Current practice in nursing care of the adult

Issues and concepts

Kennedy · Pfeifer

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Preface

In view of the current proliferation of nursing literature, nurses in general practice are in need of a concise, pertinent, and broadly based text that will provide access to current issues, specific nursing care techniques, and alternatives for approaching patient care problems.

The topics chosen were, in our opinion, those with which the registered nurse will come in contact frequently, if not daily. Each chapter has a bibliography that the reader is encouraged to use for a more in-depth study of a specific topic. In view of the timeliness of the content, professional journals will also provide a wealth of data for follow-up study.

Chapters are written from varying philosophical and conceptual bases. Occasionally the viewpoints conflict; no efforts were made to assure congruence, since we believe that diversity is healthy and stimulates inquiry.

This book is designed as an instant resource for nurses in general practice who wish to update their knowledge. To this end, we plan biennial revision to assure the relevance of the content.

By including varied current clinical data and major professional issues, we hope that this text will be useful to (1) nurses in practice who need to know the implications that key professional issues may have for their practice, (2) beginning practitioners who need clinical guidelines for assessing or intervening in specific nursing situations, (3) nursing students who need an introduction to the complexities of professional nursing practice, and (4) inactive nurses planning a return to practice.

Maureen Shawn Kennedy
Gail Molnar Pfeifer

Contents

part I

CURRENT PRACTICE

1 A guide for assessment

JANET F. QUINN

Perhaps the most important skill that a nurse must acquire is the ability to accurately and completely assess any client in any situation. There can be no doubt that some areas of practice require very specialized and advanced techniques for nursing intervention. However, unless the nurse is able to identify the unique needs of each unique client, these specialized skills will be useless. A nurse attempting intervention without first completely assessing the client is as sound as a surgeon beginning an operation without looking at the x-ray films or a jury returning a verdict before the trial even begins. Yet all too often nursing intervention is initiated on the basis of one or two obvious facts about the client or of what is known to be true about some disease entity, with little consideration of the whole person. The nurse must have an understanding of assessment as it relates to nursing practice and of guidelines for an accurate, holistic assessment process.

DEFINITION OF TERMS

In this chapter, the term "assessment" will mean:

> Collection and interpretation of data about a client's biological, social, psychological, and cultural dimensions and about the interactions between these dimensions for the purpose of identifying patterns that are actually or potentially unhealthy.

There are several important concepts on which this definition is founded, and these concepts should be made clear at the outset. Each part of the definition bears thorough investigation and will be discussed separately.

Collection and interpretation of data . . .

Anyone can be trained to ask questions and fill out forms. It requires no special talent to elicit certain basic information from a client, such as name, address, age, occupation, or even the chief complaint. It would seem, then, that if a comprehensive list of questions was available, anyone could assess a client. In reality, nothing could be further from the truth for at least two reasons.

First, any list of questions used to collect data is incomplete by nature. It is impossible to design a questionnaire that is broad and comprehensive enough to elicit every bit of data about any and all clients in every possible situation. A questionnaire can only be a guideline, a starting place for the interview, and it will only be as useful as the interviewer is skilled. Each client's unique answers to certain questions should trigger other questions in the interviewer's mind. It requires the special skill of a trained professional, the nurse, to elicit information beyond the basics required by any standardized assessment form.

Second, the collection of data is only part of a complete assessment and is essentially useless unless the data are subsequently analyzed and interpreted. For example:

"The patient's blood pressure is 200/110."
So?

"She is a corporate executive."
So?

"She weighs 290 pounds and smokes three packs of cigarettes a day."
So?

Without interpreting the data collected about a client, all we have is a hodgepodge of miscellaneous, isolated facts. But when we start looking at these facts, analyzing the relationships among them, comparing them with established norms and with the client's norm, we can begin to see some patterns emerge. Based on these observations, a conclusion or a judgment can be made about the client's level of wellness. Thus assessment is a two-part process: the collection and interpretation of data.

. . . about a client's biological, social, psychological, and cultural dimensions . . .

Humans are multidimensional, holistic beings. They cannot be understood by looking at isolated parts, systems, or cells. The different dimensions of the human, the biological, social, psychological, and cultural aspects, are all inextricably bound together to form an integrated, organized whole.

Frequently a client enters into the health care system because of some acute biological problem. Just as frequently, medical and nursing intervention is based on that acute biological problem as if it existed separately from the client. The client does not have a problem, but his heart does, or his liver does, or her uterus does. This approach obviously ignores the essential wholeness, and any intervention based on such an approach can be, at best, only partially effective.

In collecting information about the four dimensions of the client, the nurse looks for two types of data: objective and subjective.

Objective data. Anything that the nurse sees, feels, smells, or hears during an interaction with a client is considered objective data. Examples are the size and shape of a laceration, the presence or absence of abnormal lung sounds, the color and odor of any discharge, the temperature of the skin, or the way a client holds his body.

Subjective data. Anything that a client tells the nurse about himself or others is considered subjective data. Examples are a complaint of any kind (pain, shortness of breath, etc.), an answer to any question, a description of family interactions, or statements such as "I'm nervous." Both objective and subjective data give information about how the client perceives his state of health, which is just as crucial as the professional's interpretation of this state.*

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*At the end of this chapter a series of questions has been included. They may be helpful as a guide in eliciting subjective data from a client.

. . . and about the interactions between these dimensions . . .

It is not enough to say that every person is composed of biological, social, psychological, and cultural dimensions. What makes each person unique is the particular way in which each of these dimensions interacts with the others. For example, we have all heard music played by different orchestras. Each orchestra has a unique sound, although each may be composed of the same instruments. The difference in the end product, the music, is the result of the unique interaction among all of the instruments in any given orchestra. The interactions between all human dimensions are what define and make each human whole.

All behaviors, all states of being, are manifestations of these dynamic interactions. We know, for example, that a physical or biological problem is often rooted in some other dimension of the client. The emotional component of asthma, peptic ulcers, migraine headaches, and colitis, to name but a few, have long been acknowledged. There is recent evidence which suggests that anywhere from 50% to 80% of all illness is psychosomatic,[1] and research continues. Social and cultural patterns contribute to a person's psychological state, and some biological conditions are endemic to specific social or cultural groups.

The four human dimensions cannot be separated. I have heard nurses say "We'll deal with his physical problems first, then we'll get to his other problems." It is easy to make this kind of mistake. When hospitals are short staffed and nurses pressed for time, which seems to be almost always, they attempt to establish some priorities for intervention, "Get the really important things done, the rest can wait." This is not wrong in and of itself. The mistake is that the "really important" things usually turn out to be treatments and procedures related to the medical diagnosis; thus the client is treated for a biological problem as if it existed separately from him. But the biological problem may only be the symptom of the underlying dis-ease of the client. There may be some pattern of living, social conflict, psychological or spiritual stress that is literally making this client sick. If the nurse intervenes only on the biological level, the symptom may disappear, that is, the acute physical problem may be resolved. But if the real dis-ease, which happens to be manifested physically, is ignored, little has been accomplished. The client will return to an unhealthy pattern of living, and will probably develop the same physical problem, or a new one, manifesting his dis-ease.

Except in acute life-threatening emergencies, there is no way to establish priorities, to ascertain what the "really important" things are for the *client,* not the nurse, except by learning about the relationships among the four human dimensions.

. . . for the purpose of identifying patterns that are actually or potentially unhealthy

Nursing's unique focus is health and wellness. This differs from medicine's focus, which is primarily disease oriented. Nurses are concerned with promoting wellness, maintaining wellness, and, when necessary, restoring wellness to the highest level possible for each client. If, during assessment, the nurse seeks to identify only patterns that are actually unhealthy, valuable opportunities for preventive intervention will be missed. Assessment must conclude with the identification of patterns that are actually or *potentially* unhealthy.

FORMULATION OF CONCLUSIONS: END PRODUCT OF ASSESSMENT

To complete an assessment as defined here, the nurse must collect data about each dimension, synthesize all data, and make some conclusion about each of the patterns that the client manifests. The conclusions that the nurse makes will provide the foundation for a nursing diagnosis and are actually judgments about (1) whether the patterns manifested by the client are within normal limits (WNL) or are deviant (different from the usual norm), and (2) whether the patterns manifested by the client are detrimental to, or supportive of, an optimum level of wellness for that client.

Careful synthesis and analysis of all the data must precede the nurse's conclusions if they are to be accurate and meaningful for a particular client. It is very easy to find some deviant pattern in a client and jump to the conclusion that this deviant pattern requires intervention. In a country of meat-eaters, for example, vegetarianism is a deviant nutritional pattern, but this does not mean that nursing intervention is automatically indicated. If the client appears to be in good health and well nourished and if the nutritional history reveals that the client's daily diet includes the proper amounts of carbohydrate, complete and incomplete proteins, and fat, the nurse would conclude that, although the pattern is deviant, it is supportive of optimum wellness for this person. Likewise, the nurse might discover that a client's pulse rate is only 50 beats/min. This is a deviant cardiovascular pattern. But unless the client is less well because of the slow pulse or it represents a sudden change for him, intervention may not be indicated.

Unless analysis of the data is complete, errors can just as easily be made in the opposite direction—not all normal patterns are supportive of optimum wellness for all persons. The Italian client who drinks wine and eats pasta and bread with every dinner is manifesting a normal pattern. If this same client happens to be a diabetic, his normal pattern may well be detrimental to his optimum wellness.

Thus the conclusions that the nurse reaches must be based on careful and thorough analysis of all of the data at two levels: is the pattern normal or deviant, and is it supportive of or detrimental to optimum wellness *for this individual?*

PATTERN SUMMARY

Standardized nursing history forms such as those found in many acute care settings often consist of some kind of questionnaire, which is followed by a space for the nurse to write a diagnosis. In using this type of format for client assessment, errors in judgment such as those just discussed are more easily made. What is needed is a format that requires the nurse to synthesize the data and make conclusions about the patterns observed before attempting to arrive at a nursing diagnosis. To this end, I am presenting the following *Pattern Summary*. This is a new tool, used only by freshmen students in introduction to nursing courses thus far, and it will no doubt require testing and revision. It is an attempt to bridge the gap between data collection and diagnosis, committing to paper the part of the assessment process that is usually completed in thought alone. I believe that students and beginning practitioners will find this approach particularly helpful.

Directions for use

The Pattern Summary is not to be used for the recording of raw data, except as a justification for a conclusion. Any data collection tool, such as the one included