Answer Guidance

# Chapter 14: Assessment, Planning, Implementation and Evaluation (APIE): The process of nursing

## Activity answer guidance

### Activity 14.2

The Twelve Activities of Living outlined in Roper et al.’s (2008) model are frequently used as a tool to assess a patient. They are:

 maintaining a safe environment

 communication

 breathing

 eating and drinking

 elimination

 washing and dressing

 controlling temperature

 mobilising

 working and playing

 expressing sexuality

 sleeping

 death and dying.

Within this assessment, when considering the activity of ‘elimination’, you may ask the patient when and how they use the toilet and listen to, analyse and interpret their response; you may measure and observe their urine, use your sense of smell to detect incontinence and examine their genitalia, if appropriate.

#### Answer guidance:

How do you think you could assess a patient’s ability to undertake the other 11 activities?

*As with the given example of elimination, you would use a process of asking open questions and listening to the patient, and their family if they are contributing, then analyse and interpret their response. You may undertake a visual observation or use your other senses to form an assessment. For example, with breathing you might ask about their exercise tolerance (in layman’s terms) and if they use any inhalers or nebulisers, you might ask if they have a cough or produce sputum. You might look at their breathing as they talk to you, assessing if they speak in full sentences and if they sound wheezy. You might look for other signs like clubbed fingers, nicotine-stained fingers, or cyanosis of the lips.*

How could you assess their mental health, mood, behaviour, and past medical and psychiatric history?

*You could ask the patient to tell you about their past medical history and drug history, but you could also review their medical notes before speaking with the patient. You could ask them about their mood and how they are feeling. You may also pick up on verbal and non-verbal queues from the patient and their family, such as head down, tearful, anxious, angry, etc.*

How could you assess risk/social issues?

*Take a full social history from the patient and ask about their home, for example, do you live alone, do you go out much, tell me about the kind of house you live in, how many steps, etc. You could complete a falls risk assessment if appropriate.*

How could you include carers, family members, or other healthcare professionals in the assessment?

*The family or carers could be involved in the admission process and they could contribute to answering these questions with the patient’s consent. A multidisciplinary approach is also really important–the patient should not be asked the same questions multiple times as an interprofessional care plan can be used, as well as regular team updates.*

### Activity 14.3

Reflect on your experience of using APIE to care for Graham:

How do you feel about using APIE?

How did APIE enable you to care for Graham?

Did you feel there were any limitations in using this approach?

Did you consider the role of the carer during Graham’s admission? Thinking about the need for Graham’s care to continue when he goes home, might there be a need for his carers to receive further training?

#### Answer guidance:

There are no right or wrong answers for this approach as you are asked to describe how you feel about using APIE, you may feel really confident to do this, but you may feel that you need more practice. APIE should have enabled you to fully assess Graham’s activities of daily living, as well as his medical, drug, and social history. You should have specifically focused on his nutritional state, his recent weight loss, and his dehydration. You may have selected the use of tools such as a fluid balance chart, a MUST nutritional assessment, or a Waterlow assessment. You should have written a SMART short-term goal for each of his nutritional needs. After implementing this plan, you will have reviewed and used REEPIG to identify actions to help achieve the goals. You will then have evaluated the impact of your care plan. You may have identified limitations to the APIE model, such as difficulty documenting the process, the subjectivity of the person completing the process, or a lack of education and training around the use of the process for some.

## Case study answer guidance

### Case Study 14.1: Jainil

Jainil is four years old and has become withdrawn and quiet and is refusing to play or drink. He just wants to sit on his mother’s lap and look at books, which is uncharacteristic for him as he is usually very active. When talking to his parents it becomes apparent Jainil has not had his bowels open for six days and that he has abdominal pain exacerbated by movement. Jainil’s behaviour and his psychological and emotional responses have all been affected as a result of his physical pain.

List the skills you need to perform an assessment upon Jainil. Think about how you assessed the object in Activity 15.1 and. relate these skills to performing an assessment of a patient.

#### Answer guidance:

*The list might include: Observe. Measure. Listen. Question. Examine. Explore. Analyse. Interpret.*

### Case study 14.2: Andrew

Andrew is 24 years old and has been brought into an emergency department in a semiconscious state. Staff Nurse Gray immediately looks at Andrew’s face and chest, then puts her cheek down to Andrew’s mouth and lays one hand on his forehead and another on his wrist.

 What information do you think the nurse was trying to ascertain by these actions?

#### Answer guidance:

*By looking at Andrew’s face the nurse will be able to assess his conscious level and if he is alert and breathing, as well as any difficulty in breathing e.g. obstruction, visible swelling or signs of cyanosis. By observing his chest the nurse will be able to see if he is breathing normally or too fast/ too slow and if the breathes are deep or shallow, as well as if the chest is moving equally on both sides. By placing their cheek to the patient’s mouth, the nurse will be able to feel breathes coming out of the patients mouth too. By placing a hand on his forehead, the nurse will be able to check if Andrew is cold, cold, clammy, etc. Finally, by placing a hand on Andrew’s wrist, the nurse will detect the presence or lack of a pulse and will be able to assess the speed, strength, and regularity of this.*

### Case Study 14.3: Graham

Graham is 34 and has moderate learning disabilities. He lives in a flat, supported by paid carers. Graham has physical disabilities and uses a wheelchair to get around. He has a history of urinary and faecal incontinence and his care staff assists him to manage his continence routine. He has recently lost weight.

 List all the possible ways you can collect data to enable a full assessment of Graham’s needs to be produced.

 What tools would be useful to you in this assessment?

#### Answer guidance:

*You may start by reviewing existing medical notes before asking Graham and his carers/ family, what brought him to the hospital and what his primary concern is. You could take a full medical, drug, and social history and ask Graham about his activities of daily living to identify any problems. You would most likely use the following tools to assist in your assessment: A-E assessment, undertake vital signs and complete a NEWS2 chart, a MUST screen, a Waterlow assessment, a fluid balance and diet chart, a moving and handling assessment, and an SSKIN assessment of his skin integrity and pressure areas. This list is not exhaustive but is a good start in assessing Graham on admission.*

### Case Study 14.4: Graham revisited

Let’s go back to Graham, whom you assessed earlier. It was identified that he had recently lost weight. Through a thorough assessment, it was recognised that he had lost 8 kg within the past three months and was malnourished and dehydrated.

Concerning Graham’s dehydration, a specific, measurable, achievable, realistic, and timed short-term goal could be that he will have an oral fluid intake of 2.5 litres every 24 hours for 72 hours. A long-term goal might be that he maintains hydration by achieving a daily oral intake of 2 litres of fluid.

Write a SMART short-term goal for Graham’s nutritional needs.

#### Answer guidance:

*The SMART goal for Graham’s nutrition could be that he gains 0.5 kg weight per week and achieves a 3000 calorie oral intake per 24 hours.*

### Case Study 14.5: Graham’s weight

Remember Graham? He had lost weight and was found to be malnourished, and you set a SMART goal? Now you need to think about how you will achieve it. Let’s say your goal stated that Graham gains a minimum of 0.5 kg per week and achieve a daily oral intake of 3,000 calories.

Using the REEPIG criteria, write down what actions you will need to take in order to ensure this goal is achieved.

#### Answer guidance:

*Your actions might include that you talk to Graham about his favourite foods and drinks, ensuring they are supplied and offered; with informed consent, refer Graham to a dietician to ensure a high-calorie diet containing foods favoured by Graham; the maintenance of a food and fluid chart; assist Graham to eat and drink as required; ensure Graham is offered and provided with snacks every hour when awake; weigh Graham once a week (0900 hrs Tuesdays); weekly nutrition assessment tool completion; talk to Graham about his eating habits and possible reasons for weight loss.*

### Case Study 14.6: Graham’s evaluation

Graham has been nursed by you for a week now, working in partnership with him, and you are evaluating his care plan.

 What documents and data would you need in order to undertake this evaluation?

 How would you write your evaluation of Graham’s care?

#### Answer guidance:

*Your evaluation might say something like Graham has gained 0.6 kgs in seven days, his nutrition score is X; he consistently consumes all meals offered when assisted to eat and has achieved an average of 2500 calories per 24 hours. Graham achieves a 2-litre fluid intake per 24 hours and says he looks forward to mealtimes although does not feel hungry in between meals. From this evaluation, you can see Graham has gained weight but is not achieving the goal set of 3000 calories or 2.5 litres oral intake although he is eating all his meals and has a positive response to meal times. Graham is still malnourished and the need still exists; the actions and implementation are suitable since they are starting to achieve the short-term goal; it would be appropriate to continue and revaluate this in a week.*

### Case Study 14.7: John Smith

John Smith is a 65-year-old MH patient who is admitted to a medical ward with a chest infection. John has Parkinson’s disease and usually lives at home with his wife; he is usually mobile with the assistance of a frame although this is currently limited due to him feeling so unwell.

On admission, the nurse (Sam) greets John and his wife, who accompanies him. Sam talks to John and explains what is going to happen in terms of his admission and assessment process over the next few hours. Sam orders John’s medical notes and then gathers all the equipment she will need to assess him, closes the curtains around John, and sits next to him. Sam asks John why he thinks he has been admitted to the ward and asks what has happened today leading up to this. John explains that he has been feeling unwell over the past three days and has today developed a productive cough and has felt hot, they visited his GP who arranged for John’s admission to the ward. John becomes breathless after he has talked so his wife also provides some information, to which John nods in the agreement. A letter from the GP accompanies John, Sam reads this which confirms the events already explained as well as provides additional information on John’s usual drug regime; past and present medical conditions.

Sam explains it would be useful to perform some basic observations on John, which he agrees to and she measures his temperature, pulse, respiration rate, and blood pressure. As Sam put the blood pressure cuff on John’s arm she notices he feels warm to the touch and has a reddened face, his temperature recording confirms he is pyrexial (an elevated temperature). Following a full assessment of John, Sam identifies he has pyrexia and is breathless. Sam is able to discuss these needs with John who agrees to feel hot and short of breath, rather weak, although feels well otherwise. The goals set an aim to reduce John’s temperature to below 36.8C and for him to feel comfortable and for John to have a respiratory rate of between 12 and 16 breaths per minute; with oxygen saturations >94% and for him to state, he does not feel short of breath. Sam prescribes and implements actions that will help achieve these goals, ensuring the actions are realistic and evidence-based. After 24 hours of care, John feels much better; his temperature and respiratory rate have reduced to within normal limits although he states he feels more breathless than usual. Sam and John discuss John’s progress and decide to evaluate in another 24 hours.

 Highlight, in this case, study the aspects which pertain to assessment, planning, implementation, and evaluation. Think about how Sam has accomplished APIE, involving John and his wife, and consider how you might have done it differently.

#### Answer guidance:

*The nurse undertakes the following assessments: reviewing medical notes and GP letter, asking the patient for information, visual observation of shortness of breath and unable to talk in full sentences, vital signs, the patient tells Sam he feels hot and weak, he has a raised respiratory rate. Saturations are not documented but the nurse aims for Sp02 over 94% (it doesn’t say if John has COPD or why Sam selected this %.*

*It does not say if Sam completed a sepsis screen, for example, blood, sputum sample, urine sample, etc.*

*Sam and John evaluated the care at 24 hours and agreed to review it again in 24 hours. We would need more information to know what interventions were undertaken and if regular observations were taken during that 24-hour period. I think I would have used an A-E approach and assessed the airway and breathing first. I would also have collaborated with the medical team to set oxygenation goals.*