The importance of needs assessment in nursing practice nursing essay

Health & Medicine, Nursing

Patient assessments concern the collection of data about an individual's health state that identifies and defines patient problems in order for solutions to be planned and implemented in line with their preferences (Roper el at 2000). Therefore, a clear idea about health is important because this determines which assessment data should be collected. The World Health Organisation (WHO) (2001) defines health as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. Whilst this is a broad definition, it implies that the nursing approach to health care is holistic in nature and therefore health assessments should reflect the whole person and their circumstances. Nurses are obliged to take in to consideration a patients physical, emotional, spiritual, social and intellectual needs when making an assessment (UK Department of Health, 2003). `When nurses are conducting a health assessment on a person it may require knowledge of techniques of collecting and analysing subjective and objectives data to include both what the person says about themselves and physical assessment funding from inspecting, percussion and palpating during physical examination (UK Department of Health, 2003). Potter and Berry (2005) argue that if inaccurate, incomplete or inappropriate data is recorded then the overall care of the patient may be affected, including wrong diagnosis and even the wrong treatment. The Nursing and Midwifery Council (NMC) (2002), Code of Professional Conduct, urges all nurses to work in a professional manner and abide by the policies set out by the trust they work in. It suggests that recording or the documentation of information is essential and any deviation could lead to potential consequences for the individual if standards are not met. The

purpose of health assessment is to make a judgement or diagnosis because all health treatments and decisions are based on the data gathered during assessment. It is vital that the assessment is accurate and complete, providing the foundation for clinical decision making (RCN, 2007). This gathered information provides a comprehensive description of the patient. It focuses on the patient's needs at that time and possible needs that may need to be addressed in the future (NMC, 2007). It should be a fair and accurate account of the individual and their life. Overall assessment is a way of delving deeper into a patient's illness and preventing more problems from arising. Case study 2 about a 68 year old Afro Caribbean retired bus driver male called Carl, who has being married for 45 years with 5 grown up children and 8 grand children. He smokes 20 cigarettes a day and enjoys nightcap before sleep. His vital signs observations were respiratory 20 bpm, blood pressure 168/105, pulse 92bpm, Spo2 95%, BMI was 32kg/m2 and medication are statins, betablockers, aspirin and frusemide. Recently, his wife noticed Carl seems to have forgetfulness and he cannot remember his way home from the supermarket and kept losing items. He is getting frustrated and taking it out on his wife and grand children, especially when he cannot read them a story. Fairy (2006) suggests that, for a process to commence a model of assessment is utilised and this model needs to be holistic in all aspects of patients' needs. Therefore, proper attention needs to be paid to the biological, psychological and social situations of the patient. It is important that the health assessment includes a thorough examination of the patient's ' activities of daily living' (Department of Health, 2002) . The twelve activities of daily living (ADLs) are communication, safe environment,

breathing, eating and drinking, elimination, washing and dressing, temperature, death and dying, mobility, working and playing, sexuality and sleep (Roper, Logan and Tierney model 1996). It is important to remember that all ADLs about individual life activities are interlinked and when one or more activity is affected due to illness, then most of the activities can become compromised. (Montaque el at 2005)The ADLs that are appropriate to assess Carl's needs are communication, breathing, eating and drinking, elimination, working and playing, safe environment and mobility,. The rest are important but not needed by Carl at the moment. Communication is essential for building a nurse – patient relationship (Sulla and Dallas 2005). For Carl, due to his state of forgetfulness, memory lost, out of character behaviour and frustration especially when he cannot read for his grandchildren, he may need referral to see opticians for eye check, and the behavioural therapist. Breathing is the first sign every health professional look for during patient assessment. Being able to breathe normally ensures that we can attempt other activities without any difficulties, for example running. For Carl his breathing may be affected by smoking for 20 pack years as well as his higher BMI both of which can cause shortness of breath. Referral to the NHS stop smoking service or radiographs for chest x-ray to check for infection will be essential. The use of early warning score (EWAS) tool will check all vital signs including the use of peak flow meter to check the lungs. A nebuliser may be considered. Ensuring adequate hydration and nutrition is essential if health is to be maintained and in Carl's case he has a higher BMI and he is in a state of confusion which may relate to fluid intake. Waugh and Grant (2006) suggests that dehydration as well as urinary tract

infection (UTI) can contribute to his state of confusion. The (MUST) tool can be used to assess nutrition levels and the (MMSE) tool for assessment of possible dementia (NICE 2012). Referrals can be made by nurses for Carl to see the dietician and also physiotherapist for physical exercise regime. Elimination is very important, and in Carl's situation review of his medication will be important since some may cause constipation or frequent urination. Higher BMI as a result of being obese as well as chronic chest problems can cause urinary incontinence (Kamm, 1998). Also in males, disease of the prostate may lead to the obstruction of the flow of urine (Abrams el at 2002). The Bristol stool chart can be used to assess constipation, the dipstick tool can also be used to check for infection or UTI and the fluid balance chart can be use to assess for dehydration by checking input over output. Mobility can be a problem since Carl has a history of forgetfulness and the need to urinate frequently due to some of his medication. Fear of not being able to find his way home, being incontinent in public and even fear of falling in a new environment may stop him from mobilising. Human assistance will be needed and the fall assessment tool would appraise his risk of a fall. Carl may need an assessment on working and playing since he is retired, has memory impairment and get upset when he cannot read for his grand children. Referral to psychologists and also arranging for Carl to meet with other people in day centres may be an option, if Carl agrees. It will be important to assess these areas when talking to Carl to establish possible needs (Brooker and Nichol 2003). According to the RCN (2004), nurses will always need an assessment tool to guide their daily nursing practice in terms of their professional accountability and responsibility. In Carl's case the Mini-

Mental State Examination (MMSE) will be essential for his current needs. The rationale for using this assessment tool is that it is found to be appropriate for assessing elderly people with Dementia by the practice placement. The multi professional team also found the tool reliable and considered it to meet the patient’s needs and ensured clinical effectiveness and evaluation. The MMMSE tool is the most commonly used instrument for screening cognitive function. The tool has a series of questions that tests a number of different mental abilities, including a person's memory, attention, language, orientation, calculation, registration, recall, visual construction and the ability to follow a three step command each of which scores points if answered correctly (Folstein 1975). In general, scores of 27 or above (out of 30) are considered normal, 21-24 as mild, 10-20 as moderate and less than 10 as severe impairment (Folstein 1975). He continuo that, a score below this does not always mean that a person has dementia or delirium but their mental abilities might be impaired. The MMSE was found to be highly reliable in detecting cognitive impairment and is now used around the world and in many clinical settings and by General Practioners (Hunte 2004). Thirty seven studies were carried out over ten years using the MMSE to show progress of patients with dementia and an average change of score was3. 3 points, Tom burgh and McIntyre (1992). The MMSE has its limitations , it is found that cognitive performance as measured by the MMSE varies within population by age and education, with lower scores for oldest age groups and those with less education and it is insensitive to very mild cognitive decline particularly in highly educated individuals, (Miller et al, 1997). To ensure a successful assessment, quiet and pleasant environment is needed. Questions needs to

be spoken clearly and words needs to be repeated for clarity. Proper communication has to take place to ensure Carl understands what is about to happen and consent for it. Questions such as what is your name can be asked due to his state of confusion to establish a conversation (Stevenson 2006). In orientation, Carl was asked to give the year, season, date, month and the day (1 point for each correct answer) and he was also asked to tell where he lives, state, country, town, hospital and floor (1 point for each correct answer). Under registration three objects were mentioned, apple, door, table and Carl were asked to repeat them (1 point for each correct answer). In attention and calculation, Carl was asked to subtract 7 from 100 then repeat from result and continued five times for example 100, 93, 86, 79, 65 (I point for each correct answer). Recall, Carl was asked for the three objects he has learned earlier (one point for each correct answer). Under language, Carl was ask to name a pencil and a watch (2 points), again he was ask to repeat no, if's, ands or buts(2 points). He was further asked to follow a 3 stage commands ' take a paper in your right hand, fold it in half, and put it on the table (3 points). He was asked to read and obey instructions such as ' close your eyes (1 point), write a sentence (1 point). Finally, he was asked to copy a drawing of intersecting pentagons (1 point) (REF). Carl's overall score was 11/30. He scored 5/9 on language, 0/3 on recall, 3/10 on orientation, 1/3 on registration, 2/5 on attention and he scored 0/1 on copying. Carl's MMSE result is under 20 reflecting a poor cognitive function and memory problems. His needs require a holistic nursing care based on physical, psychological, social, and spiritual needs (Department of Health 2002). For example referral to physiotherapist for regular physical activities

such as walking will help maintain good weight. Also referral to the occupational therapist to arrange for cognitive behavioural therapist will be essential since they are known to treat people with depression associated with dementia (Small 2002). In the long term, implying cognitive stimulation will help. This may involve his family, by talking to him and allowing him to discuss his feelings and thoughts, and introduce recreational activities such as problem solving activities that may enhance his quality of life and wellbeing (Piteroni and Vaspe 2000). Also referral to the reminiscence therapy is known to help people with mild to moderate dementia. In conclusion, this essay has looked at the importance of needs assessment and how it plays a major role in the prevention and administration of quality care. It has looked at how different tools can be used to aid in patient needs and provide satisfactory result for both patient and professionals. This will help greatly in the future when making patient assessment.