

Describing the assessment process for hospital ward patient nursing essay



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The purpose of this assignment is to describe how a nurse assesses a patient admitted to a hospital ward. It will discuss the history of the patient, any pre-existing medical conditions and the reason they were admitted to the ward. It will also describe the hospital setting, the nursing model used, the risk assessment tools and the information collected from the assessment including the needs identified and what can be and will be done.

For the purpose of this assignment the patient, healthcare professionals and the trust must remain anonymous, and will be referred to by pseudonyms. This is in accordance with the Nursing and Midwifery Council (NMC) code, where it clearly states “ you must respect peoples right to confidentiality” (NMC Code, 2008). The patient receiving assessment and care will be referred to as Mrs Ethel Morris.

Mrs Ethel Morris was admitted to an orthopaedic trauma ward within the North West. Orthopaedics is the correcting of deformities to the skeletal joints and bones, which have been caused by damage or disease (McFerran, 2008).

The ward consisted of many staff, including, nurses, health care assistants, a house officer, medical consultants and physiotherapists. It had three bays, 2 being female, with 8 beds in each and one ten bedded male bay. Also, there were 4 side rooms for patients that needed to be isolated.

This was an acute setting with various Orthopaedic conditions, including fractures of all types. The ward admits patients twenty-four hours a day from Accident and Emergency (A&E) and transfers from other hospitals. Many of

the patients admitted have pre-existing medical conditions, which have to be taken into account alongside their fractures.

Ethel was an 82-year-old lady who had fallen whilst she was out shopping with her daughter. She usually walked with a walking stick to aid her balance, but with a previous history of dementia she had forgotten it.

Dementia is a progressive deterioration of the brain, caused by structural and chemical changes within the brain. Symptoms include, memory loss, disorientation and changes in personality (Ouldred, 2007).

Ethel's friend had called an ambulance immediately after the fall, and she was admitted to the ward through accident and emergency.

Ethel's fall had resulted in a fracture to the neck of femur in her left leg.

Marieb (1998) states that the femur is the strongest and largest bone in the body. It consists of a ball, which is known as the head of the femur, which is carried on the neck of femur to the long bone. The neck is the weakest part of the femur.

Elderly people are more at risk of falls as their muscles become weaker they become less flexible. This then interferes with their movement and balance, they become more inactive and this increases the risk of falls. (Skelton et al, 1999)

Ethel also has osteoporosis, which may have contributed to her fracture.

Liscum (1992) states this is the formation of the bone having decreased.

Elderly women suffering from osteoporosis, who subsequently sustain a fractured neck of femur, face a fifty percent chance of not walking again.

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Ethel appeared confused when she arrived on the ward, not knowing how she had come to be in hospital, apart from being aware of the pain and discomfort she was suffering with her hip. The nursing staff reminded Ethel what had happened and checked her drug kardex immediately for pain relief. The doctor who had seen Ethel in A&E had written her up for 5ml of oromorph every three hours to control the pain. As oromorph is a controlled drug the nurse checked the dosage with another registered nurse and give it to Ethel orally.

Once Ethel was comfortable, the nurse in charge of the bay began the nursing assessment.

An assessment is the collection of information from an individual, to establish their needs and develop a clear prospective of their situation. The nursing process relies upon complete and thorough assessments to be a success. A key nursing skill is observing a patient, using all five senses, from listening to gain information, to touching them, assessing their temperature and the condition of their skin (Brooker and Waugh, 2007)

Holland et al (2008) also states that an assessment identifies the priority amongst the problems. Data can be collected in a number of different ways, from observing a patient, communicating with them and through their clinical notes. Collection of information can also be made through a secondary source (a relative), if, for example, the primary source (the patient) was unconscious.

A named nurse approach was used on the ward; this provides individualised care for the patient from admission to the point of discharge. Named nursing
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has been developed from primary nursing and is very closely connected to team nursing. (Dawe, 2008)

The ward follows a philosophy of care to meet individual needs. Providing patient centred care, meeting individual needs whilst respecting their privacy, dignity, religious and cultural beliefs. They strive to provide high quality care and aim to maximise the potential of individuals to adapt and cope with their conditions.

The ward's philosophy reflects the National Service Frameworks (NSFs) quality of care. NSFs are in place to improve care in twelve specific areas, including blood pressure, diabetes and mental health. The standards have been implemented nationally and they have all been set certain time scales. (Department of Health (DOH), 2008)

The ward uses most of the NSFs depending on which patient they are dealing with. In Ethel's case the main ones being blood pressure and older people, which has eight different standards of its own.

The nurse firstly recorded Ethel's clinical observations, and her saturations appeared to be very low at only 89%. Oxygen saturations are monitored through an electronic device called a pulse oximeter. This reads the oxygen levels of haemoglobin in the arteries and is updated with each pulse (Jevon, 2000).

The nurse immediately put her on four litres of oxygen through a nose cannula. A Nose cannula is two small plastic tubes that are inserted into each nostril to administer oxygen. This allows room air to be breathed in at

the same time and is secured by tubing over the ears, which fits onto the oxygen cylinder (Brooker and Waugh, 2007).

The nurse carried out Ethel's assessment by her bedside with the curtains drawn to respect her privacy. As Ethel had dementia her daughter was present for the assessment, to confirm details and help with the process.

Barrett et al (2009) states that nurses who carry out disorganized, incomplete assessments, may fail to notice a major concern, or recognize an underlying problem.

Nursing models are used in the assessment process in most care settings. They are in place to establish the information that is required, ways it can be gathered for the best results, and the detail that is likely to be more helpful. (Aggleton and Chalmers, 2000)

Roper et al (2000) says that models are used to help organize thinking by creating theory. They are global views that have been summarised into systems.

There are many different Nursing Models used in clinical settings from Orem's self care model to Henderson's model of nursing. Nursing models are used to provide a distinctive framework, to highlight what the patients needs are (Fawcett, 1989).

The nursing model used on this ward was Roper Logan and Tierney, Activities of living model. Roper et al (1996) activities of living consists of twelve activities that ensure survival, these are, maintaining a safe environment, communicating, breathing, eating and drinking, eliminating, <https://assignbuster.com/describing-the-assessment-process-for-hospital-ward-patient-nursing-essay/>

personal cleansing and dressing, controlling of body temperature, mobilising, working and playing, expressing sexuality, sleeping and dying. These activities are all as important as each other and one cannot be done without another. The impact of illness will affect more than one of these activities.

Roper et al (2000) activities of living was first written in 1980 for nursing practice to be introduced to students. At this time there were five concepts in the model that included activities of living, lifespan and individuality in living. The model became the United Kingdom's most popular model and was also widely used throughout Europe.

The nurse used a number of risk assessment tools when assessing Ethel. These were, the malnutrition universal screening tool (MUST), waterlow score, falls risk assessment score for the elderly (FRASE) and the Abbey pain scale. The MUST tool is a nutritional screening tool that recognises over nutrition (obesity) and under nutrition (BAPEN, 2008).

The MUST tool was developed so nutritional care would improve in all care settings, by the malnutrition advisory group (MAG) of BAPEN. This tool can be applied to all adult patients, even those who are bed bound (BAPEN, 2008).

As a result of the MUST screening tool, Ethel was commenced on a fluid balance chart. This measures the quantity of liquid intake, including Intravenous (IV) fluids and drinks, against the total urine output. Also to be monitored was Ethel's food intake, this was to be done on a food chart. This needed updating after every mealtime to show how much was being eaten at different times.

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The waterlow score is to determine whether a patient is at risk of developing a pressure ulcer (Waterlow, 2005).

This tool uses a scoring system, based on patient's data. The categories include skin type, age, and continence. (Thompson, 2005) Ethel's score was sixteen and she was at high-risk of pressure sores, this was due to her age and mobility.

Waterlow (2005) first designed this tool for students use in 1985. It is the most frequent risk assessment tool in the United Kingdom (UK), and is used throughout hospitals, nursing homes and within the community. Pressure ulcers are most common in people with bony surfaces, thin skin and an unhealthy diet.

Ethel was found to be a high risk of developing a pressure sore, as she was immobile and had tissue paper skin. The nurse commenced her on a turns chart so she would be rolled or moved every three hours to check and relieve her pressure areas. Also a pressure-relieving mattress was ordered for Ethel, this alternates the body areas under pressure by rotating the air throughout the mattress. (Collins, 2004)

The FRASE assessment tool is to assess if a patient is at risk of a fall, taking into account their history and their current state. (Bolton NHS, 2003)

Connard developed a fall risk assessment for the elderly in 1996; this was then adapted into a hybrid tool, known as the FRASE tool. It is in similar context to the waterlow score as they both use a points scale to assess the patient's level of vulnerability (Kinn and Hood, 2001)

The nurse carrying out the assessment began Ethel on a falls care plan, as she was at high-risk from having another fall. A member of staff was to update the care plan each day, noting any unsteadiness or falls. This was going to play a greater part after Ethel's operation, as for the time being she was bed bound.

The Abbey pain scale was developed in Australia to assess patient's pain levels. It was used for individuals who had trouble communicating effectively and who suffered from dementia (Turner-stokes and Higgins, 2007).

Abbey (2004) researched and developed the abbey pain scale between 1997 and 2002, and wanted it to be a straightforward and effective tool, used by all health care staff. It consisted of six scales to measure pain including physiological changes to changes in body language.

Ethel's score was seven and her pain level was acute to chronic during the assessment. The nurse had previously administered 5ml of Oromorph, and because of this the abbey scale was to be updated every hour to monitor the success of the pain relief.

During the assessment the nurse collected various information from Ethel, including objective and subjective data.

Newson (2008) states that objective data is information collected that can be measured such as temperature and blood pressure. The MUST tool was used to measure Ethel's weight, and other observations were recorded, including blood pressure which was 142 systolic and pulse of 84; these were all in satisfactory limits.

Any data collected outside the normal range would have been given an early warning score. A doctor and the outreach team need informing if a score totals three or above (Baines and Kanagasundaram, 2008).

Also collected was Ethel's details that included her, address, date of birth, and her medical history. This can be obtained through medical notes. as original records cannot be tampered with and all records made must be clear and accurate (NMC Code, 2008).

Subjective data is information that cannot be measured, for example, information that the patient has given about him or herself, or the nurse's insight on the patient (Newson, 2008). The nurse asked Ethel questions to gain this information, if she felt nauseas, or in pain and how she felt about what had happened. Also observed was Ethel's behaviour to see if she was agitated or frightened, closed body language showed she was as her arms were wrapped around herself. The nurse also looked at and noted the condition of her skin, nails and hair.

Due to Ethel's dementia she didn't understand very much of what was going on and didn't know how she had ended up on a hospital ward. Short-term memory is affected alongside some long-term memory loss. This affects the ability to communicate with people and can result in the patient asking the same question repeatedly (LEHR, 2006). The nurse had to keep reassuring Ethel about what had happened, how she ended up on the ward and what her plan was.

Communication is a key skill in nursing and it is an essential part in building the patient-nurse relationship. The nurse has to gain lots of information from <https://assignbuster.com/describing-the-assessment-process-for-hospital-ward-patient-nursing-essay/>

the patient so it is important to know whether there is a communication barrier, such as a hearing problem or if the patient cannot read or speak the same language. They may need to speak more loudly or slowly so the patient can lip-read (Holland et al 2008).

McCabe and Timmins, (2006) states that communication should be focused on the patient, rather than task centred. Listening, empathy and support are essential communication skills in nursing, but the main being to develop a relationship with the patient, and nurses should make time to spend with them.

Ethel's daughter stayed during the assessment process to help the nurse gain accurate information and communicate effectively with Ethel. The nurse had to speak slowly so she understood, and if she looked confused the nurse would reassure her and repeat the question. This process took a long time but it was necessary so Ethel could gain trust in the nurse. This made her feel more relaxed and comfortable as she could feel the warmth that had developed between them.

This assignment has shown how a nurse has an important role in assessing, planning and the implementation of patient care. It has shown that nurses have to obtain data by using a various number of different sources, from assessment tools to observing patients behaviour. The nurse must also use a nursing model to help complete full and accurate assessments of patients and their needs. If there is a communication barrier, nurses must be able to overcome it by using an interpreter or picture cards. The needs identified during the assessment process have to be implemented and care plans

introduced. Nurses then have a responsibility to keep regularly updating the care plans by re-assessing the patient on a regular basis.