# Defining assessment and the importance of assessment nursing essay

" Assessment is the first stage of the nursing process, in which data about the patients health status is collected and from which a nursing care plan can be devised" (Oxford dictionary for Nurses 2008)

## Introduction

## What assignment is about.

## Define assessment and the importance of assessment within the nursing process.

As found in the work of Barrett et al assessment is a procedure in which the nurse will need to gather information from questions that are asked during the assessment process and on-going observations. This gathered information provides a comprehensive description of the patient. It focuses on the patient's needs at that moment in time and possible needs that may need to be addressed in the future. It's a fair and accurate account of the individual and their life. Overall it's a way of delving deeper into a patient's illness and preventing more problems from arising.

The gathering of information for the assessment can pose problems if the patient is suffering from an injury or illness which can affect their speech. Thus meaning that the process is delayed and any time constrictions which are laid down during the assessment process are affected. To resolve this problem nurses use past medical history to complete the assessment. Although this may mean that this information is not up to date as the patient's needs may have differed from the last time they used medical services.

Yura and walsh (1967) initialised the importance of the nursing process. It was seen as a problem solving approach to nursing care. The nursing process provides a methodical approach to examine patient's problems and looks at ways of resolving these problems. The nursing process can be applied to all nursing settings, although the way in which it can be applied depends on patient needs and the environment at that time. It consists of four stages and is cyclical in nature.

Assessment is the first stage of the nursing process and enables the nurse to undertake a holistic assessment of the patient considering all of the individuals needs in order to identify their problems.

Planning is the second stage and is the process that the nurse and patient set achievable goals and plan how they can be achieved. The goals may be short term, for example, nil by mouth prior to surgery or long term, for example, what implementations will be in place for discharge.

Implementation is the third stage of the process where clear direction is given about what is to be done, when it is to be done and by whom. This gives the patient a clear picture of the care and encourages them to take part.

Evaluation is the final stage and is the most important of the whole process as it informs the patient whether goals have been achieved or are being achieved. At this stage some problems may be noted and so the cycle must start again with assessment.

Newson suggests that for the process to commence a model of assessment is utilised. This model needs to be holistic in all aspects of the patients needs. Therefore attention needs to be paid to the biological, psychological and social situations of the patient. Roper Logan Tierney's twelve activities of daily living is one if the more common models that are used by healthcare professionals.

The patient will be asked questions, during the assessment process, surrounding the twelve activities and it will be established as to how the patient usual does these tasks. It acts as a guide and ensures that all areas of the assessment process are covered (Dougherty et al).

## Skills required.

National Institute for Health and Clinical Excellence (2007) suggests that that good communication between healthcare professionals and patients is essential. It should be supported by evidence-based written information tailored to the patient's needs. Treatment and care, and the information patients are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

If the patient agrees, carers and relatives should have the opportunity to be involved in decisions about treatment and care. Carers and relatives should also be given the information and support they need.

Adult patients in acute hospital settings, including patients in the emergency department for whom a clinical decision to admit has been made, should have: physiological observations recorded at the time of their admission or

initial assessment a clear written monitoring plan that specifies which physiological observations should be recorded and how often. The plan should take account of the: patient's diagnosis presence of comorbidities agreed treatment plan. Physiological observations should be recorded and acted upon by staff who have been trained to undertake these procedures and understand their clinical relevance. Physiological track and trigger systems should be used to monitor all adult patients in acute hospital settings. Physiological observations should be monitored at least every 12 hours, unless a decision has been made at a senior level to increase or decrease this frequency for an individual patient. The frequency of monitoring should increase if abnormal physiology is detected, as outlined in the recommendation on graded response strategy. Staff caring for patients in acute hospital settings should have competencies in monitoring, measurement, interpretation and prompt response to the acutely ill patient appropriate to the level of care they are providing. Education and training should be provided to ensure staff have these competencies, and they should be assessed to ensure they can demonstrate them.

The nurse needs to adopt various skills in order for the assessment to be carried out appropriately as suggested by Barrett et al. Some of the skills may become second nature to the nurse and others will be developed over time.

Visual observational skills are required to note the patient's general wellbeing for example, the colour of their skin or how well they have been caring for themselves.

Sense of smell is needed to decide if the patient has stale breath or whether they have been drinking alcohol or smoking.

Sense of touch should be used to feel if the patient is hot or cold or whether their skin is clammy or dry.

Sense of hearing is required to detect if the patient has noisy breathing or whether they have slurred speech.

Measuring skills to record accurate information from the patient i. e. how much fluid intake the patient has had or even how much they weigh. The nurse must also be able to interpret the results of the measurements i. e. what do they mean, how serious are they and what is normal?

Interviewing skills are also required and is fundamental. The nurse must learn to empathise and be must be able to listen and take in information.

Communication skills are required as the nurse needs to be able to talk and listen to patients, carers, relatives and the multi-disciplinary team. Must also have the ability to refer and report information to others, ability to seek advice, establish a relationship, trust and confidentiality.

Record keeping and documentation skills needed to write and record information accurately and to be truthful and IT literate.

Overall the nurse must work in a professional manner and abide by the policies set out by the trust, NMC (2002) code of professional conduct and government legislation. It also suggests that the recording of information is

essential and could lead to potential consequences for the individual if their standards are not met.

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 wrong treatment.

## Primary and secondary sources of information. How are these used to inform the assessment. Objective and subjective information. (625 words)

To collect all the relevant information different sources can be used. The main (primary) source would be from the patient or advocate and secondary sources would be from the patient's relatives, patient notes or any documentation on the patient file.

Objective data is information that is measurable such as pulse, blood pressure, respirations and weight. Subjective data is descriptive information that forms an opinion and is the sort of information that can be gained by asking someone ' How do they feel?' or ' What is worrying you?'. It is also information that be gathered by the nurse and their perceptions at the time of the assessment. (Barett et al 2009)

Observed information is information that can be gathered whilst observing the patient. This might include the condition of the patient's skin or their ability to walk and move. Observing the patient will also give you some information about how well they can communicate.

Clinical information: this might include vital signs, medical diagnosis, blood results, X-Ray or scan results. (Barrett et al 2009)

All this information will be considered and recorded in the patient notes. Ideally the nurse should record their findings in a non-judgemental way and consideration needs to be paid to other members of the multi-disciplinary team who may need to see the notes.

## Assessment tool – one that i'm interested in and understand. Describe how the tool may support the assessment process and the benefits of the tool. Say why they are valuable – universal, scientific approach. (625 words)

Assessment tools are used by all healthcare practitioners. The aim of the tool is to help pick out certain information which may not have been picked up during initial observations of the patient. Most assessment tools have a scoring system, the scores are added up to give an overall score. Depending on that score would depend on the care for the patient or medical intervention. The tool should complete the overall assessment process and will depend on the needs of the patient and the type of clinical setting to which tool is used as found in the work of (Brooker et al).

Early warning scoring systems aim to predict which patients are in need, allow preventive management, and determine who might need a step up to higher levels of care. It is as important to be able to identify patients for whom such care will be futile to give enough time for appropriate discussions to take place with the patient and family. The number of patients who can be accommodated in the intensive care and high dependency units is limited.

Selecting the patients who may benefit from critical care is, therefore, crucial.

A bewildering array of methods to quantify the severity illness are available. The first was developed in Australia, and several other systems have since been developed around the world, incorporating many physiological variables and trigger algorithms.

Early warning systems rely on observations of the physiological status of the patient, reflecting a clinical evaluation of oxygen delivery and organ perfusion. The rationale for choosing specific physiological variables is based on studies of the relation between physiological abnormalities and mortality. This concept is not new, but ensures that small deviations from the norm are noticed. Rather than wait for an obvious change in an individual variable the trend over time can be objectively observed. It also enables the response to primary interventions to be monitored. However, they do not predict outcome.

Of all the parameters, respiratory rate is thought to be the most sensitive indicator of a patient's physiological wellbeing. This is logical because it reflects not only respiratory function but cardiovascular upset for example, pulmonary oedema and metabolic imbalance as seen in diabetic ketoacidosis.

The modified early warning scores system is an updated version of the early warning scores system, adding two parameters, a patient's urine output and deviations from their normal blood pressure. If the total score exceeds a

predefined cut-off this triggers immediate actions, including calls for experienced senior clinical advice and critical care outreach assessment.

Physiological observations should be monitored at least every 12 hours unless a decision has been made at a senior level to increase or decrease this frequency for an individual patient. Monitoring should be more frequent if abnormal physiology is seen.

In the UK the early warning scores system and the modified system trigger a call to the patient's own team or an intensive care unit outreach team. The aim of outreach teams is to monitor and help in the management of acute patients and provide support and advice about critical care. The UK Department of Health and others use such teams to try to avert admissions to critical care, as well as to help in their discharge. Nurses need to familiarise themselves not just with local early warning scores system but also with local outreach services because they are there to help to make important early decisions.

The tool has had some criticism and has been suggested that it may not work. It has been said that nurses should be able to use their nursing intuition to assess whether a patient is deteriorating. The student British Medicial Journal would argue that the Early Warning Score does work and recent research found that 84% of patients had documented observations of clinical deterioration within eight hours of cardiopulmonary arrest. On these grounds it is essential that the tool works to help detect early signs of deterioration in critically ill patients.

## Positive professional relationship. Talk about the importance of communication, appropriate behaviour, code of conduct, confidentiality, diversity all things that build up a positive relationship. Barriers – disabilities, language barriers, cultural barriers. (625 words)

The nurse-patient relationship should be started from the initial assessment. This is the first stage of the nursing process and therefore any issues affecting the patient can be identified. The relationship relies on specific components being in place including rapport, empathy, genuineness, warmth and positive regard.

Castledine (2004) argues that the nurse-patient relationship is extremely important within the healthcare setting as it's helps the patient to make informed decisions, it avoids isolation and de-humanisation, acts as an advocate for vulnerable patients, helps with the patient assessment and problem solving, helps patient undertake, or carry out for them, activities of daily living and human needs, teach and promote health education and learn about new ways of nursing and caring for people in a changing world.

In nursing, the use of language must be appropriate to the patient and be clear, free from jargon and encourage feedback. We want to find out not only patient's immediate medical symptoms but also their nursing history, including their strengths, weaknesses and ways that they have adapted and coped with their life and health problems. Castledine (2002)

Peplau (1998) emphasises the importance of the nurse as a skilled communicator, using both verbal and non verbal levels to develop their relationship with the patient.

Members of the public cannot always see the difference between a student nurse and someone who is qualified and registered with the NMC . That is why a student's conduct is important in upholding the reputation of the professions, both when studying and in personal life. (CAIPE 2010)

An appropriate environment needs to be established to ensure privacy, dignity and patient comfort. This will help build up a rapport with the patient and allow them to feel more at ease in an unusual environment. (While 2002)

Empathy means that the nurse takes on the patients feelings in order to understand them, but does not let the experience affect how the nurse is going to help the individual. Too much sympathy for a patient may result in the nurse crossing boundaries which allow the patient and nurse to engage in a therapeutic caring relationship as argued by Castledine (2004)

Genuineness and trusting relationships are instrumental in reducing anxiety and helping patients to cope with pain. Nurses can help to build a trusting relationship by listening to the patient, believing the patients pain experience, acting as a patient advocate and providing patients with appropriate physical and emotional support. Kenworthy et al (2002) writes that positive regard refers to the idea that there should be no conditions to acceptance and care for the people. People should be accepted for who they are no matter what their background is. This is extremely important as nurses because they care for people from all walks of life from rich to poor.

The Nursing and Midwifery Council (2002) recognises the importance of the nurse-patient relationship in the code of professional conduct. Registered

nurses are responsible for ensuring that they safeguard the interests of their

patients and develop and maintain appropriate relationships.

## Conclusion – sum up the assignment.

The nurse-patient relationship is based on the patient's need for care,

assistance and guidance. It is a relationship established solely to meet the

patients needs and is therefore therapeutic in nature.