

Based on the twelve activities of living, assess the patients support during admi...



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This essay is based on the twelve activities of living, recommended by Nancy Roper, Winifred Logan and Alison Tierney. Every patient has an assessment done when they are first admitted into hospital, so that the nursing staff and other members of the multi-disciplinary team can access the patient's medical records, at any time. Assessment is the first component of the nursing process, there are three other areas to the patient's assessment during the admission, they are, planning, implementation and evaluation.

The process is an ongoing and continuous activity using a problem-solving framework. during the patient's stay whilst they are in hospital. I will be using a framework of care that will help me assess my patient holistically and is used within my hospital's local trust. The most used model in nursing is the Roper, Logan and Tierney model of nursing (Roper, Logan and Tierney 1994).

It reflects on the 12 activities of living (AL) and is based on the patient's needs whilst in hospital and in the community, other influencing factors I have to take into consideration in the assessment are the physical, psychological, environmental, socio-cultural and politico economic needs in order for an holistic approach to the assessment of my patient. However for the purpose of this essay I shall concentrate on the physical and psychological factors My patient's name will be changed to Rachel during my essay so that I can comply with patient confidentiality and privacy (NMC 2002).

I have also left areas blank on the assessment form due to this. In the appendix there will be a copy of the assessment form completed. During the placement I had been asked to do an admission on a patient. The patient

arrived on the ward and I introduced myself to the patient as the student nurse. I thought it would be a good idea if the patient were shown to her bed space on arrival so that she felt safe and was settled into an unfamiliar environment, Once we reached her bed space, Rachel got up out of the wheel chair that she had been brought up onto the ward in.

She transferred safely. I noticed that there was not any problem with her mobility. (Provisions and use of work equipment regulations 1992) I feel that the safety of the patient is very important whilst under the care of any accountable healthcare professional. (N. M. C Code of professional conduct,) “ As a registered nurse, you must act to identify and minimise the risk to patients and clients”. Once the patient was settled onto the ward I returned to the nurse’s station to take a hand over from the escort nurse.

I thought it would be best if the hand over was taken somewhere quiet and private, as I wanted to keep my patients medical details confidential. (The office of civil rights/health insurance portability and accountability act 1996, OCR/HIPPA) my ward mentor the escort nurse and myself went into the staff room where it is private and quiet, and the hand over started. We were told that the patient’s name was Rachel and she is a thirty-five year old lady. She has come into hospital to have a bilateral breast reduction. Rachel was admitted two days previously but was sent to a medical ward, due to a shortage of surgical beds.

She is due for surgery after the weekend, but she has come into hospital as an elective admission. Her consultant felt she needed monitoring before she is eligible to go in to theatres. “ When assessing a patients blood pressure

for the first time, take measurements in both arms, when a patient is due for surgery monitor their observations on a regular basis, before and after, an example of this would be documented on an observation chart as “ pre” and “ post” observations” (Lippincott Williams and Wilkins Medical surgical nursing 2004)

I collected the equipment that I would need to do an accurate set of observations on my patient, such as, a blood pressure monitor, saturation monitor and a thermometer. I approached my patient and explained in a friendly manor that I would need to take a set of observations, and then ask her some questions so that I could conduct an accurate assessment that would be documented in her admission folder. I took all observations and explained that her blood pressure was that of a normal range of 110/75. (Ted Smart The human body 2001) Also her temperature was 36. celsius, and her saturation reading was 100% on air. I recorded the observations in the chart. I then asked Rachel if I could wiegh her and record her hieght so I could get her BMII told Rachel that I would now need to ask her some questions. Rachel told me that I was a very pleasant and a well-mannered nurse and that I was very easy to get on with. “ Communication occurs on two levels, the relationship level and the content level, the relationship level refers to how, the two participants are bound to each other.

The content level refers to words, language and information” (Watzlawick, P, Beavin, J and Jackson, D. D The Pragmatics of human communication 1967)

As Rachel was dictating to me her personal and medical details, I monitored her visually ” a more accurate observation is obtained if the patient if the patient is unaware that their respiration’s are being counted”. (Nicol, M, <https://assignbuster.com/based-on-the-twelve-activities-of-living-assess-the-patients-support-during-admission-essay-sample/>

Bavin, C, Bedford-Turner, S, Cronin, P, Rawlings-Anderson, K, Essential Nursing Skills 2004) and noticed that there was no problems regarding her respiratory rate or breathing. Normal adult respiratory rate of 12 to 20 breaths/a minute, with some variations depending on the patients age” (Lippincott, Williams, Wilkins, Portable RN 2005) I asked Rachel about her eating and drinking routine and she informed me that she drank regular and eats three square meals a day, she told me that she has two young children and that she would sometimes go with out a meal,” Eating and drinking is not just a physical act but also it is the activity of obtaining and preparing food. ” (Roper, Logan, Tierney Model in action 1991) as she did not want her children to go without.

Rachel told me that sometime she liked to go out to restaurants and eat out, but could not do this all the time, as her and her husband could not afford it. “ The impact of work on our lives does not end at the office or factory door, it spills over into many aspects of our lives such as our private or personal lives” (Moore S, Sociology alive third addition 2001) I thought it would be good to ask Rachel about elimination regarding her toilet routine, her told me that she opens her bowels daily and has not got ant problems with passing water, I recorded this into the admission notes.

It is important for us as health care professionals to monitor our patient’s elimination and bowel movements. For Rachel eliminating is important, as she will need to be nil by mouth and have an empty bladder and an empty abdomen when she is admitted to theatres for her operation. Also because Rachel would be given a lot of anaesthetic and analgesia which could make her constipated “ Eliminating is an essential activity of living in which <https://assignbuster.com/based-on-the-twelve-activities-of-living-assess-the-patients-support-during-admission-essay-sample/>

problems may cause enormous inconvenience, pain, embarrassment and misery” (Roper, Logan, Tierney Model in action 1991)

Rachel told me that she was feeling very hot, and said that the bay she was in was very warm. I took Rachel’s temperature again, and explained to her it was still in normal range. “ Temperature: a degree of heat hot or cold in an environment or on a person. ” (The Collins English Dictionary 2005) I asked Rachel if she would like me to help her take off her jumper, but she declined and said she could manage it herself and joked to me that “ I have not lost my independence”.

I then asked Rachel if she had any problems with her washing and dressing in the morning. She said that she has no problem in this area and would not need any assistance. I documented in the admission pack that Rachel has not got any problems with her personal cleansing and dressing “ The science of health and study and the study of ways of preserving it, particularly by promoting cleanliness” (Oxford dictionary for nurses fifth edition 2005) I asked Rachel about the operation that she was going to have after the weekend.

Rachel told me that she was having a Bilateral breast reduction because she feels that her breast size is too large and felt depressed because they made her feel “ ugly” and self conscious, I told Rachel that she should not feel ugly and low about herself. “ All damage to the body is first and foremost damage to the self and there is no really good treatment which does not take into account the primary necessity for healing and establishing the ego, for

making the self picture whole again. " (Chapman. C Sociology for nursing 1982) Next I asked Rachel if she any problems regarding her sleeping habits.

She told me that she sleeps eight hours a night and would not wish to be written up and sleeping tablets on her hospital drug chart. (Complying with the medicines drug act 1968) I complied with Rachel's wishes, and documented on the admission chart that she wished not to have any sedation at night times. Also she feels most comfortable sleeping in a bed rather than a chair. I feel that by listening to the needs of my patient I could build up a rapport and a healthy, nurse/patient relationship. Also by agreeing with Rachel's choice not to have medication I was giving her the right to her own autonomy.

Once I had finished the assessment on Rachel I offered her a hot drink and something to eat as she told me that due to answering all my questions she felt hungry. I then made sure Rachel was comfortable before I returned to the nursing station to hand over all my findings to the nurse in charge. Rachel was referred to the breast care nurse, because it would be good nursing practice to refer Rachel so she would get the specialist nursing needed. I feel that by using the Roper Logan and Tierney model when admitting my patient to the ward that it helped guide me with the questions in which I should ask Rachel.

Also to find out the information that I would need for Rachel's stay at hospital in order to get a holistic approach, and to make sure that all Rachel's needs were identified and met. I feel that the twelve activities of living were very helpful when conducting an assessment on a patient in a

care environment and some of the activities where a lot easy to meet then others and they are all very important but in many different ways. I feel that by using the model correctly then the holistic approach will be met and all of the needs identified. Patient Profile

For the purpose of this essay and in accordance with the NMC code of conduct, My patient will be given a pseudonym to maintain her confidentiality and privacy. My patient's name will be changed to Rachel during this essay. She is a 35-year-old woman who lives with her husband and their two boys who are two and four. She has come in to hospital for a bilateral breast reduction to reduce her breasts from cup size LL to DD because she felt they made her look ugly and was very self-conscious of them, Also she was having trouble with her back because of the weight of her breasts.