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Short Communication

A qualitative study to develop an instrument for initial nurse assessment

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ABSTRACT

Complex health care needs focus on accountability and necessity of inclusion of nurses in documenting and monitoring clinical care plans have brought in the concept of initial nurse assessment and nursing process. However, no standardized form exists in the Armed Forces Medical Services to document initial nursing observations while a patient is being admitted in service hospitals.

A focus group design was utilized to explore and conceptualize an initial nurse assessment form that may be utilized by service hospitals.

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Introduction

Increasingly complex health care needs and the current focus on accountability require a shift toward high quality care that is patient-centered, evidence-based, and outcome-oriented.^{1,2} This shift will require nurses, the largest group of direct care providers in health care to be full partners in the process of care by taking responsibility for identifying problems, devising plans for improvement, monitoring improvement over time, and serving as strong patient advocates.³

Nursing process (NP) has now become recognized as a systematic scientific method, based on efficient achievement of nursing objectives in patient care. The first phase of the NP is patient assessment, when the nurse collects information to establish a clear image of the patient's health status that will

constitute the basis for diagnosis and further interventions.⁴ This initial assessment is not always performed systematically, either due to lack of time⁵ or lack of sufficiently useful instruments to guide patient assessment.⁶

Nurse documentation is considered a core element of nursing with a specific purpose of securing well planned, evaluated and documented patient care as well as promoting communication among the care-givers. An additional profit of quality nursing documentation is the opportunity in facilitating continuity, individualized care, and patient safety.⁷

Initial nursing assessment as an essential component of NP and nursing care plan is being practiced in all service hospitals. However, no standardized format exists for documenting the assessment process, resulting sometimes in loss of continuity, missing of vital information, and failure to evolve a proper nurse diagnosis.

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The aim of the present study is to design an initial nursing assessment form that can be adopted for use in hospitals of the Armed Forces Medical Services (AFMS).

Materials and methods

A focus group design was used to explore the perception of nursing officers in developing the initial nurse assessment form. Focus group involves organized discussion with a selected group of individuals to gain information about their views and experiences of a topic and to obtain information of qualitative nature from a pre-determined and limited number of participants.⁸ Focus group discussions allow the researcher to probe both the cognitive and emotional responses of participants while observing the underlying group dynamics.⁹

The study is of descriptive design with a qualitative approach and study participants were 8 clinical female nurses with professional service ranging from 1 to 18 years, with a median service of 7.5 years. The inclusion criterion of a participant was being acute member working at acute in-patient units of the hospital with experience in patient care. Purposive sampling was utilized by the nursing management to ensure representation from all wards of the hospital in the study group. All participants were informed of the objective and design of the study and a written consent taken from each of the participants.

Effective focus groups need a well-researched interview guide, starting from general topics to specific questions. Various nurse assessment forms in the literature were studied to identify common topics for initial assessment and open-ended questions were developed on such topics to stimulate discussion by the group. The entire group discussion was facilitated by the principal author, audiotaped as well as hand-written notes being taken during the discussion. Coding them occurred, transforming and combining the raw data into specific themes, which allowed for the description of relevant content characteristics.

Results

The qualitative analysis led to the emergence of various important themes from the focus group data.

Basic information about the patient

The first theme that emerged in respect of the initial nursing assessment was basic information about the patient. All participants agreed that duplication of information between medical case sheet and nurse assessment form must be avoided. However, certain basic inputs like history of any allergy or absence thereof, body weight, radial pulse, body temperature, and pain score must be noted during initial assessment. The pain score was specially emphasized, pain being recognized as a fifth vital parameter. Participant 3 commented.

“How the patient was brought in the ward, need for assistance while being admitted, his educational status and his/her capability to communicate with the nursing staff is

a vital input that must find a place in the Basic Information theme.”

Orientation to hospital services

All informants of the focus group were unanimous that certain information must be provided to the patient and his attendants during admission, specially location of sanitary facilities, availability of nurse call bells, visit policy, and ban on any outside medication for the patient. Moreover, all initial queries of the patient and his relatives must be clarified and a summary of the same noted in the assessment form.

Mental and emotional status of patient

The theme of mental status of the patient at the time of admission evoked spirited discussion with difference of opinion as to its necessity for assessment by the nursing officers, as the same is supposed to have been evaluated by the admitting medical officer. However, participant 7 commented.

“Continuous monitoring of the patient, particularly those in critical condition falls within the purview of nurse responsibility. Hence, a baseline observation in respect of mental status during admission is vital during initial nursing assessment.”

Valuables

Participants agreed that withdrawal of valuables should be completed at the accident and emergency department during admission. However, experience of the participants while working in patient care wards has taught them that this important issue is frequently missed and should be included to prevent any theft in their wards.

Diet plan

Participant no 5 commented on the diet plan.

“There are certain types of Diet laid down in Armed Forces Hospitals, such diets being reflected in daily Diet sheet being prepared by in-patient wards. However, the concept of Therapeutic Diet is much wider than the present diet scales and therapeutic diet plans prescribed by specialist officers must form part of initial nursing assessment.”

Other participants voiced their concern that simply noting down a particular type of diet not available in ration scales may not lead to catering of correct diet for a patient, especially in smaller hospitals without dieticians or catering officers posted with such hospitals.

Vulnerability assessment

Assessment for vulnerability has been recognized as a key evaluation parameter for nurse evaluation and diagnosis and the same is particularly true for those patients who are vulnerable due to age, physical condition, or psychological dependence. The participants whole-heartedly agreed on

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