing sound indicates bronchiole constriction. Kate's breathing was audible and the rate was also above normal and that is why breathing was prioritised as the first need.

Oxygen saturation level was also monitored with the use of a pulse oximeter. The normal saturation level is 95-99% (British National Formulary ((BNF)) 2011a). Nevertheless the doctor said that 90-95% was fine for Kate, considering her condition and her age. Kate was started on two litres of oxygen and she maintained her oxygen saturation between 90 and 94%. The peak expiratory flow was monitored and recorded to identify the obstructive pattern of breathing that takes place in asthma (Hilton, 2005). 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 is administered. It is the Trust's policy to do hourly observations on patients who have had one, two or three abnormal readings, until readings return to normal. Kate was observed for any blueness in the lips and tongue and for oral mucosa as this could be a sign of cyanosis. All the prescribed nebulisers, inhalers, bronchodilators, corticosteroids, antibiotics and oxygen therapy were administered according to the doctor's instructions. Bronchodilators are given to dilate the bronchioles constricted due to asthma, and corticosteroids reduce inflammation in the airway (BNF 2011b). Kate was also started on antibiotics

to combat the infection because, on auscultation, the doctor found that the chest was not clear.

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, 2011). In this position, Kate was comfortable and calm while other vital signs were being checked. Pulse rate and blood pressure were also being checked and recorded because raised pulse can indicate an infection in the blood.

Cleansing

Due to breathlessness and loss of mobility it was difficult 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. The skin is the first line of defence, so it is vital to maintain personal cleansing to protect the inner organs against injuries and infection (Hemming 2010). Field and Smith (2008) stated that personal cleansing also stimulates the body, produces a sense of well-being, and enables nurses to assess the patient holistically. Personal hygiene is particularly important for the elderly because their skin becomes fragile and more prone to breaking down (Holloway and Jones 2005). Therefore this need was very important for Kate; she needed to maintain her hygiene as she used to, before she was ill.

The goal for meeting this need was to maintain personal hygiene and comfort. The care plan prescribed involved first gaining consent from Kate, explaining what was going to be done. Hemming (2010) recommended that identifying the patient's usual habit is very important because each

individual has different ideas about hygiene due to age, culture or religion. Identifying usual habits helps individuals to maintain their social life if things are done according to their wishes. Though Hemming said all human beings need personal hygiene, Holland (2008) argued that it is important to ask patients how they feel about being cleaned, especially in private areas. Kate indicated that she didn't mind being assisted with washing and dressing. She preferred washing daily, shower and a hair wash once a week, and a mouth wash every morning and before going to bed.

Kate was assisted with personal care 5-10 minutes after having her medication, especially the nebuliser. Individuals with asthma experience shortness of breath whenever they are physically active (Ritz, Rosenfield and Steptoe 2010). After having medication Kate was able to participate during personal hygiene. According to NMC guidelines on confidentiality (2009a), privacy and dignity should be maintained when giving care to patients. Therefore, whenever Kate was being assisted with personal care, it was ensured that the screens were closed and she was properly covered. Field and Smith (2008) suggested that assisting a patient with personal hygiene is the time that nurses can assess the patient holistically. Since Kate was immobile, it was very important to check her pressure areas for any redness. She was also checked for any pallor, jaundice, cyanosis or dry skin that needed attention. The care was always carried out according to her wishes.

The Role of Inter-Professional Skills

Considering Kate's age and condition, she needed multi-professional teamwork. NMC (2008) encourages teamwork to maintain good quality care.

Kate was referred to the respiratory nurse who is specialised in helping people with breathing problems. Since Kate was on oxygen since admission, the respiratory nurse taught her the importance of healthy breathing and taught her some breathing exercises to help wean her from oxygen. Kate was also referred to the physiotherapist who did breathing exercises with her. Kate was not able to walk without aid so she was also referred to the occupational therapy department to assess how she was going to manage at home, or if she required aids to help her manage the activities of living. Upon meeting together, all the multi-disciplinary team agreed that Kate needed a care package, as she could no longer live without care. She was referred to social services so that they could assess this aspect of Kate's future.

After one week Kate was medically fit but could not go home because she was waiting for the care package to be ready. Her nurse shared information with the multi-disciplinary team in order to establish continuity of care for Kate. The team prepared for her discharge: the occupational therapy staff went to visit her home to check if there was enough space for her walking frame; social services arranged for a care package; and her nurses referred her to the district nurse to help her with her medication and make sure it did not run out.

Outcome

Kate responded well to the medication she was prescribed; normal breathing was maintained, her respirations became normal, ranging from 18 to 20 respirations per minute, and her oxygen saturation ranged from 95% to 99%. Kate was able to wash and dress herself with minimal assistance. She was

discharged on a continuous care package comprising care three times a day, and the district nurse helped her with the medication to control her asthma.

Evaluation

The model of the twelve activities of living was followed successfully on the whole. The nurse collected subjective and objective data, allowing a nursing diagnosis to be formulated, goals to be identified and a care plan to be constructed and implemented. Privacy is very important in carrying out assessments, and this was not achieved fully in Kate's assessment. However, this lower level of privacy has to be balanced against causing anxiety to the patient. Kate's daughter thought that the bedside assessment would be more comfortable for her mother, and therefore cause least anxiety. This was very important because of the effects of potential panic on breathing; therefore, this was the correct balance to strike.

A multi-disciplinary team was involved in meeting Kate's care goals. This is a good example of the use of inter-professional skills, as a number of different departments were involved in creating and implementing the care plan. However, the system was not as efficient as it should have been: Kate spent unnecessary time in hospital after recovery because the care plan was not yet in place.

Assessment can also take a long time, especially with the elderly who are usually slow to respond. Therefore, more time is needed to be sure that the necessary progress has been achieved before taking further steps. However, poor staffing also affects performance in this area, an observation supported by the Royal College of Nursing (2012).

In conclusion, the assessment of this patient was completed successfully, and the deviation from best practice recommendations (the lower level of privacy) was justified by the clinical circumstances. Progress from assessment to care goals was good, and at this point an inter-disciplinary team was used successfully. However, the one flaw in this process was delays, caused partly by the difficulties of working across different departments, and partly, it seems, by staff shortages.

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