

Chapter 2

Understanding our role in patient assessment

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NMC Future Nurse: Standards of Proficiency for Registered Nurses

This chapter will address the following platforms and proficiencies:

Platform 3: Assessing needs and planning care

At the point of registration, the registered nurse will be able to:

- 3.4 understand and apply a person-centred approach to nursing care, demonstrating shared assessment, planning, decision making and goal setting when working with people, their families, communities and populations of all ages.
- 3.5 demonstrate the ability to accurately process all information gathered during the assessment process to identify needs for individualised nursing care and develop person-centred evidence-based plans for nursing interventions with agreed goals.

Platform 4: Providing and evaluating care

At the point of registration, the registered nurse will be able to:

- 4.1 demonstrate and apply an understanding of what is important to people and how to use this knowledge to ensure their needs for safety, dignity, privacy, comfort and sleep can be met, acting as a role model for others in providing evidence-based person-centred care.

Chapter aims

After reading this chapter, you will be able to:

- identify the nurse's role in patient assessment and discuss why it is so important;
- describe four ways of knowing and the nature of truth;
- use Standing's cognitive continuum and identify its relevance to nurses and patient assessment; and
- understand some consequences of stereotyping.

Introduction

Case study: Mr Tyler's dog bite

Mr Tyler keeps a number of very large dogs. One of them recently bit him on the left hand while he was trying to separate a dog fight in his back garden. Mr Tyler attended the local minor injuries unit, where he had the wound cleaned and dressed and was given a tetanus booster and a course of antibiotics.

You are on placement with the community district nurses, who have been asked to check the wound and continue the dressings as necessary. Mr Tyler answers the door and you are faced by a man who has numerous piercings and tattoos and who is wearing a death metal T-shirt. You feel quite intimidated. Before you can clean the wound, the old dressing has to be removed, and it appears quite dirty. The district nurse asks Mr Tyler what he has been doing to get the wound dressing so dirty. Mr Tyler starts to get angry. The district nurse tries to calm him by saying that until she knows what his needs are, she cannot offer any potential solutions to keep the wound clean. Mr Tyler identifies that he repairs motorbikes and needs to use both hands to do this, and he cannot take time off as he has a number of projects due for completion. The district nurse suggests that he could wear gloves while he does this and identifies where he might buy these. She also emphasises the importance of keeping the wound clean in order to help it heal. She explains that the healing process will take longer because Mr Tyler is still using his hand. Afterwards, you ask if she felt intimidated. The district nurse explains the importance of meeting people where they are. Her priority is assessing the individual's needs rather than imposing an ideal solution.

The case study above highlights the importance of courage – one of the 6Cs – as you confront your fear and focus on the person instead (to review the 6Cs, see Chapter 1). In the previous chapter, you were asked to explore your values and beliefs around person-centredness. Our values can also form part of the framework for patient assessment. The Nursing and Midwifery Council's code of professional standards of practice and behaviour for nurses, midwives and nursing associates (NMC, 2018b) clearly states the values nurses are expected to apply within their professional work. Nurses come from different cultural contexts and backgrounds where their own individual value systems will have started to develop. It is important to recognise the origins of your own attitudes and beliefs and how these will influence how you see things, especially how they might affect the way in which you undertake patient assessments.

The case study above highlights how someone's dress and personal presentation can be interpreted as reflecting values and beliefs that may be very different from yours, and you may find this challenging and potentially intimidating. How you feel can influence not only how you behave, but also the way you frame your patient assessment, and may also affect how much time it takes. It is important, as the case study identifies, to work

with the patient in planning their care. What is most important here is that the assessment is about the patient's health needs, not about who they are or what they believe. This chapter will explore factors that may promote or inhibit effective patient assessment. It will also look at how to build on your current skills and knowledge (learnt both in nursing and outside) to develop your patient assessment technique. It will begin by clarifying what patient assessment means and then continue by considering how attitudes, beliefs and stereotyping can affect the accuracy of patient assessment, and how to balance subjective and objective forms of assessment.

What is patient assessment?

Properly done, patient assessment is the *holistic* process of evaluating the patient's mental, physical, social, cultural, spiritual and personal needs, and of identifying the patient's wishes in relation to the options available for meeting these needs. Failure to recognise and respond to patient needs can result in those needs not being met and a failure of care (McCormack and McCance, 2016; Wilson et al., 2018). This will be detrimental to the patient and may be professionally damaging for health professionals caring for the patient, including you. For example, you may not pass the practice assessment component of your programme. Within patient assessment, it is important to consider the patient's *lifeworld* in order to identify that patient's needs. Lifeworld refers to the history, culture, people, relationships and situations that are part of a patient's experience (West et al., 2007). The following case study helps to illustrate these points.

Case study: Graham's medical ward placement

Graham was in the second year of his nurse preparation programme, working on a ward specialising in diabetes care. Sam, a student undertaking a law degree, was newly diagnosed with diabetes and was struggling with managing his blood sugar level control. Graham was asked by his practice supervisor, Brett, to complete Sam's admission assessment.

Graham checked Sam's notes before meeting him and identified that he had had two hypoglycaemic episodes in the last few days, the most recent being one that brought him to accident and emergency.

Graham asked Sam about his medical history and then checked his understanding of diabetes. He noted that Sam was a vegan and that he had been given advice from the dietitian previously. Graham assumed that Sam would therefore know what foods he could have and those he needed to take care with. Sam told Graham that he had completed his exams recently, which he thought might have contributed to his hypoglycaemic episodes, due to the stress affecting his eating pattern.

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Graham completed the assessment, documenting Sam's veganism in the biographical section. He was pleased with managing to complete the paperwork and informed Brett that Sam's admission was complete without highlighting the issues about Sam's recent stress and the disruption to his eating pattern.

Activity 2.1 Critical thinking

In the case study above, what might be the repercussions for Graham, Brett and Sam of failing to report the issue of Sam's stress and disrupted eating in the patient assessment? How does this scenario relate to the 6Cs?

An outline answer is given at the end of the chapter.

As the case study highlights, assessment undertaken with – rather than on – patients is preferable because an inclusive approach is more likely to gain patient cooperation and more accurate information. Not only that, but the planned outcomes it elicits are more likely to align with what the patient actually wants. Such an assessment is called person-centred because not only does it take account of the patient's wishes, but it also takes account of the patient's lifeworld. This means all the elements that make up the patient's everyday life, including relevant family/friends, daily activities, preferences and interests. In their research into trust in the pre-hospital non-urgent care setting, Norberg Boysen et al. (2017) identify how attention to the lifeworld of the patient by healthcare professionals contributes to the patient having trust in the professional and the care environment; something which, contrary to what many nurses believe, is not automatically granted in many care interactions.

As the case study highlights, adding the information about Sam's recent stress and eating pattern might enable a broader assessment of his needs and more focused use of resources. The purpose of assessment is to identify what treatment, services or care the patient needs, but more importantly whether the patient also wants them (Field and Smith, 2008). Graham's response suggests he is focused on the task of admitting Sam and completing the documentation rather than listening attentively to what Sam is saying. We now proceed to look at the nurse's role in patient assessment.

What is the nurse's role in patient assessment?

Undertaking a patient assessment requires the nurse to draw on different forms of knowledge. Carper (1978) defined the 'ways of knowing' required in nursing as

empirics, aesthetics and ethics (page 14). In essence, what this means is that evidence-based knowledge (empirics) should be used to underpin patient assessment, but that employing caring behaviours to help build a therapeutic relationship (aesthetics) with your patient is of equal importance and also needs to be underpinned by ethical behaviour. The Royal College of Nursing has acknowledged that trying to define the knowledge that nurses use is complex and not necessarily helpful, as nursing is constantly evolving (RCN, 2003). In 2009, Moule and Goodman (page 15) defined nursing knowledge as being ‘drawn from a multifaceted base’ and including ‘evidence that comes from science (research and evaluation), experience and personally derived understanding’.

A more recent definition of nursing knowledge suggests:

Nursing knowledge is characterized by diverse and multiple forms of knowing and underpins the work of all nurses, regardless of field of practice.

(Sakamoto, 2018, e12209)

From this perspective, nursing knowledge stems from implementing both theory and practice, including psychosocial and cultural elements as well as practical processes. One of the dangers of applying simplistic holism, that is holistic practice which does not account for the variety of ways of knowing, is that nurses limit their perceptions and understanding of practice (Stiles, 2011) and in so doing limit the offer of care available to the patient. As a nursing process, therefore, patient assessment also draws on the expertise of the nurse in being able to evaluate what is helpful, and what is less so, within the assessment process. Reflecting on such processes helps to add to your knowledge base and develop your practice as a professional.

It is important for you to clarify the focus of the assessment in order for patients to be able to respond appropriately. This requires you to start from a position of understanding your own feelings about the assessment and the patient, as these can influence the assessment process and be revealed by your body language. The following case study offers an example of a nurse needing to control her own feelings when assessing the needs of a patient.

Case study: Vanessa’s child assessment

Vanessa was in the first year of her child nursing training. She was working with her practice supervisor, Meena, on a children’s ward in an acute hospital. Vanessa had previously been shown how to carry out an initial admission assessment, and so was completing the assessment under supervision today.

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Emily was 5 years old and was being admitted from accident and emergency (A&E) with a broken arm following a fall from her bicycle. The A&E nurse told Meena and Vanessa privately that there was some suspicion that the fall might not have been accidental. Vanessa began the assessment by checking how Emily was feeling. However, Vanessa found it difficult to maintain eye contact with Emily's mother when she was asking her the assessment questions. Emily's mother responded by giving short answers. A few times Meena had to intervene to find out more information. Afterwards, Meena discussed with Vanessa how she thought the assessment had gone. Vanessa said she felt that she had got the relevant information but found it difficult to talk to the mother because of thinking how Emily might have broken her arm. Meena explained how she had observed Vanessa's non-verbal communication betraying her judgement of Emily's mother, which affected the responses the mother was making, and therefore the quality of the patient assessment. Meena emphasised the need to suppress our personal feelings in order to get the necessary information and to give unbiased care. Vanessa acknowledged that she found this a hard lesson to learn.

The case study above illustrates how personal feelings can sometimes cloud our judgement and why it is important first of all to master our own feelings and behaviours. Completing Activity 2.2 will help you to examine your own feelings about some of the different patients you might encounter.

Activity 2.2 Reflection

Make a list of situations where you have found it difficult to provide unbiased care for a patient, or to talk to a member of their family or someone accompanying them. Now reflect on why you found it difficult to care for them. What does the code of professional standards of practice and behaviour for nurses, midwives and nursing associates say a nurse must do in such circumstances (see the NMC weblink at the end of the chapter)?

Which of the 6Cs is most relevant and absent in your experiences and in the case study above?

Although this activity is based on your own experience, there is a limited answer at the end of the chapter.

Your experiences, or those of people close to you, are likely to have influenced the list you made. For example, you might have included those who perpetrate domestic violence or other abuses. Being aware of your reactions is an important first step to being able to deal with them, especially as in many cases our original suspicions about someone may turn out to be wrong. Having the 6Cs at the forefront of your thinking, and

being aware of the code of professional standards of practice and behaviour for nurses, midwives and nursing associates (NMC, 2018b) can help you to reflect on your reactions and to respond positively.

If you have a number of patients to care for, you will also need to prioritise whose assessment is the most clinically important (Sully and Dallas, 2010) rather than reacting according to your own biases or prejudices or making snap moral judgements (Hill, 2010). There are ethical elements to prioritisation, and failure to get it right can be detrimental to the patient and cause the nurse moral distress (Suhonen et al., 2018). Nurses do need to make judgements about care needs, but should not make judgements about people, as these can be based on assumption, and therefore skew the accuracy of the patient assessment. The nurse's role in patient assessment is to work with patients to identify their nursing needs and preferences and to gather information on behalf of other professionals involved in the patient's care.

Why is accurate patient assessment so important?

Accurate patient assessment is important in order to plan appropriate care that meets the patient's needs. To be able to carry out an accurate patient assessment, you may also need to employ assessment tools (e.g. a wound assessment tool or a pressure area scoring system). Such tools enable the nurse to integrate important subjective information with objective data to produce a more accurate and reliable profile of the patient's needs. You can read more about how to use subjective and objective information in Chapter 3 and about assessment tools in Chapter 4. The following case study illustrates why accurate patient assessment is so important.

Case study: Mustafa's assessment

Mustafa is 88 years old and has recently lost mobility. He is cared for by his daughter at home. After a recent fall, he has lost confidence and wants to stay mainly in bed. As a result, he has developed a pressure sore on his sacrum. The district nurse, Katarina, is looking after him. Katarina has a holiday booked in the next week and Mustafa's daughter has noticed him becoming agitated.

Katarina is keen to ensure that her colleagues who are going to look after Mustafa maintain the same regimen, as she knows he does not like change. She is therefore careful to document the pressure ulcer score and any contributing factors, as well as the wound dressing used. To aid with assessment, she also takes a photograph – with Mustafa's consent – so that all the assessment data can be reviewed subjectively and objectively.

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Mustafa does not respond well to Gabby, Katarina's replacement, often refusing to cooperate. She calls another nurse, Fatima, to help out. Fatima changes the pressure ulcer dressing after three days and notes that it appears to look better. She is basing this on visual inspection. She documents the improvement and tells Mustafa, who is pleased.

When Katarina is back from her holiday, the first thing Mustafa tells her is of the improvement in his pressure sore. When she inspects it and compares it to the photo she took, Katarina notes that it has in fact enlarged at one edge. She is left with the dilemma of what to say to Mustafa without compromising her colleague.

The case study highlights that it is important to be able to assess changes objectively and accurately, where this is possible, in order to provide appropriate treatment and accurate information, as well as document the care planning process. When Fatima assessed Mustafa, the assessment was incomplete because she had based it on her subjective opinion and not included more objective information, such as that provided by the photo of the wound. Therefore, while the wound may have appeared to be getting better, the information about this that she gave to Mustafa was inaccurate. Any wound assessment needs to encompass wound bed condition as well as wound size and other factors such as the presence of slough or granulating tissue. What makes an assessment good is making sure the information collected is complete and, as far as possible, objective. This may involve other professionals who may have a different view of the assessment required but whose input to the overall evaluation of the problem is important (Kara et al., 2018). Completing Activity 2.3 will help you to identify what other professionals might be involved in Mustafa's care and how these individuals might contribute to a more holistic overall assessment.

Activity 2.3 Critical thinking

When thinking about Mustafa's case, who else do you think might be involved in his care and what would they be assessing in particular? Ask your practice supervisor who the tissue viability nurse is in your placement area and ask that individual what assessment strategies they use.

Which of the 6Cs is most relevant to Mustafa's case and why?

An outline answer is given at the end of the chapter.

Completing this activity should not only help you to identify other relevant professionals involved in Mustafa's care, but also demonstrate the importance of integrating their different perspectives before planning care. One review of the literature relating to interprofessional collaboration in the care of older patients (Tsakitidis et al., 2016) identified among its benefits:

- increased professional satisfaction;
- increased patient satisfaction;
- improved quality of healthcare; and
- reduced mortality.

It is important for patients to experience a seamless service if they are to be confident that their needs are being properly assessed and communicated. In Mustafa’s case, this means using validated standardised approaches to wound assessment or treatment, as well as using the objective data available from the photograph. Most health and social care organisations have adopted specific tools that are incorporated into their patient assessment documentation. Such tools are usually generated based on research, which in turn informs both guidelines and organisational policy. Wound assessment charts vary between organisations, but commonly consider the dimensions of the wound, the appearance of the wound bed and surrounding skin, any exudate or bleeding, the level of pain, and the location of the wound to be entered on the body map (Dougherty et al., 2015). The case study highlights that professionals need to be honest about any gaps in their understanding and explain to patients why they are pursuing certain avenues of enquiry, because our ways of knowing vary.

Four ways of working with facts

Healthcare practice is uncertain because we are dealing with unique individuals who do not always respond in the ways we expect. It is important for health practitioners to be able to deal with this uncertainty constructively in order for patients to be able to trust them. When we are working, we usually access our knowledge to try to make decisions about what to do. Girard (2007) identifies four ways of knowing. How this relates to dealing with facts is set out in Table 2.1 using Johari window principles to consider areas that are known, others we are currently blind to, some we have not yet discovered, and others we are unaware of (Luft and Ingham, 1955, cited in Hillson and Murray-Webster, 2007, page 116).

<p>Facts you know you know</p> <p>Available information that you can use (e.g. the name and age of the patient and the patient’s problem)</p>	<p>Facts you know you don’t know</p> <p>Gaps in the information, where you know you need to find out more (e.g. what medication the patient takes/whether the patient has any allergies)</p>
<p>Facts you know but don’t know that you know</p> <p>Knowledge you have but are not aware of until it is needed (e.g. how to deal with a fire)</p>	<p>Facts you don’t know you don’t know</p> <p>Information you are not aware that you need and need to discover (e.g. what to do about a patient’s non-compliance)</p>

Table 2.1 Four areas of factual knowledge

Being able to identify the four areas of factual knowledge is an important step to understanding how you think and how you can tap into knowledge that you might not know you have. Read the following case study and then complete Activity 2.4 in order to find out what you currently know and don't know, and more importantly what else you need to know to understand patients' needs and give effective care.

Case study: Mr Haughton's admission

Mr Haughton is a 60-year-old man with leukaemia. He is admitted to the ward with pyrexia of 38.6°C and nausea. He had a laparoscopic cholecystectomy two months previously. Mr Haughton has blood taken and an abdominal X-ray is done. He is started on IV fluids and antibiotics. After ten days in hospital, Mr Haughton is able to return home.

Activity 2.4 Reflection

Review Mr Haughton's case and try to identify how your knowledge fits into the four areas illustrated in Table 2.1.

An outline answer is given at the end of the chapter.

Mr Haughton's case highlights that patients may have a number of concurrent problems, and this makes assessing and caring for them complex. While you may have knowledge about some of these, there are also areas that you need to discover more about. You may also need to understand how different problems interact with each other. Understanding that there are always gaps in our knowledge and that we need to be aware of areas we are ignorant of is an important aspect of understanding yourself in the assessment process and what you need to do. You might identify that you lack knowledge about the patient's condition or what decision to make. You might want to include others, such as your practice supervisor or another professional, in your thinking and decision-making processes. Standing's (2023) cognitive continuum might offer some ideas regarding how we think about making decisions in practice (for more information on making decisions within patient assessment, see Chapter 9).

Standing's cognitive continuum and relevance to nurses and patient assessment

Making decisions when assessing patients means understanding the evidence base for practice. There are a number of modes of practice according to Standing (2023, page 8). These are:

- intuitive judgement – sensing patient concerns and changes;
- reflective judgement – moment-by-moment reviewing and revising of your practice;
- patient and peer-aided judgement – reaching consensus decisions with the patient and others;
- system-aided judgement – making use of policies and assessment tools;
- critical review of experience and research evidence – critical evaluation of your experience and available research that underpins this;
- action research and clinical audit – evaluating practice against benchmarks;
- qualitative research – interpreting the patient experience;
- survey research – making use of trends of evidence within particular populations; and
- experimental research – identifying generalisable evidence.

It is important for you to know what evidence you are drawing upon within patient assessment and care planning in order to ensure that you can justify the decisions you make to the patient and to the profession. This will be discussed further in Chapter 9, but we begin here with a case study and an activity to help you critically consider your current knowledge and skills.

Case study: Lily's bowel problem

Lily is 45 years old and has recently been having problems with urgency and faecal incontinence. She has seen her GP, who has diagnosed irritable bowel syndrome, and as part of her care refers Lily to the specialist bladder and bowel nurse, Nicky. At Lily's assessment, Nicky takes a full history and asks Lily to keep a diary of her dietary and fluid intake and bladder and bowel actions. She also completes a bladder scan, which is normal. Nicky asks Lily to look at the Bristol stool chart and identify which best matches her normal stool appearance. Lily identifies that her stools best match types 4 and 5, which are smooth and soft, sometimes too soft. Nicky advises Lily that she needs to cut down on her fruit intake and explains ways for Lily to manage her occasional faecal incontinence. Nicky makes an appointment to see Lily again in six weeks.

In the case study, Nicky, the specialist bladder and bowel nurse, has gathered her evidence through talking to Lily about her history and eating habits, identified precisely the type of stool Lily is producing, excluded a bladder problem via the scan, and used her knowledge of research and practice to advise Lily on a plan of action. When completing an assessment, if we simply said to patients, 'You need to stop eating so much fruit', they would understandably be reluctant unless we can provide the evidence for our recommendation. Completing Activity 2.5 will help you to explore how you might use the different modes in your own practice.

Activity 2.5 Reflection

Think about your last placement and the different patients you nursed. Consider in what circumstances you can identify using a particular mode from Standing's (2023) continuum. Why was this mode of practice particularly relevant to the situation?

Although this activity is based on your own experience, there is a limited answer at the end of the chapter.

You might have made a system-aided judgement by using an assessment tool to help gain further information, or reflective judgement adapting how you were communicating as you talked with the patient. Less obvious is how we add all the understandings from the modes of practice together to come to the decisions we do. It is important to understand these thinking processes ourselves so we can explain them to the patient (as we saw Nicky do) and to other health professionals to justify the courses of action we propose. Given reasonable and well-presented evidence, patients might be more informed, and therefore more inclined to engage in the assessment and subsequent treatment processes. That said, it is important to recognise the subjective nature of truth in terms of what patients tell us and what we think is important. Completing Activity 2.6 will help you to understand that the truth we are seeking in patient assessment is what patients' needs are and the most effective way to help them.

Activity 2.6 Reflection

Reflect on what various forms of evidence you might need to undertake an assessment of a patient and plan their subsequent care.

An outline answer is given at the end of the chapter.

How we put together the narratives patients give us with the other facets of our information-gathering within the context of our practice knowledge and policy is complex. Much of our initial assessment will be based on what the patient is reporting, but they may not understand that a minor symptom to them could aid in assessment of their care needs. The following case study will illustrate this point.

The nature of truth

Case study: Lucy's pain experience

Lucy was a woman with learning disabilities living in an assisted living setting. She complained of stomach cramps during her normal menstruation and was usually given paracetamol by the support workers. Lucy was admitted to the local hospital for a minor procedure. A carer came with her but could not stay all the time. Lucy became distressed when she was in pain. The staff on the ward tried to calm her but Lucy got more and more distressed. Lucy was given pain medication, but not as frequently as she could have it, as the staff assumed that her agitation was part of her normal behaviour. The assessment tool they used for assessing pain was validated for use with children. Lucy was left unnecessarily in pain because the staff did not believe her and had made assumptions about her.

What Lucy's case study highlights is that we may use our own pain experience or behavioural norms to interpret the experiences of others rather than accepting the truth taken from their perspective. In doing so, we may use stereotyping assumptions for interpretation. McCaffery (1968) famously stated that 'pain is whatever the experiencing person says it is, existing whenever the experiencing person says it does' (page 95); this highlights the issue that people both experience and express pain in different ways. The role of the nurse is to accept this definition without being judgemental or applying our own preconceived ideas as to what pain is or is not.

The case study illustrates a failure to live by three elements of the 6Cs: communication, care and competence. The nurses failed to communicate meaningfully with Lucy, they failed to provide adequate pain relief, which is a failure in care, and they demonstrated a lack of competence in understanding pain from her point of view.

Truth is determined by ourselves in accordance with our values and beliefs, by others and how influential we perceive them to be, and by society as a whole. For example, those perceived to be in a powerful position, such as doctors, may not be questioned about their version of the truth. In mental health nursing, we might call into question the singular nature of reality when many patients experience something very different. Therefore, truth remains tentative and uncertain and subjective in nature. Sometimes when truth is perceived to be what is expressed by another, the subjective view is discounted, closing down the ability to look at personal experience (Frosh, 2002). What this means is that if professionals impose their interpretation of the patient's experience on to the patient, it is less likely that patients will be able to tell what their actual experience is, and they may just go along with what the professional suggests. Decisions based on such a flawed perspective will then be compromised and may fail to be in the patient's best interests (however the patient defines these).

Stereotyping

Stereotyping is a way of categorising things and people that allows us to draw on previous experiences of those categories to direct our actions, which is quicker than forming new categories (Goodman and Clemow, 2010). That is to say we put people into categories (or boxes) according to our previous experiences, or assumed prejudices, of people we perceive as being similar to them. The negative effect of stereotyping is making assumptions about another person that are unlikely to be accurate. We stereotype based on our personal values, beliefs and experiences, and this may relate to patients, colleagues and peers. For example, if we saw a man weaving along the street looking dishevelled, we might stereotype him as being drunk, even though there are many reasons why someone might be moving in that way (e.g. they may have multiple sclerosis, be experiencing a diabetic hypoglycaemic episode or have sustained a head injury). As highlighted in the case study of Lucy, stereotyping can equally cause us to make inaccurate assumptions about why someone is behaving in a particular way. If a health or social care professional is working from such an assumption, patient assessment will not only be affected, but it could be wildly inaccurate and dangerous. Completing Activity 2.7 will help you to examine situations where you may have been stereotyping people.

Activity 2.7 Reflection

Think about a recent practice experience where you think you, or someone else, might have been stereotyping someone and consider the following questions:

1. Why do you think that person was stereotyped?
2. What was the result of stereotyping that individual?
3. What experiences might have led to the stereotyping of this person?

As this activity is based on your personal experience, there is no outline answer at the end of the chapter.

You might be stereotyping by using norms for situations, such as how to behave in class or in the professional setting, and expectations of particular roles (Goodman and Clemow, 2010). You might assume that someone is suffering from a particular condition because you have seen something similar before – this is itself a form of stereotyping as we are drawing on our ‘previous experiences of those categories’ to direct our thinking. Such stereotyping, or perhaps more correctly categorisation, is not always a bad thing: it enables professionals to respond quickly and assuredly in an emergency situation, for example. However, if stereotyping results in diminishing someone else’s choices, the effects are not helpful. We need to consider our own values and responses and adjust our professional behaviour.

Conclusion

Good patient assessment is the goal for the nurse because in order to provide good care, we need to learn a lot about our patients. We can only do this by accessing and applying the full range of relevant evidence at our disposal. This process of gathering and responding to the collected knowledge is what is known as an inductive process; that is, a process in which the nurse allows the evidence to guide them to a conclusion rather than forming a conclusion and looking for the evidence to support it – sometimes called deductive reasoning (Creswell and Poth, 2017). Nevertheless, it is also recognised that nurses and patients are individuals who have their own values and ideas which need to be reconciled in order for accurate patient assessment and care planning to ensue. This may sometimes be difficult to do, but in the process we can learn a lot about ourselves and become better professionals.

Chapter summary

This chapter has clarified what patient assessment is and why it is important. It has identified some factors that are helpful and some that are hindering to effective patient assessment, looking in particular at the influence of personal values and attitudes and application of the 6Cs. The activities included have invited you to consider your own values as you need to grasp how influential these are when you are assessing a patient. The chapter has also introduced Standing's (2023) nine modes of practice as a way of thinking about how you justify your thought processes and the decisions that you make. This will be discussed further in Chapter 9.

Activities: brief outline answers

Activity 2.1 Critical thinking (page 24)

Graham has not thought through the implications of Sam's strict veganism and how this might affect his diabetes at a time of high stress. A further dietitian referral might be needed, or it might not, depending on what actually caused the hypoglycaemic episodes. Brett is accountable for this gap, and by not following up the information, his mistake could result in Sam being at further risk of poor management of his diabetes when he leaves the hospital. Sam's knowledge about how to manage his diabetes remains compromised due to his dietetic and stress management needs not being adequately explored by Graham. This case study highlights how important commitment – one of the 6Cs – to the person is, and not just the task being completed.

Activity 2.2 Reflection (page 26)

You might have included the following within your list:

- drunk driver;
- drug addict;

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- paedophile;
- rapist;
- murderer; and/or
- terrorist.

The code of professional standards of practice and behaviour for nurses, midwives and nursing associates (NMC, 2018b) is clear that all nurses must treat people as individuals. This means you must:

- treat all people with kindness, respect and compassion;
- avoid making assumptions and recognise diversity and individual choice;
- act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment; and
- be aware at all times of how your behaviour can affect and influence the behaviour of other people.

Compassion – one of the 6Cs – is the most relevant here because it demonstrates drawing alongside someone and not judging them, but trying to discern their needs.

Activity 2.3 Critical thinking (page 28)

The other people involved in Mustafa's care are likely to include his GP, who will be overseeing the progress of healing of his pressure ulcer. Mustafa may also be assessed by a dietitian, who will be evaluating his nutritional needs and preferences. Mustafa could also be assessed by the specialist tissue viability nurse, who will be monitoring the wound and healing specifically and offering advice on wound dressing options. A multidisciplinary meeting would help to integrate these assessment processes, but in the community setting comprehensive integrated notes are more often used for this purpose. Competence – one of the 6Cs – is the most relevant to this case in terms of how Fatima assessed Mustafa's pressure ulcer. Of course one element of Mustafa's care which may need to be re-addressed is his fear of falling and there may be good reasons to refer him to the community physiotherapy team to help get him on his feet again.

Activity 2.4 Reflection (page 30)

The facts you know are Mr Haughton's age, the conditions he has come in with, his history of a laparoscopic cholecystectomy, and that he is pyrexial. The facts you know you don't know are his normal medication, any allergies, what type of leukaemia he has and how it is normally treated, and whether the pyrexia is due to his leukaemia or something going on with his previous surgery. The facts you don't know you know are about blood components and what they do, and you can therefore link this to how Mr Haughton is likely to be affected by his leukaemia. The facts you don't know you don't know are likely to be related to Mr Haughton's healing response in the light of having leukaemia and any other aspects of his condition or care that you have not thought about.

Activity 2.5 Reflection (page 32)

You are likely to have used intuitive judgement such as realising that the patient was upset when you made your assessment and trying to understand the patient's response. At the same time, you are likely to have reflected on your own communication – one of the 6Cs – with the patient and how perhaps your tone of voice allowed that person to open up to you. You will have needed to interpret the patient's experience from what he or she told you. You may have needed to consult with your practice supervisor about the assessment or care planning process, as well as checking whether the patient was in agreement with what you planned. Using an assessment tool such as

the Bristol stool chart might have helped you to collect accurate details on which to base your clinical judgement. When evaluating your practice experience more broadly, such as for your portfolio, you may have considered how your practice fits with the NMC Standards and the 6Cs and what you are actually using to underpin what you do.

Activity 2.6 Reflection (page 32)

You might have included:

- the story/history that the patient gives about a need or problem;
- nursing observations;
- assessment tool results;
- peer-aided judgements such as discussion with your practice supervisor or multidisciplinary meeting outcomes;
- research findings; and/or
- policies and guidelines.

Further reading

Goodman, B and Clemow, R (2010) *Nursing and Collaborative Practice: A Guide to Interprofessional Learning and Working* (2nd edn). Exeter: Learning Matters.

A useful book for understanding how professionals' values can influence their approach to patients and each other and guidance on how to work more collaboratively.

Standing, M (2023) *Clinical Judgement and Decision-Making in Nursing* (5th edn). London: SAGE.

This book introduces decision-making theory and its relevance to nursing practice.

Useful website

www.nmc-uk.org

The website of the Nursing and Midwifery Council, where you can find a great deal of professional information, including the latest guidance on the code of professional standards of practice and behaviour for nurses, midwives and nursing associates.