



UNIT

1

Foundations of Nursing Health Assessment

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The Nurse's Role in Health Assessment

LEARNING OBJECTIVES

- 1 Describe the role of the professional nurse in health assessment.
- 2 Demonstrate knowledge of the purposes of health assessment.
- 3 Explain the relationship of health assessment to teaching and health promotion.
- 4 Explain the nursing process, critical judgment thinking, and clinical in nursing care.
- 5 Demonstrate knowledge of the differences in the types and frequencies of assessments.
- 6 State the components of a comprehensive health assessment.
- 7 Describe organizing frameworks for collecting health assessment data.



CLINICAL JUDGMENT CASE

Top Patient Findings: What Matters Most?

Next Generation NCLEX Style Question

Nurse's Notes

Ms. Maria Ortiz (prefers Ms. Ortiz, pronouns she/her/hers), a 52-year-old Mexican American woman, has a follow-up appointment related to type 2 diabetes, which was diagnosed 2 weeks ago during an annual physical assessment. Her primary language is Spanish. Although she speaks English well, she has difficulty understanding complex medical terminology. Ms. Ortiz has been married for 30 years, and her three grown children live nearby.

Ms. Ortiz is 1.52 m (5 ft) tall, weighs 75 kg (165 lb), and has a body mass index (BMI) of 32.2. She eats a diet high in fats and starches. Her blood glucose levels at home have been elevated. She is otherwise healthy. Current vital signs are temperature 36.5°C (97.7°F) tympanic (ear route), right radial (wrist) pulse 82 beats/min, respirations 16 breaths/min, and blood pressure (BP) 138/92 mm Hg right arm. Medications include an oral hypoglycemic to lower blood sugar and a daily vitamin.

- Identify the top four patient findings that will require follow-up.

Patient Findings	Top Four Findings
Diagnosed 2 weeks ago with diabetes	
Married for 30 years	
BMI 32.2	
Elevated blood glucose	
Right radial pulse 82 beats/min	
BP 138/92 mm Hg right arm	

Critical Thinking Challenge

- What is the role of the nurse in providing care for Ms. Ortiz at this visit?
- How is the nursing process used when performing Ms. Ortiz's care?
- What framework will be used to collect subjective and objective data?
- How will the nurse use priority setting frameworks to care for Ms. Ortiz?

STRUCTURE AND FUNCTION

ROLES OF THE PROFESSIONAL NURSE

“Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations,” according to the American Nurses Association (ANA, 2021). This definition serves as the basis on which the standards of the professional nursing practice and the scope of nursing practice are structured. Nursing has a focus comprising four main goals:

1. To promote health
2. To prevent illness
3. To treat human responses to health or illness
4. To advocate for individuals, families, communities, and populations.

The *Code of Ethics for Nurses With Interpretive Statements* (ANA, 2015a) and *Nursing: Scope and Standards of Practice* (ANA, 2015b) further describe nursing and its associated practice standards. The *Code of Ethics* focuses on the conscience of the nurse and respect for the individual. It provides direction in the clinical setting. The four concepts in the *Code of Ethics* (2015a) include autonomy, beneficence (kindness), justice, and nonmaleficence (do no harm). The following concepts are included in the *Code of Ethics*:

- The nurse practices with compassion, dignity, and respect for every person.
- The nurse advocates for and protects the rights, health, and safety of the patient.
- The nurse takes action to provide optimal patient care, continue professional growth, advance the profession, and integrate social justice into practice.
- The nurse collaborates and communicates with other health professionals.

The *Scope and Standards of Practice* (ANA, 2015b) document describes nursing duties and works together with the

nursing process, including assessment, diagnosis, outcome identification, planning, implementation, and evaluation. The process is used to promote health and prevent illness, reduce the risk of a disease, reinforce good habits, and maintain optimal functioning (Fig. 1.1).

Roles for the generalist nurse are derived from the discipline of nursing: provider of care, designer/manager/coordinator of care, and member of a profession (American Association of Colleges of Nursing [AACN], 2008).

PROVIDER OF CARE

Nurses provide direct care to help restore health for patients who are ill in hospitals, clinics, long-term care facilities, and schools. This is compared with medical doctors who focus on the physical aspects of diseases and prescribe medications or other treatments. Nurses focus on how diseases affect activity levels and abilities to perform tasks, as well as on how patients cope with their health issues and any related losses of function. Nurses often work together with primary care providers on medical diagnoses and collaborative problems. Independent nursing interventions include patient teaching, therapeutic communication, and physical procedures, such as turning patients or assisting them with ambulation. Advanced practice nurses may function autonomously and practice independently after licensure.

MANAGER OF CARE

Nurses are constantly making treatment decisions to manage and coordinate care. Nurses often spend more time with patients and their families than other healthcare providers do and thus know their issues more completely. Nurses communicate findings to appropriate people and document data to share information and identify trends. Referral of patients to other healthcare providers is made after appropriate assessment. To become aware of the assessments done before this referral, there is a feature, “SBAR: What Can I Do?” that includes information on collaborating with the

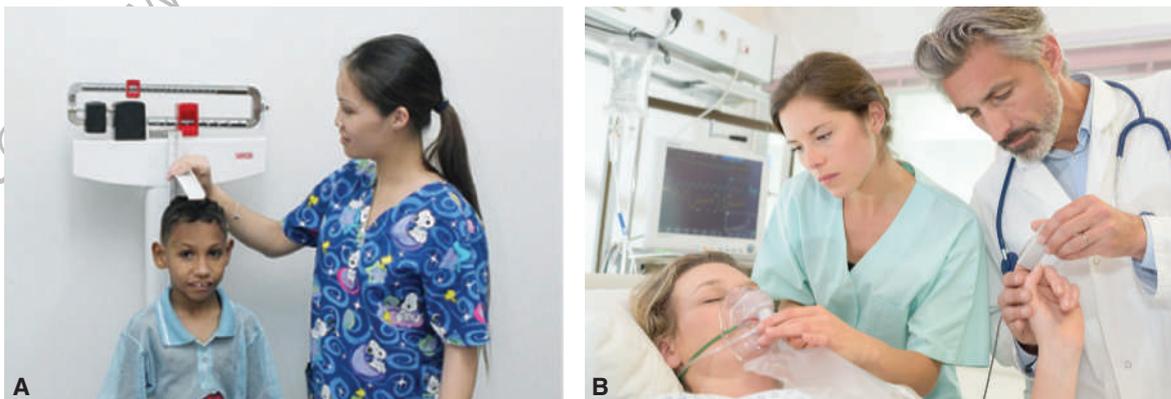


Figure 1.1 Nurses promote health and treat responses to illness. (A) Nurses maintain optimal functioning in schools. (B) Hospital nurses promote healing.

interprofessional team” at the end of the chapters in this text. It uses the format of **S**ituation, **B**ackground, **A**nalysis, and **R**ecommendation (SBAR) to make suggestions to the team about what is needed for the patient's care. Documentation of care is described in the “Analyzing Changing Findings: Progress Note” feature, which uses SOAP note organization (subjective, objective, analysis, plan). Nurses use interprofessional communication and collaboration to improve patient health outcomes.

MEMBER OF A PROFESSION

Nursing research and evidence-based practice can be traced back to Florence Nightingale in the mid-1800s. Today, nurses perform scholarship and research to provide care based on current evidence. Professional nursing practice is grounded in best practice, critical inquiry, and skilled questioning. Knowledge of patient care technologies and information systems is essential in the management of care. Nurses use systems to influence healthcare policy, finance, and regulatory agencies. Health promotion and disease prevention are necessary to improve health at both the individual and population levels (ANA, 2015b).

Nurses are advocates for the patient and the profession in their professional role. As advocates, nurses take responsibility to protect the legal and ethical rights of patients. Values and ethical principles are beliefs or ideals to which a person is committed. Professional core values guide nurses to provide safe, humane care. Nursing values (National League for Nursing, 2021) include the following:

- **CARING:** promoting health, healing, and hope in response to the human condition
- **INTEGRITY:** respecting the dignity and moral wholeness of every person without conditions or limitation
- **DIVERSITY:** affirming the uniqueness of and differences among persons, ideas, values, and ethnicities
- **EXCELLENCE:** cocreating and implementing transformative strategies with daring ingenuity

Nurses have a unique advantage in understanding and acting on the patient's behalf in the most holistic way. Both registered nurses (RNs) and advanced practice registered nurses (APRNs) fulfill the roles described.

The Registered Nurse

The RN is licensed nationally and practices independently within the scope of nursing practice. Depending on the location of practice, the RN may be required to fulfill continuing education and practice requirements. There are numerous employment opportunities for RNs, working wherever people need nursing care—hospitals, homes, schools, workplaces, and community centers. About two-thirds of RNs work in hospitals. Other common areas of practice include in the community or for public health, ambulatory care, nursing homes, and nursing education (ANA, 2015b).

RNs in hospitals develop assessment skills related to the specialty in which they practice. For example, in the

emergency department, nurses focus their assessment on life-threatening injuries and situations. In the intensive care setting, nurses assess patients using invasive monitoring equipment, such as an arterial line that goes into the patient's heart or an intracranial pressure line that goes into the patient's brain. In these specialized settings, an RN's role sometimes overlaps with advanced practice nurse roles.

The Advanced Practice Registered Nurse

There are many opportunities for RNs to further their education and careers in a way that develops each individual's interests and uses their strengths and expertise. APRN is an umbrella term given to an RN who has achieved a bachelor's degree in nursing science, which includes educational and clinical practice requirements, as well as a minimum of a master of science in nursing (MSN) degree. The core curriculum for a master's degree (MSN) or doctorate of nursing practice (DNP) in nursing science includes advanced health assessment, advanced pathophysiology, and advanced pharmacology combined with the specialty-focused track. The advancement to a doctoral level of study supports an increasingly complex healthcare environment and contributes with the greatest level of scientific knowledge through research.

APRNs are governed and monitored by professional organizations, state law, and other regulations. The roles of the APRN include nurse practitioner (NP), certified nurse midwife (CNM), certified registered nurse anesthetist (CRNA), and clinical nurse specialist (CNS).

Nurse Practitioner. Through the core competencies of direct clinical practice, the APRN may care for patients throughout the patient's lifespan. The NP may also focus on primary care or acute care, with clinical track options in pediatrics, family practice, health of females gerontology, acute care, and psychiatric/mental healthcare.

Certified Nurse Midwife. The practice of the CNM has deep historical roots worldwide, with focus on gynecological care, pregnancy, birth, and contraceptive options. CNMs advocate for the patient to be an active participant in their healthcare choices.

Certified Registered Nurse Anesthetist. CRNAs are considered the oldest specialty within nursing practice. CRNAs have the authority to select, obtain, or administer the anesthetics, adjuvant drugs, accessory drugs, and fluids necessary to manage anesthesia, to maintain the airway, and to correct abnormal responses to anesthesia or surgery.

Clinical Nurse Specialist. The CNS is experienced and knowledgeable in a specialty area. The CNS is an RN who, through study and practice at a graduate level, is expert in a selected clinical area of nursing. Opportunities for the teaching and consulting CNS can be found in critical care, cardiology, oncology, diabetic care, and psychiatry.

REGISTERED NURSE VERSUS SPECIALTY OR ADVANCED PRACTICE ASSESSMENTS

The differences between the RN and the APRN assessments are included in each systems chapter of this text. At the beginning of each “Objective Cues” section, a table describes the usual general scope of practice for each role. This is based on the role of RNs and APRNs in Western countries, and each role varies by the specialty. For example, the RN practicing in the neurological intensive care area may be an expert in advanced neurological assessment, whereas an NP in family practice has infrequent experience in this area. An RN practicing in rural home healthcare or in a developing country may need to rely on percussion of the lungs, usually an advanced practice technique, because x-ray equipment is unavailable. Refer to current guidelines for the scope of practice in your area because the assessments vary depending upon the setting and specialty area.

TEACHING AND HEALTH PROMOTION

Health behaviors are influenced by a person’s beliefs, culture, and perceptions, as well as competing demands in the person’s life. For example, a person with a goal of weight loss may be influenced by family finances, other family members, available time, and their previous success or failure losing weight. Health beliefs and experiences determine who is likely to practice healthy behaviors and why. A nursing assessment that includes the patient’s individual situation and experiences will assist in the development of focused health promotion activities (Murdaugh et al., 2019).

As a nurse, you assess patients for nutrition, fitness, mental health, safety, and stress. When these screening questions are asked, you follow up with more in-depth questions in higher risk areas. You collaborate with the patient and family to identify areas that they view as important.

WELLNESS AND ILLNESS

Wellness is an integrated method of functioning oriented toward maximizing the potential of the individual. Illnesses are separate short or long events that may challenge a person’s desire for health. Most people fall somewhere between wellness and illness. The person who moves toward high-level wellness focuses on awareness, education, and growth. The person who moves toward illness and premature death develops signs and symptoms of disease or disabilities. Unfortunately, this is when most treatment occurs in the current healthcare system.

Health is more than merely the absence of illness. Nurses collaborate with individuals, families, and communities to promote higher levels of wellness.

SOCIAL DETERMINANTS OF HEALTH: HEALTHY PEOPLE 2030

The U.S. Department of Health and Human Services (2021) has developed a national model for health promotion and

risk reduction called *Healthy People*. The goals of this project are to increase the length and quality of life for the population of the United States and to eliminate health disparities. Every 10 years, progress is evaluated, and the goals are restructured. They will be covered in more detail in each of the chapters. *Healthy People 2030*’s five main goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

The three levels of interventions to promote healthy change are primary, secondary, and tertiary (Leavell & Clark, 1965):

- Primary prevention involves strategies aimed at preventing problems.
 - Immunizations, health teaching, safety precautions, and nutrition counseling are examples.
- Secondary prevention includes the early diagnosis of health problems and prompts treatment to prevent complications.
 - Vision screening, Pap smears, BP screening, hearing testing, scoliosis screening, and tuberculin skin testing are examples.
- Tertiary prevention focuses on preventing complications of an existing disease and promoting health to the highest level.
 - Diet teaching and exercise programs are examples.

WHAT IS HEALTH ASSESSMENT?

Health assessment is “gathering information about the health status of the patient, analyzing and synthesizing those data, making judgments about nursing interventions based on the findings, and evaluating patient care outcomes” (AACN, 2008). This process is followed in each chapter of the book, beginning with data collection and ending with evaluating outcomes.

A health assessment includes both a health history and a physical assessment. According to the ANA (2015b),

An RN uses a systematic, dynamic way to collect and analyze data about a patient, the first step in delivering nursing care. Assessment includes not only physiological data, but also psychological, sociocultural, spiritual, economic, and life-style factors.

For example, a nurse’s assessment of a hospitalized patient in pain includes not only the physical causes and manifestations

of pain but also the patient's response—such as an inability to get out of bed, refusal to eat, withdrawal from family members, or anger at hospital staff.

The health history includes interviewing to collect the patient's past medical and surgical histories, lifestyle, and current symptoms. A comprehensive health history also includes nutrition, development, mental health, culture, and safety issues. Data that you collect during the physical assessment vary depending on the seriousness of a patient's condition, health history, and current symptoms. In an emergency, you collect information that will help pinpoint the source of the issues and treat current conditions. For healthy patients seeking a wellness checkup, you focus the assessment on screening for high-risk conditions (e.g., high BMI) and teaching and health promotion associated with common issues (e.g., nutrition and exercise).

You may also perform a health assessment to gain further insight into a patient's current condition and to establish a database against which future assessments can be measured. You identify patterns and trends to determine whether a patient's condition is improving or worsening. Instead of using one piece of data in isolation, you think logically to analyze how data are related and what interventions may be indicated. You evaluate outcomes, and the assessment becomes a continuous part of the nursing process.

NURSING PROCESS

The nursing process is a systematic problem-solving approach to identifying and treating human responses to actual or potential health difficulties (ANA, n.d.). It serves as a framework for providing individualized care not only to individuals but also to families and communities. It is patient centered and focuses on solving problems and enhancing strengths. The nursing process is applicable to patients in all stages of the lifespan and in all settings.

The nursing process includes assessing the patient, analyzing data and making nursing diagnoses, determining patient outcomes or planning care, implementing, and then evaluating the patient's status to determine whether interventions were effective (Fig. 1.2).

Assess

The nursing process begins with a complete and accurate health assessment to promote health at the highest level.

SAFETY ALERT

All future care is based on the health assessment, so it is extremely important that health assessment data are complete and accurate. This is one of the most important skills that you will use as a nurse.

The nursing process is not linear (i.e., progressing step-by-step). Rather, it involves interrelated and sometimes overlapping steps. As you collect assessment data, you may also provide emergency interventions. You set outcomes collaboratively with patients. These established priorities guide

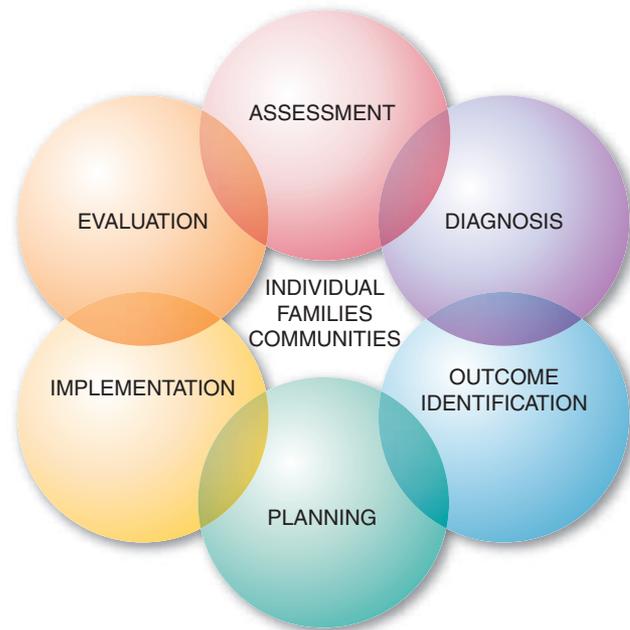


Figure 1.2 The phases of the nursing process are assessment, diagnosis, outcome identification or planning, implementation, and evaluation. Nurses apply these activities to the care of individuals, families, and communities.

not only the treatment plan but also the type of future assessments. For example, if a hospitalized patient's priority is sleep, then you may decide to eliminate taking vital signs every 4 hours during the night if the patient's condition is stable. You also evaluate results during an assessment; for example, checking patients for side effects of medications.

Diagnose

According to the ANA (n.d.), diagnosis is the clustering of data to make a judgment or statement about the patient's difficulty or condition: "The nursing diagnosis is the nurse's clinical judgment about the patient's response to actual or potential health conditions or needs." The ANA supports that nursing diagnosis is the basis for a nurse's care plan because it reflects the pain a patient feels whether caused from a bodily function, outside-of-body factors, or complications of the combination of these two things.

The International Classification for Nursing Practice (ICNP) provides a set of terms that can be used to record the observations and interventions of nurses across the world (ICNP, 2019). The ICNP provides a framework for sharing data about nursing and for comparing nursing practice across settings. Table 1.1 has three common nursing diagnoses or hypotheses that relate to health maintenance. You will see and learn more about diagnoses in each chapter.

Identify Outcomes

Outcome identification is the formation of measurable, realistic, patient-centered goals. Goals are broader than outcomes; for example, "Patient's pain is within acceptable limits." Goal identification provides for individualized care. For example, after giving a patient in acute pain the

TABLE 1.1 HYPOTHESES AND INTERVENTIONS FOR PATIENT EDUCATION

Diagnosis or Hypothesis	Description	Assessment	Interventions
Health-seeking behavior	Actively seeking ways to move toward a higher level of positive health	Expressed desire to seek higher level of wellness; concern about current conditions on health status	Prioritize learner needs based on patient preferences. Emphasize positive health benefits of positive lifestyle behaviors.
Impaired health maintenance	Impaired abilities to select, implement, or look for assistance with healthy lifestyle behaviors	Lack of health-seeking behavior, lack of resources, lack of adaptive behaviors to changes	Assess feelings, values, and reasons for not following plan of care. Assess family, economic, and cultural patterns that influence plan of care.
Acute health crisis	Not regulating and integrating a treatment for illness into daily life	Did not take action to reduce risk factors; difficulty with prescribed regimen for treatment or prevention of complications	Encourage active participation. Review actions that are not therapeutic. May involve a treatment failure or complication that needs immediate attention.

prescribed pain medication, you assess their pain level. You ask the patient what level of pain is acceptable and discuss whether the dose of medication should be increased.

Patient outcomes are specific goals: they are realistic and measurable (Alfaro-LeFevre, 2017). For example, it may not be realistic for a patient to be completely free of pain, so an acceptable outcome is “patient states pain less than 2 on a 0-to-10 scale.” Establishing outcomes also helps you identify priorities for care, especially with complex issues.

The most common nursing outcomes are discussed in the “Clinical Judgment” section of each of the system-specific chapters in this text.

Plan Care

Care planning activities include determining resources, targeting nursing interventions, and writing the plan of care. In addition to standard care and provider orders, the nursing care plan requires that you analyze the individual patient and their needs to provide individualized and holistic care. You communicate the care plan verbally and document it in the patient’s chart so that the next care provider is aware of the plan. The agency or institution where you work will determine whether the plan of care is documented in a care plan format or in a concept care map, case note, clinical pathway, teaching plan, or discharge plan. Regardless of format, the care planning document incorporates elements of the nursing process and critical thinking that nurses incorporate into the patient care.

Implement

An intervention is defined as “any treatment, based upon clinical judgment and knowledge, that a nurse performs to enhance patient/client outcomes” (Butcher et al., 2018, p. xii). It is important for you to be aware of the standards of care within the agency where you work because these standards define expected practice (e.g., taking vital signs every 8 hours). Types of nursing interventions include assessment, education, supervision, coordination, referral, support, therapeutic communication, and technical skills.

The ICNP is a unified nursing language system that supports standard nursing documentation at the point of care.

The resulting data-based information can be used for planning and managing nursing care, financial forecasting, analysis of patient outcomes, and policy development (ICNP, 2019). The most common nursing interventions are discussed in the diagnostic reasoning of the system-specific chapters in this text.

Evaluate Outcomes

The evaluation is the judgment of the effectiveness of nursing care in meeting the goals and outcomes. It is based on the patient’s responses to the interventions. The purpose of evaluation is to make judgments about the progress of the patient, analyze the effectiveness of nursing care, review potential areas for collaboration with and referral to other healthcare professionals, and monitor the quality of nursing care and its effect on the patient. As a nurse, you will assess the promotion of and barriers to goal attainment. Goals may be completely met, partially met, or completely unmet.

You will use your interviewing skills for subjective data collection and your physical assessment skills for objective data collection to effectively evaluate. You will use critical thinking throughout the nursing process to assess, diagnose, plan, implement, and evaluate care. This is known mnemonically as ADPIE.

CRITICAL THINKING

Critical thinking in nursing (Alfaro-LeFevre, 2017):

- entails purposeful, outcome-directed (result-oriented) thinking;
- is driven by patient, family, and community needs;
- is based on the nursing process, evidence-based thinking, and the scientific method;
- requires specific knowledge, skills, and experience;
- is guided by professional standards and codes of ethics; and
- is constantly reevaluating, self-correcting, and striving to improve.

As a nurse, you are frequently involved in complex situations with multiple responsibilities. You are required to contemplate analysis, develop alternatives, and implement the best interventions. Critical thinking is essential to resolving

difficulties. If you do not think critically, then you will deliver incomplete or misdirected care. Critical thinking is also an essential skill needed to pass the National Council Licensure Examination (NCLEX). Accreditation visitors to colleges of nursing and healthcare facilities look for evidence of critical thinking ability in nursing students.

DIAGNOSTIC REASONING

The diagnostic reasoning process is based on critical thinking. Diagnostic reasoning includes gathering and clustering data to draw inferences and propose diagnoses or hypotheses. A seven-step process for diagnostic reasoning can be used in the context of health assessment (Weber & Kelley, 2018):

1. Identify strengths and abnormal data.
2. Cluster data.
3. Draw inferences.
4. Propose nursing diagnoses.
5. Check for defining characteristics.
6. Confirm or remove diagnoses.
7. Document conclusions.

Collaborative problems are those that you are monitoring and require the expertise of other healthcare providers for interventions. An example of a collaborative problem is written as follows: “Potential Complications of Diabetes.” Diabetes is a medical diagnosis. As a nurse, you monitor for signs and symptoms of diabetes and notify the primary care provider if they are present. As a nurse, you also perform interventions in collaboration, such as glucose testing and insulin administration. Interprofessional collaboration is an important skill to learn by using both written and verbal communication. Examples of this important skill are covered in the “Analyzing Changing Findings: Progress Note” and “SBAR: Interprofessional Collaboration” sections of the case study.

CLINICAL JUDGMENT

The combination of nursing process, critical thinking, and diagnostic reasoning contributes to a nurse's clinical judgment ability. Understanding the material does not always translate into sound clinical judgment skills (National Council of State Boards of Nursing, 2021). Your decisions matter in every unique situation, and the case studies in each chapter give you an opportunity to use your knowledge. The clinical judgment model used in the Next Generation NCLEX style questions (NGN style questions) contains the steps shown in Figure 1.3. The nurse forms hypotheses, prioritizes them, generates solutions, and then takes actions. The goal of this process is to direct you in implementing it in a way that will improve your patient's care. You will use this process as you answer the NGN case study questions in this chapter. See Box 1.1 for the steps involved.

TYPES OF NURSING ASSESSMENTS

Three types of nursing assessments are common: emergency, comprehensive, and focused. Emergency and focused

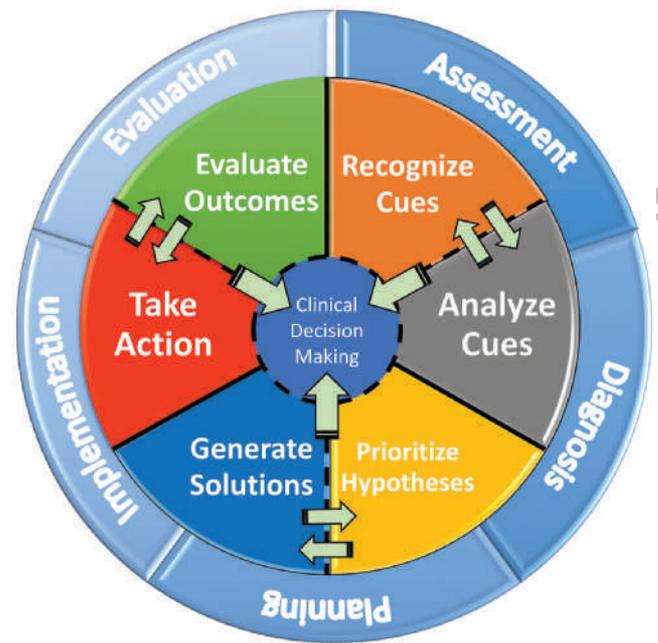


Figure 1.3 The National Council of State Boards of Nursing (NCSBN) defines clinical judgment as “An iterative decision-making process that uses nursing knowledge to: Observe and assess presenting situations; Identify a prioritized patient concern; and Generate the best possible evidence-based solutions in order to deliver safe patient care.”

assessments center on the immediate and highest priority problem. Comprehensive assessments are broad and complete. The amount and type of information vary depending on the patient's needs, purpose of data collection, healthcare setting, and the nurse's role.

EMERGENCY AND URGENT ASSESSMENT

The emergency assessment involves a life-threatening or unstable situation, such as a patient who has experienced a critical traumatic injury (Smith & Bowden, 2017). Staff members use triage to determine the level of urgency by considering assessments based on the mnemonic A, B, C, D, E:

- A—Airway (with cervical spine protection if an injury is suspected)
- B—Breathing: rate and depth, use of accessory muscles
- C—Circulation: pulse rate and rhythm, skin color
- D—Disability: level of consciousness, pupils, movement
- E—Exposure

SAFETY ALERT

All life-threatening problems identified during the initial assessment require the initiation of critical interventions:

- Assist with circulation (cardiopulmonary resuscitation if needed).
- Open the patient's airway.
- Assist the patient's breathing.
- Protect the cervical spine if the patient is injured.
- Ensure the disoriented or suicidal patient is safe.
- Provide pain management and sedation.

BOX 1.1 NCLEX Clinical Judgment Measurement Model

Recognize Cues

Do not connect cues with hypotheses just yet.

Analyze Cues

Consider multiple things that could be happening.

Prioritize Hypotheses

Rank the potential issues and think about phrases such as “most likely.”

Generate Solutions

Focus on goals and multiple potential interventions—not just the best one—that connect to those goals. Potential solutions could include collecting additional information.

Take Action

For “how” questions, ensure that specific elements from the scenario are what determines approach.

Evaluate Outcomes

Focus on the efficacy of the intervention(s) from the previous items.

Identify relevant and important information from different sources (e.g., medical history, vital signs).

Organize and link the recognized cues to the patient’s clinical presentation.

Evaluate and rank hypotheses according to priority (urgency, likelihood, risk, difficulty, time, etc.).

Identify expected outcomes and using hypotheses to define a set of interventions for the expected outcomes.

Implement the solution(s) that address the highest priorities.

Compare observed outcomes against expected outcomes.

- What information is relevant/irrelevant?
- What information is most important?
- What is of immediate concern?
- What patient conditions are consistent with the cues?
- Are there cues that support or contraindicate a particular condition?
- Why is a particular cue or subset of cues of concern?
- What other information would help establish the significance of a cue or set of cues?
- Which explanations are most/least likely?
- Which possible explanations are the most serious?
- What are the desirable outcomes?
- What interventions can achieve those outcomes?
- What should be avoided?
- Which intervention or combination of interventions is most appropriate?
- How should the intervention(s) be accomplished (performed, requested, administered, communicated, taught, documented, etc.)?
- What signs point to improving/declining/unchanged status?
- Were the interventions effective?
- Would other interventions have been more effective?

Adapted with permission from National Council of State Boards of Nursing. (2019). *Next Generation NCLEX News (Winter 2019)*. https://www.ncsbn.org/NGN_Winter19.pdf

You perform assessments and critical interventions simultaneously. Examples of life-threatening and urgent problems are provided in each chapter in the section on Emergency and Urgent Assessment.

COMPREHENSIVE ASSESSMENT

The comprehensive assessment includes a complete health history and physical assessment. It is a physical similar to the one required for admission to school. In the clinic, the history may be obtained by having the patient initially fill out a written form with family history of illness, personal illness, and medical treatment or surgeries. You discuss the information with patients and clarify any incomplete or unclear areas. Note the dates of diagnoses and treatments along with the reason for taking medications; for example, if the patient is taking a heart medication for high BP or for a history of heart attack. A comprehensive history also includes a patient’s perception of health, strengths to build upon, risk factors for illness, functional abilities, methods of coping, and support systems.

It is important to reconcile the medication list with what the patient is actually taking. If the patient is unable to

participate in data collection because of the urgency of the problem, then you may need to use secondary data sources for information, such as the patient’s family members.

A comprehensive physical assessment includes all body systems and areas, usually in a head-to-toe format. This includes an assessment of the skin; head and neck; eyes; ears, nose, mouth, and throat; thorax and lungs; heart and neck blood vessels; arms and legs; breasts/chest; abdomen; musculoskeletal; and neurological systems. Rectal and genital assessments are optional. Comprehensive assessment is more in depth when performed by an APRN, as described in the last chapter of this text, Chapter 30, Head-to-Toe Assessment of Adult. The assessment for the nurse in the hospital is described in Chapter 29, Assessment of the Hospitalized Adult.

FOCUSED ASSESSMENT

A focused assessment is based on the patient’s health issues. This type of assessment occurs in all settings. It usually involves one or two body systems and is smaller in scope than the comprehensive assessment but is more in depth on the specific issue(s). An example is a patient who presents to the clinic with a cough. The health history focuses on the

duration of the cough, associated symptoms such as wheezing or shortness of breath, and factors that relieve or worsen the cough. The physical assessment includes an evaluation of the nose and throat, auscultation of the lungs, and inspection of sputum. Both the APRN and hospital nurse perform these focused assessments based on the problem and the type of unit on which they are practicing.

PRIORITY SETTING

Priority setting is an important skill in professional nursing practice. It is challenging to learn because there are many factors involved. You use clinical experience, knowledge, expertise, and judgment to determine priorities. Even expert nurses sometimes prioritize in different ways based on their experiences.

Life-threatening issues always take priority: for example, circulation, airway, and breathing take priority over elevated temperature. Another example of a situation that requires immediate attention is a patient at risk for human violence or suicide. If the patient is stable, then your priority is an issue that is very important to the patient or something on which you are spending a lot of time.

CLINICAL SIGNIFICANCE

When prioritizing, you first address any life-threatening situations and then other issues that need immediate attention.

FREQUENCY OF ASSESSMENT

The frequency of assessment varies with the patient's needs, purpose of data collection, and healthcare setting. A patient in a long-term care setting may need a comprehensive assessment once a month, whereas a patient in an acute hospital setting may require an assessment once per shift (Fig. 1.4). Patients in intensive care settings have vital signs and a focused assessment hourly and sometimes even more often. A facility's standard of care prescribes minimum frequency, so it is important for you to identify those standards for the unit and facility in which you are working.

Use judgment to collect data at other times, based on a change in the patient's condition. Patients have focused assessments following treatments to monitor their effectiveness. For example, if your patient who is short of breath is given an inhaler, then listen to lung sounds after the treatment to see if there has been an improvement in wheezing. You also perform assessments to monitor for adverse effects from interventions; for example, assessing for pedal pulses after a procedure in which the femoral artery is punctured and there is a risk of bleeding. Perform a focused assessment if the patient's condition changes.

Well visits are also an important component of health assessment. Periodic health assessment focuses on the most



Figure 1.4 In this emergency, the assessment is combined with interventions and priority setting.

common screening and prevention services for four age groups: (1) birth to 10 years, (2) 11 to 24 years, (3) 25 to 64 years, and (4) 65 years and older. Patients are seen more frequently in the youngest years to monitor growth and development and in later years for the treatment of acute and chronic illnesses.

LIFESPAN ISSUES

A comprehensive screening assessment includes cognitive and emotional development in addition to physical growth. Your aim is to identify expected growth and development patterns, expected variations, and deviations. Growth and development are marked by rapid spurts from infancy through adolescence. Development proceeds more slowly from adolescence through 25 years of age. Motor development occurs rapidly following maturation of the nervous system from birth through school age. Language skills develop rapidly in toddlers and preschool children as vocabulary increases and sentences become more complex. In this text, information on the older adult is included in each chapter; pregnant people and younger populations are covered in separate chapters in Unit 4.

CULTURAL VARIATIONS AND HEALTH DISPARITIES

Knowledge of different cultures is essential for nurses working in all areas and settings of practice. *Cultural competence* refers to the complex combination of knowledge, attitudes, and skills that a healthcare provider uses to deliver care that considers the total context of the patient's situation across cultural boundaries.

Culture is defined as the traits that a group of people share and pass from one generation to the next, including values, beliefs, attitudes, and customs. Subcultures exist within larger cultural groups, so it is important to learn what the patient's specific beliefs or needs are within the larger context.

You need to recognize how each patient interacts with cultures that may differ from their immediate cultures and the extent that they identify with parallel cultures. Cues include dress, food, family, and religion. This information is integrated into each chapter.

COMPONENTS OF THE HEALTH ASSESSMENT

Nurses use communication skills to gather data during the patient interview. In addition to speaking with the patient (verbal communication), you also observe the patient's body position, facial expression, and eye contact (nonverbal

communication). Introduce yourself initially and then explain the purpose of the interview. Confidentiality is important: you must obtain permission from the patient for other people to be present during the assessment, otherwise you will need to ask present to step out for a few moments to allow some privacy. More information about the interview is found in Chapter 2.

The purpose of the health history is to collect family and personal history of risk factors and past issues. Review the family history of medical difficulties or mental health issues with patients. Begin the personal history with biographical data on date of birth, primary language spoken, and allergies. A detailed history includes data on all systems, psychosocial and mental health, and functional status. Document the dates of problems along with treatments and treatment outcomes.

SUBJECTIVE CUES

The primary source for subjective data collection is the patient. Subjective data are based on patient experiences and perceptions. The individual describes the feelings, sensations, or expectations; you then document them as subjective data

or put them in quotes. Your role relative to subjective data collection is to gather information to improve the patient's health status and to help determine the cause of the patient's current symptoms.



CLINICAL JUDGMENT CASE

Collecting Subjective Data: Where Do I Start?

Next Generation NCLEX Style Question

Nurse's Notes

Remember Ms. Ortiz. She was seen in the clinic for newly diagnosed diabetes. The following conversation provides an example of an effective communication style for collecting subjective data. The nurse asks open-ended questions that provide Ms. Ortiz with an opportunity to express and validate concerns.

Nurse: Hello, Ms. Ortiz. How are you doing today? Tell me how things have been going for you.

Ms. Ortiz: (pauses) Well, 2 weeks ago, they told me that I had sugar diabetes. It runs in my family, so I shouldn't be too surprised. I just haven't gotten used to this new diet or activity or the medicines. I would like to know more.

Nurse: Tell me more about your concerns.

Ms. Ortiz: Well, my mother was diabetic, and she couldn't eat sugar. But they said that I can have a little dessert—just a little though. But the dietitian seemed to be more concerned about the cheese that I add to my refried beans.

Nurse: The dietitian is thinking about the long-term effects of the fat in the cheese because it contains calories and cholesterol that can damage your blood vessels and lead to difficulties over time. It's a different way of thinking about it than it used to be.

Ms. Ortiz: Yes, it doesn't make sense to me... (looks down) But things always change. Like this... I didn't think that I would end up with diabetes, too.

Nurse: Yes, it sounds like this is a little overwhelming to you.

- Complete the following sentence by selecting the correct options from each list.

The priority problem for this patient is _____ (list 1) _____ as evidenced by the patient's _____ (list 2) _____.

List 1

diabetes management with new diagnosis

diet restrictions for sugar and fat

family history of sugar diabetes

List 2

expressed concern over family history of diabetes

lacked understanding of sugar and fat restrictions

requested diet, activity, and medication information

Critical Thinking Challenge

- Is this an example of an emergency, comprehensive, or focused assessment? Provide examples of the different types of assessments.
- How is the role of the RN different from that of the APRN when working with Ms. Ortiz? Consider assessment, health promotion, and teaching.
- What parts of the nursing process are used in the conversation? Give examples.

OBJECTIVE CUES

The physical assessment follows the history and focused interview and includes objective data, which are measurable. You observe the patient's general appearance; assess vital signs; listen to the heart, lungs, and abdomen; and assess peripheral circulation. Chapters 11 to 24 include focused techniques specific to each body system. Only the most important screening assessments for each system are included in the head-to-toe assessment because it is too overwhelming and time-consuming to complete all focused techniques at once. Use clinical judgment to decide which additional focused assessments to perform based on the individual patient.

DOCUMENTATION AND COMMUNICATION: PROGRESS NOTE AND SBAR

Documentation of both subjective and objective findings is essential to meet legal requirements and also communicate findings to others. Accurate documentation provides a baseline so that changes can be noted between assessments. The Health Insurance Portability and Accountability Act of 1996 (Health Insurance Portability and Accountability Act, 2003) regulates the security and privacy of information. Confidentiality of documentation is essential, and only information pertinent to the care of the patient is shared. More information on documentation is found in Chapter 4. This text uses the SOAP note format, although other formats also document nursing thinking. Patient examples of SOAP documentation are included in each chapter.

Communication of assessment data is also verbal. Care of the patient is collaborative, and nurses use an organized method when communicating with other healthcare providers. Nurses describe the situation, background, and assessment data to make recommendations about the treatment that is indicated—a system known as SBAR communication—situation, background, assessment, and recommendation (IHI, 2018). Nurses also use an organized method when giving a report between shifts or when transferring (handing off) patients to other departments, such as when a patient is sent to the operating room (IHI, 2018). More information about SBAR and examples are included in Chapter 4 and the systems chapters.

Since the discovery of safety lapses resulting in patient deaths in hospitals, efforts have been made to improve this very large problem by bolstering interprofessional communication. Interprofessional collaborative practice competency domains include the following:

- Values/ethics for interprofessional practice
- Roles/responsibilities
- Interprofessional communication
- Teams and teamwork

“Front-line” health professionals identify the importance of clearly describing one's own professional role and responsibilities. It is also essential to understand other healthcare workers' roles and responsibilities. A common language for interprofessional communication is the Team-STEPPS training program, which endorses practices such as SBAR, call-out, and check-back (see Chapter 4). The goal is to have communication that is clearly expressed and understood.

In this text, the examples of documentation (SOAP note) and verbal communication (SBAR) all use a shared medical language that is learned by team professionals. Although the medical terminology is challenging to build, it is essential to learn and use so that others can understand you clearly.

FRAMEWORKS FOR HEALTH ASSESSMENT

There are three major frameworks for organizing assessment data: functional systems, head-to-toe system, and body systems (Table 1.2). All these methods provide an organizing framework so that no important assessment data are overlooked. Each type begins with a general survey of the patient, vital signs, and level of distress. Developing a consistent and organized approach is more important than considering which system to use.

FUNCTIONAL ASSESSMENT

A functional assessment focuses on functional patterns that all humans share: health perception and health management, activity and exercise, nutrition and metabolism, elimination, sleep and rest, cognition and perception, self-perception and self-concept, roles and relationships, coping and stress

TABLE 1.2 COMPARISON OF ASSESSMENT FRAMEWORKS

Functional Systems	Head-to-Toe System	Body System(s)
Nutrition and metabolism	Head and neck	Neurological and cardiovascular
Cognitive perceptual	Eyes and ears	Neurological
Nutrition and metabolism	Nose, mouth, and throat	Gastrointestinal and respiratory
Activity exercise	Thorax and lungs	Respiratory
Activity exercise	Cardiac	Cardiovascular
Activity exercise	Peripheral vascular	Cardiovascular
Sexuality and reproduction	Breast	Reproductive
Nutrition and metabolism, sexuality and reproduction, elimination	Abdominal	Gastrointestinal, urinary, and reproductive
Activity exercise	Musculoskeletal	Musculoskeletal
Cognitive perceptual	Neurological	Neurological
Sexuality and reproduction	Male or female genitalia	Reproductive
Sexuality and reproduction, elimination	Anus, rectum, and prostate	Gastrointestinal and reproductive
Health perception, sleep, cognition, self-perception, roles, coping, sexuality, value	Functional health status	Mental health

tolerance, sexuality and reproduction, and values and beliefs (Gordon, 1993). Nurses often use the functional patterns to collect subjective data and a head-to-toe approach for the physical assessment.

HEAD-TO-TOE ASSESSMENT

A head-to-toe assessment is the most organized system for gathering comprehensive physical data. It is very inefficient to collect physical data by functional status because data in one

functional area are collected from different parts of the body. For example, peripheral circulation is assessed in both the arms and the legs. It is more organized to proceed from head to toe rather than assess the arms and legs and then come back to listen to the heart and lungs. When exposing the chest, both the heart and the lungs are auscultated. The chest is covered, then the abdomen is assessed and covered, and finally, the legs and feet are assessed. You can see how this method is more efficient in addition to providing more modesty for patients.



CLINICAL JUDGMENT CASE

Documenting Changing Findings: What Could It Mean?

Next Generation NCLEX Style Question

Nurse's Notes

Alert and oriented. Skin pink, warm, and dry. Appears with increased weight and high BMI, good personal hygiene, appears stated age. BP 138/78 mm Hg, pulse 82 beats/min, and respirations 16 breaths/min. Height 1.52 m (5 ft), weight 75 kg (165 lb), and BMI 32.2. Recent blood glucose 260 mg/dl and hemoglobin A1c of 7.5%.

> For each finding below, check the appropriate box to indicate if the finding is consistent with the nursing diagnoses of obesity, diabetes, and risk for nutritional excess. Each finding may support more than one diagnosis.

Patient Findings	Obesity	Diabetes	Risk for Nutritional Excess
BMI 32.2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Takes oral hypoglycemic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recent blood glucose 260 mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemoglobin A1c of 7.5%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note: Each column must have at least one response selected.

BODY SYSTEMS APPROACH

A body systems assessment approach is a logical tool for organizing data when documenting and communicating findings. This method promotes critical thinking and allows you to analyze findings as you cluster similar data. Data from

the functional and head-to-toe assessments are reorganized. If the patient with shortness of breath is also cyanotic and wheezing, then you suspect a respiratory issue. Rather than identifying one piece of data in isolation, a systems approach allows you to cluster similar data to identify issues.

CLINICAL JUDGMENT

You must use a variety of cues from both subjective and objective data to establish priorities of care based on the patient's health problems and analyze what they mean. *Priority setting* is the ability to make decisions about the rank order in which nursing actions should be taken using nursing judgment (ATI, n.d.). To prioritize what comes first, think of four frameworks: what is most life-threatening, airway-breathing-circulation, safety risks, and least invasive interventions. Three other frameworks are Maslow's Hierarchy of Needs, nursing process, and urgent versus chronic condition.

DECIDING WHAT TO DO FIRST

Critical thinking, decision-making, prioritization, and time management are four skills necessary for nurses to be able to provide nursing care in an efficient and safe manner (ATI, n.d.).

Critical thinking is the process of analyzing and evaluating information. It leads to accurate care planning and delivery. Decision-making is the process by which a course of action is determined. The course of action may be in response to an actual or potential health threat. Priority setting is the organization of activities according to the order in which they should be done. Time management is used in the clinical environment, where the nurse decides how to cluster and organize care. It is making the best use of time to complete tasks.

PRIORITY SETTING

Nurses must continuously set and reset priorities to meet the needs of multiple patients and to maintain patient safety. Priority setting requires decisions about the order in which patients are seen and assessments are completed. It also factors into when interventions are provided and how patient care is completed. Prioritize in the following order (ATI, n.d.):

- Systemic before local (“life before limb”)
- Interventions for a patient in shock over interventions for a patient with a localized limb injury
- Acute (less opportunity for physical adaptation) before chronic (greater opportunity for physical adaptation)

- Care of a patient with a new injury/illness (or acute exacerbation of a previous illness) over the care of a patient with chronic illness
- Actual problems before potential future problems
- Administration of medication to a patient experiencing acute pain over a patient with chronic pain
- The timing of administration of antidiabetic and antimicrobial medications as more important than administration of some other medications
- Signs of medical emergencies and complications (stroke, heart attack) versus expected patient findings.

PRIORITY SETTING FRAMEWORKS

There are several ways to prioritize patient care in the clinical setting. Five to six frameworks might be used on any given day. Priority setting is a complex skill that needs to be put into context and takes several years to develop at an expert level. When answering questions on tests and the NCLEX exam, read through the answers to see if the question is asking you to use a specific framework to prioritize. For example, if a question asks, “What will you do first?” and the answers include assess, diagnose, plan, and evaluate, then know that the question uses the nursing process framework. If a question asks, “Which patient will you see first?” and the answers include symptoms of airway, breathing, and circulation, then know that this is an ABCD (airway, breathing, circulation, disability) question (and choose airway first).

MASLOW'S HIERARCHY OF NEEDS

The nurse should consider Maslow's Hierarchy of Needs when prioritizing interventions. The five levels of Maslow's hierarchy, in order of priority, are physiological, safety and security, love and belonging, self-esteem, and self-actualization. For example, the nurse should prioritize a patient's need for airway, oxygenation (or breathing), circulation, and potential for disability over need for shelter. The nurse should also prioritize a need for a safe and secure environment over a need for family support.

URGENT AND ACUTE VERSUS CHRONIC

Always identify any life- or limb-threatening condition and intervene before continuing with further assessments. Focus on the urgent problem at the beginning of each assessment, then focus the assessment and take action. You may need to work on interventions as you do further assessments and get assistance as needed. Rapid response teams save lives, and they know when it is appropriate to call for extra help. As you answer questions on tests, think of the “red flags” for high-risk conditions, such as warning signs of stroke and heart attack, and shock. These urgent conditions are identified at the beginning of each subjective cues section for each body system with a “safety alert.”

AIRWAY, BREATHING, CIRCULATION, DISABILITY FRAMEWORK

The ABCD framework identifies the three basic needs for sustaining life in order. The severity of symptoms should also be considered when determining priorities. A severe circulation problem may take priority over a minor breathing problem (ATI, n.d.). An open airway is necessary for breathing, so it is the highest priority. You should remember this from cardiopulmonary resuscitation (CPR). Breathing is necessary for oxygenation of the blood to occur. Circulation is necessary for oxygenated blood to reach the body’s tissues. Disability addressing the high priority given for dehydration, coma, and convulsion. Exposure (“E” can be added) means avoid exposure to environmental hazards.

Priority interventions for ABCD include:

- **Airway:** Identify an airway concern (obstruction, stridor), establish a patent airway if indicated, and recognize that 3 to 5 minutes without oxygen causes irreversible brain damage secondary to cerebral anoxia.
- **Breathing:** Assess the effectiveness of the patient’s breathing (apnea, depressed respiratory rate) and intervene as appropriate (reposition, administer Narcan).
- **Circulation:** Identify circulation concern (hypotension, dysrhythmia, inadequate cardiac output, compartment syndrome) and institute appropriate actions to reverse or minimize circulatory alteration.
- **Disability:** Assess for current or evolving disability (neurological deficits, stroke in evolution) and implement action to slow down the development of disability.
- **Exposure:** Keep patient warm, identify all injuries and threats, and avoid hypothermia.

SAFETY/RISK REDUCTION

First evaluate the environment for a safety risk. For example, is there a finding that suggests a risk for airway obstruction, hypoxia, bleeding, infection, or injury? Next ask, “What’s the risk to the patient?” and “How significant is the risk compared to other posed risks?” Give priority to responding to whatever finding poses the greatest (or most imminent) risk to the patient’s physical well-being.

NURSING PROCESS

Use the nursing process to gather pertinent information before making a decision regarding a plan of action. Remember ADPIE: assess, diagnose, plan, implement, and evaluate. An evaluation is an assessment performed after an intervention is completed. An assessment is initially performed to start the diagnostic reasoning and care planning process. For example, if you are given a patient with a low BP, then you will want to collect more data to try to diagnose the problem before calling the provider for orders for an intravenous (IV) fluid.

SURVIVAL POTENTIAL

Use this framework for situations in which health resources are extremely limited, such as a mass casualty and disaster triage (Clarkson & Williams, 2020):

- **Priority 1 (Red)** is serious but salvageable life-threatening injury/illness. This category includes burns, severe bleeding, heart attack, breathing impaired, and internal injuries. They are assigned a priority (Red) code and first priority for treatment and transportation.
- **Priority 2 (Yellow)** is a moderate to serious injury/illness and not immediately life-threatening. These are victims with potentially serious injuries, such as fractures.
- **Priority 3 (Green)** is “walking-wounded.” These victims are not seriously injured and are quickly escorted to a staging area out of the “hot zone” to await delayed evaluation and transportation.
- **Non-Priority 4 (Blue)** are those victims with critical and potentially fatal injuries and not expected to survive, so no treatment or transportation.

LEAST RESTRICTIVE INTERVENTIONS

Select interventions that maintain patient safety while posing the least amount of restriction to the patient (ATI, n.d.). For example, if a patient has low BP due to dehydration, then attempt to give oral fluids before IV fluids. In a patient with a high fall risk, move the patient closer to the nurses’ work area rather than apply restraints.

USING EVIDENCE-BASED PRACTICE

Evidence-based practice is an approach to patient care that minimizes intuition and personal experience and relies on research findings and high-grade scientific support. Evidence-based practice helps solve common problems through the following four steps:

1. Clearly identify the issue or difficulties based on an accurate analysis of current nursing knowledge and practice.
2. Search the literature for relevant research.
3. Evaluate the research evidence using established criteria governing scientific merit.
4. Choose interventions and justify the selection with the most valid evidence.

There are many ways to use research and evidence to provide holistic care to patients. The National Institute for Nursing Research (NINR), formed in 1986, greatly increased the visibility and funding opportunities for nursing research. The International Honor Society for Nursing, Sigma Theta Tau, has also increased its capacity to support and disseminate nursing scholarships for nursing research. The Cumulative Index to Nursing and Allied Health Literature (CINAHL) is a database with a focus on nursing research.

Some evidence is evaluated by performing clinical trials, such as measuring the accuracy of a new oral thermometer against core temperature. If there are several clinical trials, a systematic review of the quality trials becomes the standard criterion. The Cochrane Database, available in most medical libraries, is considered the most complete and accurate collection of systematic reviews. The National Guidelines Clearinghouse also has recommendations based on clinical evidence. PubMed, a search engine that primarily accesses MEDLINE Medical Literature Analysis and Retrieval System Online, or MEDLINE, is another website for obtaining

the most current evidence. Many nursing facilities are implementing programs in which nurses develop a clinical question and find the best evidence to plan care. In this way, nurses base individual patient decisions on the best existing evidence rather than on their personal experience. See Box 1.2 for a list of these websites and those in the preceding paragraph.

BOX 1.2 Resources to Support Research and Evidence-Based Practice

- Cochrane Database: cochranelibrary.com/cdsr/about-cdsr
- Cumulative Index to Nursing and Allied Health Literature (CINAHL): ebsco.com/products/research-databases/cinahl-complete
- International Honor Society for Nursing, Sigma Theta Tau: nursingsociety.org
- National Institute for Nursing Research (NINR): ninr.nih.gov
- PubMed: pubmed.ncbi.nlm.nih.gov/



CLINICAL JUDGMENT CASE

Analyzing Changing Findings: Progress Note

Nurse's Notes

The initial subjective and objective data collection is completed for Ms. Ortiz, and the nurse has spent time reviewing findings and results. This information now needs to be documented. The following nursing note illustrates how subjective and objective data are clustered, analyzed, and communicated in the form of a SOAP note based on the nursing process. Subjective and objective data are part of the assessment, the analysis is the diagnosis, and the plan includes the planning, implementation, and evaluation.

SUBJECTIVE: "I just haven't gotten used to this new diet."

OBJECTIVE: Alert and oriented. Skin pink, warm, and dry. Appears with weight of high BMI, good personal hygiene, appears stated age. BP 138/78 mm Hg, pulse 82 beats/min, and respirations 16 breaths/min. Current medications include an oral hypoglycemic medication and daily vitamin. Expressing concerns about diet and intake of sugar and fat. Typical diet is high in starch and fat and low in fresh fruits and vegetables.

ANALYSIS: Health-seeking behaviors related to new diagnosis and medication.

PLAN: Perform teaching on diet and safety related to potential hypoglycemia from oral hypoglycemic medication. Follow up at next visit. Refer to educator for classes.

Critical Thinking Challenge

- What priority general and focused assessments will you suggest during today's visit?
- What type of subjective and physical assessment will you perform at her next visit?
- How will you evaluate Ms. Ortiz's assessment considering her culture, religion, native language, and family?

GENERATE SOLUTIONS



CLINICAL JUDGMENT CASE

Interprofessional Collaboration: What Can I Do?

Next Generation NCLEX Style Question

Nurse's Notes

Ms. Ortiz has a follow-up appointment related to type 2 diabetes, which was diagnosed 2 weeks ago during an annual physical assessment.

SITUATION: Her primary language is Spanish. Although her English skills are good, she has difficulty understanding complex medical terminology. Ms. Ortiz has been married for 30 years, and her three grown children live nearby.

BACKGROUND: Medications include an oral hypoglycemic to lower blood sugar and a daily vitamin. She expresses concern over a family history of diabetes. She has a lack of understanding of sugar and fat restrictions in her diet. Height 1.52 m (5 ft), weight 75 kg (165 lb), and BMI 32.2. Recent blood glucose 260 mg/dl and hemoglobin A1c of 7.5%.

ASSESSMENT: Diabetes management with new diagnosis. Diet restrictions for sugar and fat. Needs medication management.

RECOMMENDATIONS: Educate on diet, activity, and medication information. Teach about medication in collaboration with the pharmacist. Prioritize safety with potential low blood sugar reaction to medication. Increase knowledge of dietary regime in collaboration with the dietitian. Promote exercise in balance with diet and medication after they have become more stable. Physical therapy can be involved in this plan when she returns for her next visits.

- For each potential nursing intervention, place a check mark in the appropriate column to specify whether the intervention is indicated, nonessential, or contraindicated for the care of the patient.

Potential Intervention	Indicated	Nonessential	Contraindicated
Teach about medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increase knowledge of dietary regime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Promote exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note: Each column must have only one response selected.



CLINICAL JUDGMENT CASE

Plan the Care: What Will I Do?

Next Generation NCLEX Style Question

Nurse's Notes

The nurse uses this assessment data to formulate a nursing care plan for Ms. Ortiz. After the interventions are completed, the nurse will reevaluate her and document the findings in the chart to show critical thinking. This is often in the form of a care plan or case note similar to the one below.

Diagnose	Plan Outcomes	Implement	Rationale	Evaluate Outcomes
Health-seeking behaviors (related to new diagnosis and medication)	The patient states what to do for symptoms of hypoglycemia.	Discuss signs and symptoms of hypoglycemia. Discuss what to do if the patient is hypoglycemic, and provide a list of appropriate foods to increase blood glucose level.	Written information reinforces verbal information and can be used as a resource once the patient is at home.	Patient stated signs and symptoms of hypoglycemia. Patient named four foods that contain 10–15 g fast-acting carbohydrates. Patient will bring questions to next clinic visit.

- The nurse has received orders from the healthcare provider. Identify the three orders that the nurse should perform immediately.

- Discuss what to do if the patient is hypoglycemic.
- Provide a list of appropriate foods to increase blood glucose level.
- Make appointment for follow-up after 2 weeks.
- Discuss signs and symptoms of hypoglycemia.



CLINICAL JUDGMENT CASE

Evaluating Outcomes: Did It Help?

Next Generation NCLEX Style Question

Think about how you built your knowledge of a nurse's role while interviewing Ms. Ortiz. Notice how you modified and individualized her assessment based on your new knowledge.

Nurse's Notes

During Ms. Ortiz's assessment, you noted that she was overwhelmed but was willing to learn about her newly diagnosed diabetes. Her physical examination showed that she appeared to have a high BMI. Current medications include an oral hypoglycemic medication and daily vitamin. Recent blood glucose 260 mg/dl and hemoglobin A1c of 7.5% are unchanged. She was expressing concerns about diet and intake of sugar and fat. The nurse identified the safety issue of the side effect of low blood sugar as a priority.

Ms. Ortiz was reassessed following patient teaching. She stated signs and symptoms of hypoglycemia, named foods that contain fast-acting carbohydrates, and will bring questions to her next clinic visit.

Note how you used Ms. Ortiz's condition to prioritize, critically think, apply clinical judgment, and intervene. Weight reduction and better nutrition are needed, but these things can be discussed after safety issues are addressed. Nursing, nursing students, and professional nurses have an opportunity to uniquely affect the lives of others in this way. It is both a responsibility and a privilege to learn to function within this nursing role and provide excellent care to patients.

➤ The nurse has performed the interventions as ordered by the healthcare provider. Select the assessment findings that indicate improvement in the patient's condition. These findings are part of the outcomes that are evaluated to see if the interventions are working.

- Stated signs and symptoms of hypoglycemia
- Recent blood glucose 260 mg/dl
- Named four foods that contain 10–15 g fast-acting carbohydrates
- Stated she will bring questions to next clinic visit
- Hemoglobin A1c of 7.5%

Key Points: You've Got This!

- The role of the professional nurse is to promote health, prevent illness, treat human responses, and advocate for patients.
- Nurses are providers, designers, managers, and coordinators of care as well as advocates and educators.
- Nursing values include caring, diversity, integrity, and excellence.
- Health can be conceptualized as a point between wellness and illness, as either a high or a low level of health.
- *Healthy People* is a U.S. government initiative to focus on health promotion and risk reduction strategies.
- The four main goals of nursing are to promote health, prevent illness, treat human responses to health and illness, and advocate for individuals, families, and communities.
- Steps of the nursing process include assessing, diagnosing, setting goals and outcomes, planning, intervening, and evaluating.
- Diagnostic reasoning is a process by which nurses use critical thinking to cluster the assessment information and to draw inferences and propose diagnoses.
- The clinical judgment model used in the NGN style questions (1) forms hypotheses, (2) prioritizes them, (3) generates solutions, and then (4) takes actions.
- Types of assessments are emergency, comprehensive, and focused assessments.
- Subjective data are based on the patient's experiences and perceptions.
- Objective data are measurable and usually collected as part of the physical assessment.
- Organizing frameworks for assessment include functional, head-to-toe, and body systems.
- Evidence-based nursing relies on research findings and high-grade scientific support, including CINAHL, Cochrane Database, and MEDLINE.

REVIEW QUESTIONS

- A patient is having adverse effects resulting from a medication. The nurse calls the primary care provider to request a change in the medication order. The nurse is functioning as a(n)
 - educator.
 - advocate.
 - organizer.
 - counselor.
- Nurses advocate for underserved populations to reduce health disparities. This promotes
 - autonomy.
 - altruism.
 - respect.
 - human dignity.
- Nurses belong to the ANA as part of their
 - ongoing professional responsibility.
 - role as manager of care.
 - wellness promotion for patients.
 - cultural education activities.
- The purpose of health assessment is to
 - obtain subjective and objective data.
 - intervene to correct difficulties.
 - outline appropriate care.
 - determine whether interventions are effective.
- The nurse documents the following information in a patient's chart: "Cough and deep breathe every hour while awake." This is an example of
 - evidence-based nursing.
 - priority setting.
 - comprehensive assessment.
 - nursing interventions.
- The nurse provides teaching about smoking cessation to a 20-year-old patient. The nurse assesses that the patient is concerned because their father died from lung cancer. Which theory would the nurse most likely use when providing teaching to this patient?
 - Health belief model
 - Diagnostic reasoning model
 - Cultural competence model
 - Body systems model
- Which of the following processes is the most important when providing nursing care to a patient who is ill?
 - Writing outcomes
 - Performing a focused assessment
 - Collecting objective data
 - Using clinical judgment.
- A patient is admitted to a hospital for surgery for colon cancer. What type of assessment is the nurse most likely to perform on admission?
 - Emergency
 - Focused
 - Comprehensive
 - Illness
- Which of the following are the components of a comprehensive health assessment?
 - Nursing diagnoses
 - Goals and outcomes
 - Collaborative problems
 - Examination of body systems
- The nurse conducts the health history based on the patient's responses to the medical diagnosis. This type of framework is based on the
 - functional framework.
 - objective framework.
 - coordinator framework.
 - collaborative framework.

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