Guide to understanding the Assessment data/Critical Thinking Worksheet

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How to read the instructions.

Basic assessment data according to Orem - In this section, you need to identify your assessment data. That is all the information you have obtained from your history and physical assessment, as it pertains to each self-care topic.

- Examples include: all physical, psychological and pertinent social findings such as: VS, lung sounds, pt's mood, urinary output (ect)

Comprehensive assessment data according to Orem - In this section, extrapolate on your assessment findings. Here are some examples: (This is not an all inclusive list)

- If you tested the patient's O2 sat on room air (off O2), report the value here.
- If you obtained additional history from a family member or health care team member.
- If you have noted a pattern of change in the patient(i.e. weight loss over a few days or change in pattern of vital signs)
- Pertinent past medical history related to a self care NURSING need (Hx of smoking related to nursings need to provide smoking secession teaching)
- Implications of medical diagnosis (OK to use the medical diagnosis but identify the symptoms which affect nursing care such as; "Pt has CHF which compromises his respiratory abilities and pot for fluid overload")
- Pertinent lab data
- Erickson's developmental stages
- Grief theory stages
- Pertainent medications the patient is taking

3. Rationale for performing each assessment - Why did you conduct each assessment? Why did you ask each question? What did you plan to do with the information? Ultimately, you needed to narrow down the patient story and list of symptoms into something you could help him with. This question is asking what were you trying to find out in your history and physical? What do the lab values tell you about the patient? There may be multiple items you were trying to identify or rule out. Consider the effects and side effects and interations of medications. Include appropriate research findings.

For example if your friend had flu like symptoms, you might ask the following questions:
Do you have a fever? (To determine if this is a viral or bacterial infection Vs malaise; may also dictate treatment)
Do you have nasal congestion? (To determine airway compromise; need for humidifier)
Do you have a cough? (To determine lung involvement/ O2-Co2 exchange problems/ help determine possible treatments)
What color is the phlegm? (To determine presence or absence of infection)
What have you been doing to treat yourself? (To determine patient's self care ability)

Auscultating his lungs (To assess areas of lung involvement and quality of breath sounds, which may dictate treatment)
Assess temperature (To assess the body's ability to react to infection)

Actual or Potential high-risk conditions - This is simply asking for the nursing diagnosis. Develop the nursing diagnoses', including the statements *related to(r/t)* and *as evidenced by (AEB) For* example: alt in cardiac output r/t bradyarrthymias AEB HR 50's, lightheadedness and postural hypotension Nursing diagnoses may also be potential problems such as the post operative patient always has a potential risk of infection. With potential problems, you cannot have ABE (as evidenced by) symptoms, for if you do, you have an actual problem.

Modify plan of care by synthesizing data and predicting possible outcomes - This question is asking you to develop a plan of care, that all members of the nursing team can follow. Remember, as a RN you will be responsible for directing the LVN and NA staff members. Include interventions that are realistic and appropriate for the patient. Consider using other resources such investigating your med/surg books to develop diagnosis specific interventions or consulting with the medical staff. For example: Thyroidectomy patients have a risk of parathyroid removal, which can lead to hypocalcemia. Interventions such as monitoring serum calcium levels and performing Chvostek's sign are appropriate interventions.

Final Notes:

- Make sure you cover all your bases. If you identified an abnormal assessment finding, you need to address it in sections 3, 4, & 5 of the critical thinking worksheet.
- Use your resources to develop critical thinking interventions. Use books, Doctors or experienced nurses to assist you. Know the disease process that your patient is experiencing because as the RN, you will be expected to !
- Use the patient's Kardex and existing care plan as quides.

H**ow to categorize the self-care topics.**

Orem's theory is based on a client's ability to perform self-care that is; taking care of them selves without outside assistance. Orem developed Universal; Developmental and Health-Deviational self care requisites (SCR). These items have been categorized on the attached assessment sheet. Developmental SCR's refer to the patient's ability to adjust to life in an age appropriate manner. (I.e. - Is you five year old client behaving more like a two year old, still in diapers)
Health-Deviational SCR's refer to the client's ability to adjust to life while incorporating a disease state. (I.e.- How is your diabetic client managing at home with his new health care requirements? Is he performing self-care or does he still require nursing assistance, called partially compensatory interventions)

Clinical Judgement Worksheet

The key to this work sheet is PRIORITIZATION. Ask your self, what are this patient's main problems? Where do I have to focus my nursing care? What body system am I focusing the most on with this patient?

Section 1 - List the MOST PERTINENT assessment data you identified for this patient. Do not list past, resolved problems. For example: If your patient is post operative and experiencing severe pain, then PAIN is his main symptom. True, he may be NPO and not receiving nutrition but this is not his main problem. It is expected that he will remain NPO until bowel sounds resume. In section 1, you should identify all these symptoms (pain and NPO status) but keep in mind your priority for section 2.

Section 2 - Using list 1, develop the nursing diagnosis that best pertains to the patient's main problems, then rank order them. For example: If you had a patient who had a diminished level of consciousness, you would instruct the NA not to feed the patient. The priority is to monitor the alt level of consciousness, not to address the Nutrition. The care is now INDIVIDUALIZED.

Section 3 - In this section, you need to explain why you prioritized the patient's needs the way you did. For example in section 1, the NPO status was not as critical as the pain because you would not expect the patient to have bowel sounds yet. In section 2, if the NA fed a somnolent patient, he may aspirate.

Section 4 - In this section, you need to select 6 areas of teaching and write a rationale. Include family and caregivers where appropriate.

Pointers for Nursing Care Plans, the Orem way!

Nursing Diagnosis section: include if the diagnosis is a U (universal), D (developmental) or HD (health devotional) need. Simply write the appropriate letter next to the nursing diagnosis.
Examples: U = alt in breathing pattern r/t pneumonia ABE copious secretions
D = alt in coping r/t stressful family dynamics AEB crying a times
HD= alt in self image r/t BKA AEB fears of moving, inability to look at stump

Client goals: Make these goals measurable for the patient. For example: Pt will maintain an O2 sat >95%, is more measurable than, patient will not have any SOB. You need to develop short and long term goals; then identify them ST or LT. The duration of goals will vary with individual patients.

Nursing Interventions: Orem's nursing care can be categorized into 3 types

Wholly compensatory - when the nurse is expected to accomplish all of the patient's self care needs.

Partially compensatory - when both the nurse and the patient engage in meeting the self care needs.

Supportive educative - when the nurse provides assistance with patient's decision making or behavior control or learning.

Rationale : This refers to your rationale for your nursing interventions. Your Med/Surg book may be a good guide.

Evaluation: Must refer to your goals. If your goals are measurable, this will be easy
Do not refer to each intervention! You are evaluating your goals!