Chapter 5

Assessment, Nursing Diagnosis, and Planning

Chapter 5

Lesson 5.1

Learning Objectives

Theory

1) Identify the purpose of assessment (data collection).
2) Discuss the three basic methods used to gather a patient database.
3) Differentiate objective data from subjective data.
4) Identify sources of data for the formulation of a patient database.

Clinical Practice

1) Collect assessment data for a patient and document it.

Assessment (Data Collection)

- During assessment, the nurse collects patient health data
- Data are gathered on specific topics, organized into a database, and documented
- LPN/LVNs may be asked to collect data as part of the assessment

Assessment (Data Collection) (cont'd)

- Approaches to assessment
  - Functional health patterns assessment as formulated by Mary Gordon
  - Focused assessment (focuses on a specific problem)
  - Basic needs assessment based on Maslow's hierarchy of basic needs

The Interview

- Based on gathering data—is not a social interaction
- Good communication essential
- Communication may be:
  - Verbal
  - Nonverbal, noting body posture, facial expressions, movement, and gestures

The Interview (cont'd)

- Consists of three basic stages
  - The opening, during which rapport is established with the patient
  - The body of the interview, during which necessary questions are presented
  - The closing, during which information is summarized

Chart Review

- Data collection tool; helps obtain information to interview patient or prepare for the day's patient assignment
- Chart review should include:
  - Face sheet and physician's orders
  - Nurses' notes (at least the past 24 hours)
  - Physicians' progress notes and history and physical examination
  - Medication administration record
  - Surgery operative report and pathology report
  - Diagnostic tests
  - Nursing admission history and assessment
  - Fall risk assessment and skin assessment
  - Nursing care plan or problem list

The Physical Examination

- Use techniques of inspection, auscultation, palpation, and percussion
- Carried out in a systematic manner
  - Head-to-toe examination
- Ongoing nursing data collection and examination focuses on the body systems in which there is a problem or potential problem

Head-to-Toe Assessment

- Initial observation
  - Breathing
  - How the patient is feeling
  - General appearance
  - Skin color
  - Affect

Head-to-Toe Assessment (cont'd)

- Head
  - Level of consciousness
    - Awake, alert, and oriented
  - Ability to communicate
    - Language spoken, any communication deficits
  - Mentation status
    - Able to comprehend, form thoughts
  - Appearance of the eyes
    - Pupil size, light reaction

Head-to-Toe Assessment (cont'd)

- Vital signs
  - Temperature
  - Pulse rate
    - Rhythm, strength, apical, radial
  - Respirations
    - Rate, pattern, depth; oxygen saturation
  - Blood pressure
    - Within normal limits
    - Compare with previous readings

Head-to-Toe Assessment (cont'd)

- Heart and lungs
  - Heart sounds, normal S_1-S_2
- Lungs
  - Lung sounds
  - Rales, wheezes, diminished breath sounds
- Abdomen
  - Shape, hardness, bowel sounds, last bowel movement, voiding, appetite, nausea

Head-to-Toe Assessment (cont'd)

- Extremities
  - Ability to move all extremities well
  - Ability to move within normal range
  - Skin turgor, color, temperature
  - Peripheral pulses
  - Edema

Head-to-Toe Assessment (cont'd)

- Tubes and equipment
  - Oxygen cannula, chest tubes
  - NG tubes, PEG tubes, jejunostomy tube
  - Urinary catheter
  - Type and amount of drainage
  - Dressings and drainage
  - Pulse oximeter
  - Traction devices
- Pain status

Assessment in Long-Term Care

- Extensive initial assessment performed when patient enters long-term care facility
- Reassessment at fixed intervals and as the patient's condition changes
- Physical assessment, health history, medication history, and a functional assessment performed

Assessment in Home Health Care

- Initial patient assessment in the home is usually performed by the RN
- The LPN/LVN, when doing private duty in a home, will need to perform daily assessments and maintain necessary documentation
- Changes found on assessment should be reported to the RN supervisor

Question 1

As part of an assessment, the nurse asks for information from the patient. This information is a subjective indication of illness perceived by the patient and is called a/an:

1) assessment.
2) symptom.
3) sign.
4) observation

Question 2

All of the following components can be found on the chart *except* the:

1) face sheet.
2) physician's order.
3) patient's history and physical.
4) patient's nurse assignment.

Question 3

Linda knows as part of her nursing assignment that she is to review and update the nursing care plan on her patients:

1) hourly.
2) every shift.
3) every 24 hours.
4) weekly.

Chapter 5

Lesson 5.2

Learning Objectives

Theory

5) Correlate patient problems with nursing diagnoses from the accepted North American Nursing Diagnosis Association–International (NANDA-I) list.

Clinical Practice

2) Analyze the data collected to determine patient needs.

3) Identify appropriate nursing diagnoses from the NANDA list for each assigned patient.

4) Prioritize the nursing diagnoses.

Analysis

- Database analyzed for cues that deviate from the norm
- Pieces of data are sorted
- Related data are grouped or clustered
- Missing data are identified
- Inferences are made regarding the patient's problems

Nursing Diagnosis

- A nursing diagnosis statement indicates the patient's actual health status or the risk of a problem developing, the causative or related factors, and specific defining characteristics (signs and symptoms)

Etiologic Factors

- Causes of the problem
- Signs are abnormalities that can be verified by repeat examination and are objective data
- Symptoms are data the patient has said are occurring that cannot be verified by examination; symptoms are subjective data

Defining Characteristics

- Characteristics (signs and symptoms) that must be present for a particular nursing diagnosis to be appropriate for that patient
- Supply the evidence that the nursing diagnosis is valid

Prioritization of Problems

- Problems ranked according to their importance
- Physiologic needs for basic survival take precedence (i.e., airway and circulation)
- After physiologic needs are met, safety problems take priority
- Every nurse must attempt to look at each patient holistically, keeping psychosocial needs in mind while working on physical problems

Nursing Diagnosis in Long-Term Care/Home Health Care

- Long-term care
  - LPN/LVN employed in a long-term care facility begins the care planning process when patient is admitted
  - The supervising RN determines appropriate nursing diagnoses, reviews the care plan, modifies it as needed, and finalizes it for the chart
- Home health care
  - Nursing diagnosis must include problems identified in the family's ability to cope with the illness or situation and teaching needs for care of the patient
  - Care plan encompasses patient and whole family

Question 4

Which one of the following sets of assessment data is most likely to be present with the nursing diagnosis Risk for infection?

1) Fever, dysuria, change in urine concentration, and urinary urgency
2) Abdominal pain, sore mouth, hyperactive bowel sounds, and leukopenia
3) Fatigue, electrocardiographic changes, dependent edema, and activity intolerance
4) Abdominal incision, decreased hemoglobin, and indwelling catheter present

Chapter 5

Lesson 5.3

Learning Objectives

Theory

6) Identify appropriate outcome criteria for selected nursing diagnoses.

7) Plan goals for each patient and write outcome criteria for the chosen nursing diagnoses.

Clinical Practice

5) Write specific goal/outcome statements.

6) Plan appropriate nursing interventions to assist the patient in attaining the goals/expected outcomes.

Planning: Goals and Expected Outcomes

- Goal: what is to be achieved by nursing intervention
- Short-term goals
  - Achievable within 7 to 10 days or before discharge
- Long-term goals
  - Take many weeks or months to achieve
  - Often relate to rehabilitation
- Expected outcome: statement of goal patient is to achieve as a result of nursing intervention

Interventions (Nursing Orders)

- Designed to alleviate problems and to achieve expected outcomes
- Should include giving medications and performing ordered treatments
- Individualized to the patient's needs

Documentation

- Planning not complete until plan is documented and is part of patient's medical record
- Plans constructed by LPN/LVNs must be reviewed by the RN before they are placed in the chart
- The plan of care should be reviewed and updated once every 24 hours

Question 5

A nurse has established expected outcomes for an assigned patient. The nurse carries out this important activity for the purpose of:

1) evaluating the occurrence of complications.
2) measuring quality of care.
3) measuring the effectiveness of nursing interventions.
4) stopping care when outcomes are met.