Nursing Process

Step one: “Assessment”

Nurse Caring Concepts 1A
Week 5 September 13, 2004

Nursing Assessment

• Holistic data collection approach unique to nursing
• First step of nursing process but is ongoing & continuous throughout all steps of nursing process
• Completeness of assessment step directly related to accuracy all other nursing process steps

Purpose of Nursing Assessment

To gather data that:
• Allows nurse to make judgment about patient’s health state
• Will be used for rest of nursing process
• Determines patient’s:
  • Baseline
  • Normal function
  • Presence of (or risk for) dysfunction
  • Strengths
What is Nursing Assessment?

- Deliberate gathering of information about health needs to identify those that can be managed by nursing care
- Subjective & objective information, such as
  - Signs & symptoms (s/sx) of disease
  - Diagnostic test results
  - Client’s health practices
  - Past health/functional status
  - Coping patterns
  - Desire for higher level of wellness

Assessment Skills

1. Physical Examination
2. Interviewing
3. Observation
4. Intuition

Assessment Skills: Observation

- See
- Smell
- Hear
- Touch
- Taste?
Interviewing Phases

Preparatory
• Review medical record first
• Keep open mind & awareness of own issues
• Obtain/organize needed materials
• Provide privacy

Introductory
• Develop rapport, explain purpose, content, duration & confidentiality

Maintenance: Conducting interview

Concluding: Summarize & answer questions

Assessment Skills: Intuition

• Special way of “knowing”
• Based on experience & knowledge
• Used frequently by expert nurses
• A novice should never rely on intuition alone

Collect Data

• Types:
  – Subjective: symptoms
  – Objective: signs
• Data Sources
  – Primary: client
  – Secondary: all other sources
• Document accurately & report abnormal findings appropriately
Subjective vs Objective Data

- Patient comes to the ER because he cannot move his arm, stating, “It happened about an hour ago when my headache got worse. Now I am nauseated and dizzy.”
- The nurse takes his vital signs: T 99, P 100, R 28, BP 168/96, and observes that he cannot move his left arm and his face is flushed.

Validate Data

- Double-check:
  - Discrepancies in subjective/objective data
  - Discrepancies in patient’s statements
  - Abnormal findings inconsistent with other data
  - If data source unreliable
- Methods
  - Confirm accuracy of abnormal findings
  - Clarify with patient
  - Verify with colleague

Organize Data

- Cluster data to reveal patterns & identify client problems & strengths
- Frameworks provide systems for both assessing & clustering data
  - Body Systems Model (medical model)
    - Focuses on anatomical systems
  - Head to Toe Model
    - Systematic approach starting with head & progressing downward
Types of Nursing Assessments

Initial:
• Performed on entry to healthcare facility
• More comprehensive than subsequent assessments
• Often includes: health history, physical exam, psychosocial assessment

Focused:
• Limited to particular patient problem
• Only performed when comprehensive patient database already exists

Types of Nursing Assessments

Emergency:
• Life threatening situation
• Focus on rapid identification of problems
• Assessment follows ABCs

Time-Lapsed:
• Occurs after initial assessment & period of time has elapsed (3 months or more)
• Compares current status to previous baseline