CHAPTER TWO

ADMITTING AND ASSESSING MEDICAL AND SURGICAL CLIENTS

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Learning Objectives

At the completion of this chapter, you should be able to:

- Define and discuss the process of admission and assessment of the acute client;
- Explain the concept of risk management and the importance of patient safety, specifying strategies that exist to increase safety and reduce risk;
- Discuss the use of critical thinking to inform clinical decision-making;
- Identify and discuss the role of the nurse in providing patient-centred care, including interpretation of diagnostic tests and administration of medication;
- Explore and discuss the discharge of an acute client, considering appropriate social, cultural, physical and psychological considerations.

Introduction

This chapter discusses the **admission** and assessment of medical and surgical patients. It covers the process involved in admission and assessment of these acute clients and explains the concept of risk management, how important it is to patient safety and strategies that can be incorporated to increase patient safety and reduce their risks. This is followed by a discussion on critical thinking and how it informs clinical decision-making. The role of the nurse is discussed in relation to patient centred care, interpretation of diagnostic tests and administration of medication. The chapter concludes with a discussion of discharge of acute clients and how this requires consideration of social, cultural, physical and psychological considerations.

Nursing standard

The following identifies the national competency standards for the registered nurse from the Nursing and Midwifery Board of Australia (NMBA) and the Nursing Council of New Zealand (NCNZ) that are addressed in this chapter.

Australian Registered nurse standards for practice

Standard 1: Thinks critically and analyses nursing practice

Standard 2: Engages in therapeutic and professional relationships

Standard 3: Maintains the capability for practice

Standard 4: Comprehensively conducts assessments

Standard 5: Develops a plan for nursing practice

Standard 6: Provides safe, appropriate and responsive quality nursing practice

(Nursing and Midwifery Board of Australia, 2016)

New Zealand: competencies for registered nurses

Competency 1.4: Promotes an environment that enables health consumer safety, independence, quality of life, and health.

Competency 1.5: Practises nursing in a manner that the health consumer determines as being culturally safe.

Competency 2.1: Provides planned nursing care to achieve identified outcomes.

Competency 2.2: Undertakes a comprehensive and accurate nursing assessment of health consumers in a variety of settings.

Competency 2.3: Ensures documentation is accurate and maintains confidentiality of information.

Competency 3.1: Establishes, maintains and concludes therapeutic interpersonal relationships with health consumers.

Competency 3.2: Practises nursing in a negotiated partnership with the health consumer where and when possible.

Competency 4.1: Collaborates and participates with colleagues and members of the health care team to facilitate and coordinate care. (Nursing Council of New Zealand, 2007)

Admission and assessment

The admission process is pivotal in the establishment of a positive patient experience within your acute healthcare setting. This process should be the beginning or continuation of a therapeutic nurse-patient relationship where patients are welcome and safe. To this end, part of the admission process includes orientating your patient and their family to the ward staff, environment and routines, explaining relevant procedures and medical equipment, and answering questions the patient may have.

Assessment is a vital component of nursing care and foundational to nursing care plans and interventions. The admission process provides an opportunity for nurses to perform initial assessments of patients to inform clinical decision-making and determine patient goals during the patient's hospitalisation. The admission process is also usually a good time to begin preparing for the patient's discharge from the ward, an element of care discussed later in this chapter.

Admission process and entry points

Patients may be admitted to a ward or unit in a hospital setting as a result of an emergency or planned admission. Emergency admission patients are usually transferred to a ward after presenting to the hospital's emergency department with an acute illness or injury, or an exacerbation of a chronic illness. Planned admission patients may arrive directly at the ward for admission prior to surgery or another health related procedure. For planned admission patients, ward beds should have been previously reserved for the patient via the treating doctor or surgeon. Both planned or emergency admission patients may be transferred to the ward after surgical or other procedures. In the case of planned surgery, they may have previously visited the ward or hospital as part of their pre-admission processes in which case

they may already have some pre-admission assessments completed and may have been orientated to the ward environment.

Health assessment in context

Irrespective of how a patient arrives within your ward, most hospitals will have a specific multi-disciplinary admission processes and assessments that need to be undertaken. This often commences with a nursing admission interview and preliminary patient assessment and includes an orientation to the ward. Depending on the patient's condition, learning ability and emotional status, these processes are ideally done immediately upon admission but must be done within the first 12-24 hours of admission depending on hospital policy (Royal Children's Hospital Melbourne, 2014; Children's Hospital at Westmead, 2016). During the initial assessment it is important to consider the patient from a holistic perspective, assessing not only their immediate reason for admission but their mental, physical, emotional, social and spiritual state.

Similarities and differences between medical and surgical clients

Within today's complex healthcare environments, there is often a large overlap between medical and surgical clients. Simplistically, surgical patients will usually have some kind of invasive procedure and their post-operative management often includes a focus on pain management, supporting and managing the patient's ABCs (airway, breathing and circulation) during the immediate post-operative period and then promoting their return to the best level of mobility and independence as they recover. Conversely, medical patients present with an illness not requiring surgical intervention. Medical patients may often have multiple comorbidities and usually present as unplanned emergency admissions. Common examples of medical patients requiring admission include those presenting with experiencing acute myocardial infarction, exacerbation of asthma or chronic obstructive pulmonary disease, diabetic foot ulcer, or stroke. Care for medical patients often focuses on symptom management, reversal of the underlying disease process where possible, promoting independence and supporting activities of daily living until discharge.

Admission Interview and Initial Patient Assessment Example Activities

When patients first arrive in your ward there are a number of activities that you will be required to undertake as part of your initial patient assessment and orientation. These may vary slightly depending on your context, the patient's condition, age and reason for admission. Many of these activities are related to minimising risk, promoting patient safety, building a therapeutic relationship, proactive health screening, establishing a baseline, detecting abnormalities, and promoting patient knowledge, comfort and confidence. The table below provides examples of activities that the admitting nurse may undertake with the patient and their family.

Table 2.1: Ward Admission Assessment Activities

Admission Assessment Activities	Rationale
Identifying the patient and applying identity bands (if not already done) enables correct patient identification throughout the hospital stay.	Promote patient safety. Ensure that the patient is correctly identified to prevent errors in treatment, interventions,

	medications or other events while admitted.
Confirming the reason for the patient's admission and their understanding of their illness and hospitalisation plan provides a connection with the patient and family to enable good communication (Tracey K. Bucknall et al., 2016)	Promote patient safety, detect and prevent communication errors, build a therapeutic relationship and enhance patient/family knowledge related to the patient's illness and planned care during hospitalisation.
Confirming if the patient has any allergies and applying allergy bands as required	Promote patient safety and prevent medication errors and adverse events.
Confirming the patients past medical / surgical history and any relevant family history	Baseline data to inform healthcare decisions. Ensure comprehensive health history available and minimise risk of errors / adverse events.
Confirming the patient's current medications, including prescribed medications, over the counter treatments and tobacco, alcohol and illicit drug use	Promote patient safety and prevent medication errors and adverse events. Often confirming a patient's current medications may provide additional information regarding the patient's health status and past medical history.
Performing a general patient assessment	Establish a baseline for future comparison. Identify abnormalities for more detailed investigation or intervention.
Undertaking vital signs assessment including pulse, blood pressure, temperature, respirations, peripheral oxygen situation measurements	Establish a baseline for future comparison. Identify abnormalities for more detailed investigation or intervention.
Performing a pain assessment and other symptom assessment. For example, assessing for nausea, vomiting or diarrhoea, shortness of breath or other symptoms experienced by the patient	Establish a baseline for future comparison. Identify abnormalities for more detailed investigation or intervention. Provide opportunity to intervene and promote patient comfort and well-being using evidence based interventions as indicated by assessment findings.
Performing focused assessments related to the patients presenting complaint and past medical history. For example, a respiratory assessment for a patient admitted with a medical diagnosis of exacerbation of asthma.	Establish a baseline for future comparison. Identify abnormalities for more detailed investigation or intervention. Provide opportunity to intervene and promote patient comfort and well-being using evidence based interventions as indicated by assessment findings.
Assessing the patient's weight and height	Establish a baseline for future comparison. These parameters may also be used in determining the dose of medications (for

	example anaesthetic agents or anticoagulants)
Performing a urinalysis	Proactive screening. Establish a baseline for future comparison. Identify abnormalities for more detailed investigation or intervention.
Performing a random blood glucose analysis	Proactive screening. Establish a baseline for future comparison. Identify abnormalities for more detailed investigation or intervention.
Performing an electrocardiograph (pre-surgery for patients over 50 years of age depending on hospital policy)	Proactive screening. Establish a baseline for future comparison. Identify abnormalities for more detailed investigation or intervention.
Performing patient safety assessments including their risk of falling or developing a pressure sore during hospitalisation (discussed below in patient safety)	Establish a baseline for future comparison. Identify abnormalities for more detailed investigation. Plan safety interventions or other activities to minimise risk of adverse events while patient is admitted.
Performing a psychosocial and spiritual needs assessment – exploring the patient's normal role(s), support structure, spiritual beliefs and other factors that may impact on or be impacted by their hospitalisation	Establish a baseline for future comparison. Identify abnormalities for more detailed investigation. Provide opportunity to intervene and promote patient comfort and well-being. Build a therapeutic relationship with patient and family
Considering referrals to allied health or other services for assessment and management while admitted or upon discharge	Promote patient well-being, recovery, safety during admission and upon discussion. Ensure that the patient will be ready and safe to be discharged in a timely manner.
Confirming/suspending any home care services the patient may be using on admission to hospital	Enhanced interprofessional communication, prevent unrequired home visits and allow for workload planning. Patients/families may often overlook notifying home care service providers of patient's admission to hospital – particularly in times of high stress.

Considering home care services or other supports that the patient may need upon discharge	Based on assessment of patient's current and expected discharge health status and supportive needs. Ensure that the patient will be ready and safe to be discharged in a timely manner.
Educate patient on specific requirements of their admission – for example *Nil by Mouth* prior to theatre, use the call-bell to ask for assistance prior to mobilising	Promote therapeutic relationship, patient's knowledge, comfort and safety during admission. Assists to prevent adverse events during patient's admission.

In conjunction with the assessments a nurse may undertake when admitting a patient outlined in Table 2.1 above, there are also a number of orientation activities that may be required. These are undertaken to promote patient safety, enhance knowledge, provide comfort and continue to build a therapeutic nurse-patient relationship. To begin, the nurse may provide an Introduction to staff, including nursing, allied health, medical and auxiliary supports, that the patient may encounter during their stay so that the patient is confident in the care being provided. In order to promote patient comfort, an orientation to the physical environment of the ward is also required, this may include an orientation to the bedroom environment, bathroom and toilet location, kitchen and patient lounge area. Additionally, orientation and identification of a safe place for valuables, space for clothing & toiletries, lighting, television and assistance call-bell may assist the patient in feeling secure in their new environment.

Each ward tends to have its own routines and therefore it is often helpful to provide patients with an orientation to activity of daily living and hygiene facilities available, including how to seek assistance with if necessary. Providing an overview of the ward schedules, including activities such as when medical reviews occur, meal-times and visiting times may assist patients and their families in planning their activities during the patient's hospitalisation.

Finally, being in hospital can be very overwhelming for patients and their families and the complex medical equipment used may seem frightening to those with limited experience. As such, providing explanations of specific medical/care equipment that the patient is likely to see may be helpful. Such equipment may include, intravenous therapy lines and pumps, dressings or drain tubes, monitoring equipment or mobility aids.

The patient admission process is a vital component a patient care. It establishes the therapeutic relationship between the patient and nurse, provides an opportunity for baseline assessment, proactive health screening and detection of health abnormalities that require further investigation or treatment. It is the first step of the clinical reasoning cycle / nursing process, is focused on promoting patient comfort and safety, minimising risk and enhancing patient care.

Patient Safety and Risk management

In the complex clinical environment that exists today it is imperative that health care is provided safely and competently to maximise patient outcomes. **Risk Management** and Patient Safety approaches aim to assist all involved in healthcare to understand the risks

involved and to identify and develop effective strategies to manage those risks and maintain patient safety.

Assessing and managing risk

In clinical practice settings there are many opportunities and avenues of actual and potential risk. Risk management approaches gather information through feedback, complaints, incidents and adverse event reporting to identify and minimise risk to organisations, patients, visitors and staff (. Australian Commission on Safety and Quality in Health Care, 2011). Part of the nurse's role in risk management is to identify and address these hazards to minimise harm. There are five basic principles of risk management:

1. Avoid risk: Identify appropriate strategies that can be used to avoid the risk whenever possible, if a risk cannot be eliminated then it must be managed
2. Identify risk: Assess the risk, identify the nature of the risk and who is involved
3. Analyse risk: By examining how a risk can occur; what the likelihood; and what are the consequences of this risk occurring
4. Evaluate risk: Determine how the risk can be reduced or eliminated. Document the process and response/outcomes.
5. Treat risks: Manage the risk by determining who is responsible for taking actions, when and how this will be monitored (Australian Commission on Safety and Quality in Healthcare, 2014).

When assessing risk, you need to identify:

1. Who is at risk?
2. What is involved?
3. Why can it happen?
4. How likely is it?
5. What are the consequences?
6. What can be done?
7. Is the solution applied to the situation/risk identified (Australian Commission on Safety and Quality in Healthcare, 2014)?

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Skills in practice

Edith Smith: admission for fractured neck of femur

Edith Smith is a 68-year-old who lives at home by herself after her husband Frank of 40 years died last year. Edith has a good overall fitness level but presented to the doctor last month with low blood pressure. Edith explained to the doctor that she doesn't eat as well as he should now since Frank isn't around to cook for. Edith is admitted after a fall at home resulting in a fractured neck of femur. She was found after several hours on the ground in her backyard, by a neighbour who heard her call for help. She seems a bit dehydrated and confused.

Question

Apply the questions listed above to assess Edith's risk of a fall whilst in your ward for surgical repair of her fractured neck of femur.

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However, to ensure patient-centred care, each patient requires an individualised assessment to identify any actual or potential risks that may present a problem for him or her whilst they are receiving healthcare. To assist the completion of patient-centred risk assessments a number of risk assessment tools have been developed (Table 2.2). These tools gather information from the individual using a checklist or rating scale and summarise it, producing an overall rating on the level of risk. The final rating assists the nurse to determine the appropriate strategies to decrease the risk to the patient.

Table 2.2 Examples of Australian Risk Assessment tools

Risk Assessment Tools	**Example**
Falls Risk Assessment Tool (FRAT)	Health.vic: https://www2.health.vic.gov.au/about/publications/policiesandguidelines/falls-risk-assessment-tool
Malnutrition screening tools	Queensland Health: https://www.health.qld.gov.au/__data/assets/pdf_file/0029/148826/hphe_mst_pstr.pdf
Braden pressure risk assessment tool	SA Health: https://www.sahealth.sa.gov.au/wps/wcm/connect/b24a8480438d09be9e63dfbc736a4e18/2010maybradenrisktool.pdf?MOD=AJPERES&CACHEID=b24a8480438d09be9e63dfbc736a4e18
Between the flags track and trigger observation charts	Clinical Excellence Commission: http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/between-the-flags/standard-calling-criteria

Occasionally things do go wrong and the response to these errors should not be blame but one of investigation and learning with the aim of reducing risks for future patients, organisations, staff and visitors (Lord Hunt of Kings Heath, 2002). The occurrence of an **incident** requires an incident report to be completed. Incident reports provide comprehensive data for healthcare facilities to support thorough reviews and root cause analysis of incidents to identify problems and develop improvement strategies. Incident reports will warrant questions relating to the who, what, when, where, how and why are completed.

A good report is:

- complete
- concise
- specific
- factual and objective
- de-identified where appropriate

- light on abbreviations (Department of Health and Human Services, 2013)

Despite these risk management approaches, evidence indicates that the complexity of the healthcare system still places patients at significant risk from adverse events and medical error (Kohn, Corrigan, & Donaldson, 2000; Makary & Daniel, 2016; Shojania & Dixon-Woods, 2016). Consequences of errors can result in sentinel events, significant morbidity, distress and suffering, and financial burden for patients and significant others (Ehsani, Jackson, & Duckett, 2006; Shojania & Dixon-Woods, 2016). Sentinel events are a subset of adverse events that result in death or serious harm to a patient.

In 2004, the Australian Department of Health develop a core set of sentinel events that were required to be reported by public hospitals to enable reviews of the events and planning for improvements that maybe required to prevent the event from occurring again.

Australian national core set of sentinel events:

1. Procedures involving the wrong patient or body part
2. Suicide of a patient in an inpatient unit
3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure
4. Intravascular gas embolism resulting in death or neurological damage
5. Haemolytic blood transfusion reaction resulting from ABO incompatibility
6. Medication error leading to the death of patient reasonably believed to be due to incorrect administration of drugs
7. Maternal death or serious morbidity associated with labour or delivery
8. Infant discharged to the wrong family

(Australian Government, Department of Health. 2005)

What is patient safety?

"Patient safety is a discipline in the health care sector that applies safety science methods toward the goal of achieving a trustworthy system of health care delivery. Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events."(Emanuel et al., 2008)

As part of the healthcare team, it is critical that nurses have background knowledge, skills and attitudes of the origin of error in healthcare and patient safety approaches to manage and improve safety challenges in their clinical practice.

Error types and accident causation

Reason proposes that active failures and latent conditions are associated with adverse events in healthcare (Reason, 2000). Active failures are the unsafe acts committed by the healthcare personnel who are in direct contact with the patient and can take the form of slips, lapses, mistakes and violations (Reason, 2000). These failures have an immediate impact on the patient. Latent conditions arise from decisions made by healthcare designers, managers and directors that produce inevitable "resident pathogens" in a system (Reason, 2000). Latent conditions can lie dormant for some time until combined with active failures and error

producing factors that results in an accident (Reason, 2000). As depicted in Reason (1995) Accident Causation Model, adverse events or medical errors occur when failures appear in a number of layers that momentarily line up to permit the trajectory of opportunity for an accident.

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Figure 2.1. Reason's Accident Causation Model.

Source: adapted from Reason, 1995

A key aspect to many adverse events and medical errors involves the failure to apply human factors thinking to patient care situation (Walton, 2011). Human factors refers to "environmental, organisational and job factors, and human and individual characteristics which influence behaviour at work in a way which can affect health and safety" (Flin, Winter, & Cakil Sarac, 2009). Four categories and ten topics of human factors have been identified as relevant for patient safety (Flin et al., 2009).

Table 2.3 Categories and topics of human factors in healthcare.

Category	Topic
Organization/managerial	Safety culture
	Leadership
	Communication
Workgroup/team	Teamwork
	Team supervision
Individual worker	Situation awareness
	Decision making
	Stress
	Fatigue
Work environment	Work environment and hazards

Source: Flin et al., 2009

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Reflective question

Reflect on the impact that an error could have on an acute patient and their future life. Consider not only immediate pain and suffering but also future earning capacity and the impact on their family and friends.

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Australian Commission of Safety and Quality in Healthcare

The Australian Commission of Safety and Quality in Healthcare has identified three safety and quality goals for healthcare in Australia (Table 2.4) along with ten National Safety and Quality Health Service (NSQHS) Standards (Table 2.5) used in the accreditation of healthcare

providers to support meeting the stated gaols. The standards outline the roles for different groups in healthcare to ensure safe and quality care.

Table 2.4 Australian Safety and Quality Healthcare Goals

Goal 1. Safety of care - that people receive their health care without experiencing preventable harm	
Priority area	Outcomes
1.1 MEDICATION SAFETY	Reduce harm to people from medications through safe and effective medication management
1.2 HEALTHCARE ASSOCIATED INFECTION	Reduce harm to people from healthcare associated infections through effective infection control and antimicrobial stewardship
1.3 RECOGNISING AND RESPONDING TO CLINICAL DETERIORATION	Reduce harm to people from failures to recognise and respond to clinical deterioration through the implementation of effective recognition and response systems
Goal 2. Appropriateness of care: that people receive appropriate, evidence-based	
Priority area	Outcomes
2.1 ACUTE CORONARY SYNDROME	Provide appropriate, evidence-based care for people with acute coronary syndrome
2.2 TRANSIENT ISCHEMIC ATTACK AND STROKE	Provide appropriate, evidence-based care for people with a transient ischemic attack or stroke
Goal 3. Partnering with consumers: that people receive their health care without experiencing preventable harm that people receive appropriate, evidence-based care that there are effective partnerships between consumers and healthcare providers and organisations at all levels of healthcare provision, planning and evaluation	

Source: Australian Commission on Safety and Quality in Healthcare, 2012

Table 2.5 National Safety and Quality Health Service Standards

Standard	**Description**
1. Governance for Safety and Quality in Health Service Organisations	The quality framework required for health service organisations to implement safe systems.
2. Partnering with Consumers	The systems and strategies to create a consumer-centred health system by including consumers in the development and design of quality health care.
3. Preventing and Controlling Healthcare Associated Infections	The systems and strategies to prevent infection of patients within the healthcare system and to manage infections effectively when they occur to minimise the consequences.

4. Medication Safety	The systems and strategies to ensure clinicians safely prescribe, dispense and administer appropriate medicines to informed patients.
5. Patient Identification and Procedure Matching	The systems and strategies to identify patients and correctly match their identity with the correct treatment.
6. Clinical Handover	The systems and strategies for effective clinical communication whenever accountability and responsibility for a patient's care is transferred.
7. Blood and Blood Products	The systems and strategies for the safe, effective and appropriate management of blood and blood products so the patients receiving blood are safe.
8. Preventing and Managing Pressure Injuries	The systems and strategies to prevent patients developing pressure injuries and best practice management when pressure injuries occur.
9. Recognising and Responding to Clinical Deterioration in Acute Health Care	The systems and processes to be implemented by health service organisations to respond effectively to patients when their clinical condition deteriorates.
10. Preventing Falls and Harm from Falls	The systems and strategies to reduce the incidence of patient falls in health service organisations and best practice management when falls do occur.

Source: Australian Commission on Safety and Quality in Health Care, 2011

Documentation

Documentation supports vital communication across the health care team of the patient's current condition and treatment plan as well providing information to identify patterns or trends over time that may indicate patient deterioration. Whilst Documentation plays an important role in team communication, is also a legal requirement. The Nursing and Midwifery Board of Australia Standards for Practice identify that the registered nurse "maintains accurate, comprehensive and timely documentation of assessments, planning, decision-making, actions and evaluations" and further defines that the nurse is accountable for the documentation completed (reference).

Every clinical facility will have policies and procedure regarding documentation and each nurse must practice by these standards. The essentials of quality nursing documentation have been identified to include 7 essential themes (Scruth, 2014). Nursing documentation:

- Must be patient centered
- Must contain the actual interventions of the nurse that includes the physical, education and psychosocial support and their effectiveness.
- Reflects an objective clinical approach of the nurse
- Is presented in a logical sequential manner
- Is time sensitive

- Reflect the variances in care
- Be clear and concise
- Should satisfy legal requirements including
    - Handwritten entries must be legible
    - Each page must have the patients name and medical record number
    - Each entry must include a time, date and signature with designation
    - Each entry must be accurate including spelling with correct terminology is to be used
    - Any incorrect entries must be clearly labelled
    - Use of approved abbreviations
    - Documentation of interventions recorded by the nurse performing the intervention at the time of the intervention or as close to that time as possible
    - Use of the correct ink colour according to facility policy

Adapted from Scruth (2014)

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Reflective question

Reflect on the positives and negatives of good and bad documentation. What should you document to support yourself when admitting an acute patient?

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Clinical Decision-Making

What is a decision and why do we need to make them?

In the delivery of safe patient care, nurses are required to make decisions. Decisions will be made in a variety of clinical contexts and under a range of circumstances. A decision is the act of making a judgement or choosing a particular course of action when considering all of the options that may be available at any given time (Marquis & Houston, 2012; Merriam-Webster.com, 2016). In providing health care, patients and clinicians including nurses will make clinical care decisions that will affect the outcome of care. It is important that decisions are made about issues that may arise in the delivery of clinical care so that care is not provided in a haphazard way (Swallow, Smith, & Smith, 2017).

Critical thinking, problem solving and decision making are key components to any decision making framework. It is important that clinical practitioners understand why clinical decision making is significant in the delivery of safe patient care (Swallow et al., 2017). Nurses are accountable for their actions and these actions are often based on the ability to make a decision. The ability to make a decision will be influenced by the skills, knowledge and experience that a nurse may possess. Increasingly within the health care environment we are seeing decisions being made, in partnership with patients and their carers together with health professional working in teams, about the course of clinical care. Nurses are in a pivotal

position to influence and make decisions and for this reason should have an awareness of the decision making process.

The decision making process

Using **clinical judgement** to effectively make a decision is explained by a number of theories on how a clinical decision may be reached. Some of these theories include traditional knowledge within cultures, trial and error, personal experience, education and research, logical reasoning, intuition and reflective practice (Swallow et al., 2017). As nurses are professionally accountable for the actions and decisions it is equally important to understand the cognitive steps in the decision making process:

1. Define the issue
2. Understand the context under which the decision needs to be made
3. Identify possible options
4. Evaluate the consequences of each option
5. Prioritise the options and make one choice
6. Review the decision that is made
7. Enact the decision and deal with any consequences that follow

(Russell-Jones, 2015)

The above is a description on the thought process of making a decision yet there are other factors such as prior and current knowledge which should be considered when making a clinical decision. Other factors include:

- The patient understanding and ability to influence the decision about their own care
- The information that is needed to make a clinical judgment about care
- The impact of the decision on the quality of care
- External influences, which may include the available resources to provide care
- The scope of practice of the person making the decision
- The skills and knowledge of the person making the decision
- Is the decision being made on the best evidence available

(Swallow et al., 2017)

When decisions go wrong

Even with the best available evidence sometimes a decision is made and the outcome is not what was anticipated. Possible reasons for why decisions may go wrong can be attributed to a number of reasons. Some of these may include:

Table 2.6 Examples of decisions with adverse outcomes

Reasons	Examples
Having the wrong information or data	Incorrect labelling of patient information / incorrect patient

Not receiving the right information or data in a timely manner	Delayed pathology or radiology results influencing clinical diagnosis
Incorrectly interpreting the information or data	Through clinician error caused by fatigue or lack of knowledge
Making a decision to avoid conflict rather than addressing the underlying problem	When there is a conflict about treatment regimes and usually the person who is speaking loudest influences care which may not be based on evidence based practice
Not using a decision making framework (process) and making judgements based on best guesses	Not waiting for clinical information to make a judgement eg. Pathology results and basing judgements on previous experience
Not considering that patients are individuals and that the decision should be based on their unique set of circumstances, the rule of one size fits all does not necessarily always apply in practice	Treating with an antibiotic when the patient has been shown to not respond to that antibiotic in the past
Haste – making a decision before all the facts are known	Occurs in emergency or time pressured situations

Source: adapted from Swallow et al., 2017

Within your nursing practice you will be required to make decisions on a daily and sometimes hourly basis. Decisions about clinical care should be made with the best possible information, data and evidence that is available. Developing skills to interpret this information will improve with more experience (T. K. Bucknall et al., 2016). If there ever comes a time when you are unsure about a decision that you need to make, conferring with more experienced practitioners and seeking advice should be considered. Making the best decision based on the information you have, using your critical analytical thinking skills and knowledge will help to avoid poor decisions which can have devastating consequences in practice for both patients and clinicians.

Role of the Nurse

The role of the nurse is complex in many ways, and is dependent on the reason for admission; for example, a pre-booked surgical admission or surgical admission through the emergency department; or a medical patient admitted acutely for clinical care. Registered nurses are at the frontline of the hospital admission process (Handy, 2016). The nurses' clinical decision making and, most importantly, how decisions are communicated and documented enables other health care team members to perform their duties while providing accurate care and skills are undertaken to ensure that safe, quality and best practice are achieved.

Assessment is a key component of nursing practice, required for planning and provision of patient and family centred care. The Nursing and Midwifery Board of Australia (NMBA) (2006) in their then current national competency standard for registered nurses stated that, "The registered nurse assesses, plans, implements and evaluates nursing care in

collaboration with individuals and the multidisciplinary health care team so as to achieve goals and health outcomes." The current NMBA (2016) standards expand the role of the registered nurse to being person centred where the therapeutic interaction includes not only the patient but the family and community. The assessment required by the nurse includes: Patient History (previous surgery and medical conditions), Family History, physical examination (Blood Pressure, pulse, respiration, temperature, height and weight), electrocardiograph and current and previous medication history.

What is continuity of care?

Continuity of care is described as having three types of continuity: informational continuity, management continuity and relational or interpersonal continuity (CARNA, 2008). All three facets of continuity are paramount to best practice. Informational continuity refers to the transfer of information from one party to another to provide the knowledge that has been accumulated over time, to ensure that the current care is appropriate and ongoing. Management continuity provides a consistent approach to the care of the patient, considering policy and consistent use of care plans, pathways and case management (Haggerty, Reid, Freeman, Starfield, Adair, and McKendry, 2003). Relational or interpersonal continuity refers to the ongoing interactional between the nurse, patient and their family along with other health care providers.

Aspinal, Gridley, Bernard, & Parker (2012) suggest that continuity of care is the quality care which the registered nurse provides over time. Therefore, the role of the nurse is to ensure that the patient is involved with decision making in their own care and that services are integrated to provide the best possible care for the patient while also including family members as necessary. Malley et al. (2015) suggests that the nurse's consideration of the end users who are discharging the patients back to home is paramount to good care. Both the acute medical and surgical admission process must reflect the care transition of the patient.

The more acutely ill a patient the greater the range of needs due to complex requirements, these requirements may include intravenous cannulation for hydration and antibiotics (Bader, 1999, Hirshman, Shaid, McCauley, Pauly & Naylor, 2015). If a patient has a complicated medical history and extensive information needs to be collected and assessed this is the role of the registered nurse as the frontline. The registered nurse will perform assessments and report abnormalities to the other health staff for collaboration and clinical decision making with the team (Paul and Hice, 2014).

Interpretation of diagnostics

Routine testing of patients on admission to the clinical area will include blood work up dependant on the diagnosis of the patient for admission and will include: Full Blood Count (FBC), Liver function testing (LFT) and cardiac enzymes dependant on the presentation. Other routine **diagnostic** testing includes blood glucose monitoring, urinalysis and electrocardiogram (ECG), which are nurse-initiated on presentation to the health care centre (Paul & Hice, 2014). Early intervention and interpretation of diagnostic results improves the quality of care and rapid treatment of patients providing positive outcomes for the patient.

The opportunity for the nurse to question the patient at the time of admission when undertaking routine observations assists to clarify and determine any abnormal readings prior to surgery and also during the medical admission. The nurse's role in the admission process

is to communicate normal and abnormal diagnostic findings to other health care workers to provide a collaborative approach to patient care and wellbeing.

Administration of medication

The administration of medications to patients is another important role that the nurse assumes and must be undertaken accurately and competently to promote safe, high quality care (Handy, 2016). Understanding the patient's diagnosis along with medications prescribed by the medical officers is paramount to best practice in nursing care of the patient in acute care. Roughead, Semple and Rosenfeld (2013) highlighted that medication histories taken at the time of admission remain a point to vulnerability for medication error. The nurse is responsible for ensuring that history and allergy documentation is accurate including checking the medications which patients present with to hospital. Consequences of ineffective communication and care during the admission process can lead to greater vulnerability for the patient's transition in care (Malley et al, 2015).

<Start box>

Reflective question

Reflect on your role as a student registered nurse in the admission process in an acute area and consider an interaction where you have had difficulty communicating with your patient. What did you do to overcome the difficult communication?

<End box>

Preparation for Discharge

Preparation for discharge usually begins when a patient is admitted. Much of the data collected then is useful for discharge preparation and beginning early allows time to organise services, equipment and education (Hoch & Hamlin, 2015; Palmer & Kresevic, 2014). When a patient is discharged it is important to ensure that their needs will be met. The more complex the patient's condition is, the more discharge planning is required, this is particularly the case for elderly patients and those who have comorbid conditions (Sinha, Oakes, Chaudhry, & Suh, 2014). In some instances another service or agency will assist in the provision of care while the patient is in the community (for this reason some people refer to discharge as a transfer of care) (Haley, 2014). Good communication with the patient and any carers they may have is essential if this is to be effective (New, McDougall, & Scroggie, 2016). Prior to discharge it is important to assess the patient's needs, possible benefits of involving other health professionals and any education they may need in order to optimise their health outcomes.

Assessment of need

Assessing the patient's needs usually begins with a risk assessment to identify people who will require further assessment and follow up care before leaving the ward or when they get home. It is important to assess how a patient will cope with all of their activities of daily living when they return home in order to ensure that they have a positive outcome (Haley, 2014).

Shorter lengths of stay in hospital have several benefits but this can result in a patient being discharged when they still feel quite unwell and may require family assistance. This means that the ability of the family to provide such assistance may also need to be assessed (some people may not have family or their family members may not be willing to assist) in

order to ensure that the person will cope when they return home (Haley, 2014; Hoch & Hamlin, 2015; Pierluissi, Francis, & Covinsky, 2014).

People living in Australia and New Zealand may face additional difficulties due to living in rural and remote areas. This additional distance may require assessment when preparing a patient for discharge as they may not be well enough to travel long distances at the time of discharge and may feel anxious due to the length of time it may take to acquire assistance were their condition to deteriorate. In some instances road conditions may also be poor or totally impenetrable at some times of the year (e.g. due to flooding) (Anderson & Malone, 2014; Haley, 2014).

Inter-professional involvement

Most health services will have a team of inter-professional staff who can collaborate in preparing patients for discharge. Teams are often varied and can include case managers, physiotherapists, occupational therapists, dieticians, pharmacists, community nurses etc. Some of these teams may offer **post-acute care services** where assistance can be provided to patients after they return to the community. If a wide range of services are available patients will need to be informed what the relevant services provide (this varies significantly in different areas), how that relates to them and what options are available (Sefcik et al., 2016). Patients with complex needs such as those relating to comorbidity are more likely to benefit from the involvement of an inter-professional team (Sinha et al., 2014). Even in rural and remote areas of Australia and New Zealand there are often community nurses who can assist with follow up care (Anderson & Malone, 2014; Haley, 2014). In order to give the entire team the best opportunity to address patient needs, they should be informed early of the estimated date of discharge. Family and patients themselves should also be informed of this in order to allow them to prepare (New et al., 2016).

Pharmacists can also be useful in assisting patients to learn about their medications, how to use them effectively and what side effects to be aware of. Any change in medication should be addressed so that the patient is clear about what has changed (Pierluissi et al., 2014). Patients who are being discharged should be provided with written verification of any follow up appointments with general practitioners, allied health or any other health professionals they will be expected to visit when they have returned to their community and referrals to such practitioners should be sent (Haley, 2014; Mitchell, 2015).

In some cases physiotherapy, occupational therapy or nursing assessments can indicate the need for additional equipment (sometimes short term) to assist in caring for someone after they have been discharged. Some health services have equipment available for this purpose or there may be a leasing company which hires out equipment when required. Organising equipment can take a while and sometimes patients need to make arrangements to pay for hire of such equipment – this is one reason why preparing for discharge on admission can assist as nurses will often be aware of what the outcome of a patient's admission will be (Haley, 2014).

Social, cultural, physical and psychological considerations

Each patient needs to be considered holistically when discharge is being planned. Social issues can relate to whether a patient has a carer or someone who can take on that role temporarily. Social issues are broad and also include financial issues, transport, access to medications, equipment etc. Culturally sensitive discharge planning is also essential and can include

religious considerations, dietary habits and living arrangements for not only the patient but other family members. It is important to assess a patient's ability to understand the language that is being used at all times, as we often slip into professional terminology that is difficult for patients to understand. However, when they come from a different cultural background this is even more important. Asking a patient to explain what you have said in their own words or to demonstrate what you have shown them (teach back) is essential in order to determine whether they have understood. Interpreter services should be available in all health services (telehealth has made this a much more accessible service) and professionals should be used rather than asking family members to interpret as cultures often make it difficult for some family members to discuss particular health issues e.g. a child interpreting information about sexual health to a parent (Bowman, Flood, & Arbaje, 2014).

Physical considerations for discharge vary due to the reason for admission. Where a wound is can impact on a patient's mobility or their ability to care for themselves. Features of a patient's home which they have never noticed, may impact on them after they have been hospitalised such as a small step into a shower. Assessing physical considerations therefore needs to be individualised for each patient and their ability on discharge. Similarly, psychological considerations vary. When a patient has a pre-existing psychological condition, support may already be in place, but the hospitalisation may create additional issues which are unexpected. Patients sometimes perceive hospitals as 'safe places' where they can call for help at any time and are watched and assisted constantly. For some patients the idea of discharge can cause anxiety as they may feel insecure particularly if they do not have much social support or have a great deal of pain (Mitchell, 2015).

Some patients will decide to leave against medical advice. This will probably mean that they are not well prepared and makes it even more important that some follow up is undertaken if possible. From a legal perspective it is important that such a discharge is well documented. Most health services will have a form for these patients to sign acknowledging that they will not hold the health service liable for any issues which arise, but some patients will leave without doing so (Alfandre & Schumann, 2013; Haley, 2014)

Education

Health literacy is how people understand and apply information about their health and health care to their lives and make decisions about their health (Australian Commission on Safety and Quality in Health Care, 2014). Part of our role as health professionals is to assist patients to make effective decisions about their health care in an informed way. Such assistance extends to discharge and often involves education which supports the patient after leaving the health service.

Education may be required for a patient who is returning home and/or for their family members who will need to provide them with assistance when they do return home. This may include changing dressings, use of medications, physical care or dietary needs and how to recognise a deterioration in their condition (Haley, 2014). It is also important to ensure that patients are educated about preventing complications of their treatment (Anderson, Deravin-Malone, & Anderson, 2016). Any patient who will need to self-manage their care at home, such as those with chronic conditions which are unable to be cured e.g. diabetes, chronic obstructive pulmonary disease will need to be offered education to ensure that they can cope effectively when they return home (Sinha et al., 2014).

As often as possible verbal education should be supplemented with written education so that the patient can return to the material later or if their memory fails (Hoch & Hamlin, 2015). Patient and family education are nursing responsibilities and need to be documented appropriately (Haley, 2014; Hoch & Hamlin, 2015).

Although most patients who are discharged from health services will be independent and not require any follow up treatment it is important to assess them thoroughly and in many cases an admission is a useful window of opportunity to provide education about health generally, how to avoid future admissions and how to recognise a deterioration of their condition which may require their return to healthcare (Anderson et al., 2016; Haley, 2014).

SUMMARY

Learning Objective 1

Define and discuss the process of admission and assessment of the acute client;

The process of admission for a patient to an acute healthcare environment involves providing patients and families with information about the healthcare environment, setting goals for the patient's admission, providing any required patient/family education, initiating referrals and preparing for discharge. Vital within this process is ensuring the patient feels safe and welcome within your healthcare environment. A fundamental part of the admission process is the initial holistic patient assessment that should provide a benchmark for the patient's hospitalisation.

Learning Objective 2

Explain the concept of risk management and the importance of patient safety, specifying strategies that exist to increase safety and reduce risk;

Admission into healthcare presents many risks to patients and it is imperative that risk management and patient safety approaches are maintained to maximize patient outcomes. Risk management approaches enable assessment and management of risks to protect patients from accidental injury. Patient safety thinking ensures all the healthcare team have a common background knowledge, skills and attitudes regarding error in healthcare and approaches to manage and improve safety challenges in their clinical practice.

Learning Objective 3

Discuss the use of critical thinking to inform clinical decision-making

Decisions will be made in a variety of clinical contexts and under a range of circumstances. In providing health care, patients and clinicians including nurses will make clinical care decisions that will affect the outcome of care. Using a decision making process will support decisions to be made based on the best available information and evidence and avoid poorly made decisions which can have devastating consequences on patient care

Learning Objective 4

Identify the nurses' role in continuity of care, interpretation of diagnostics and administration of medications.

The nurses' role in the admission process is a complex integration of communication, documentation and education to provide optimal continuity of care. Interpretation of a

patient's medical and surgical history including diagnostics is paramount to providing optimal care and skills to ensure that safe, quality best practice is achieved.

Learning Objective 5

Explore and discuss the discharge of an acute client, considering appropriate social, cultural, physical and psychological considerations

Discharge planning should begin at the time of admission so that everyone involved (including the patient and their significant others) can begin preparations. Discharge planning should involve social (e.g. family, transport, financial), cultural (e.g. language, religious habits, dietary habits), physical (e.g. wound care, mobility, pain) and psychosocial (e.g. anxiety, depression, fear) considerations.

Key terms and concepts

Admission: where a healthcare facility accepts responsibility for a patient's care and/or treatment

Clinical judgement: is the process by which a decision can be made based on the interpretation of information that is available. In order to make a judgement critical thinking and problem solving are required to make a decision

Continuity of care: how a patient experiences care over time, which results in the provision of good interpersonal skills and coordination of care.

Critical thinking: the analysis and evaluation of a situation

Diagnostics: used to help identify a disease, illness, or problem.

Incident: is "an event or circumstance that resulted, or could have resulted, in unintended and/or unnecessary harm to a person and/or a complaint, loss or damage" (. Australian Commission on Safety and Quality in Health Care, 2011, p. 10)

Post-acute care services: these health care services support patients after they have been discharged from acute care services (e.g. hospitals) to manage at home. Usually access is limited to a number of weeks after discharge.

Risk management: " the design and implementation of a program to identify and avoid or minimise risks to patients, employees, volunteers, visitors and the institution" (. Australian Commission on Safety and Quality in Health Care, 2011, p. 12).

Review questions

1. What are the elements required to orientate a patient and their family to your ward environment?
2. What is the nurse's role during an admission assessment?
3. Identify some of the possible reasons for clinicians making poor decisions
4. Discuss patient safety and the nurses' role as part of the healthcare team.
5. Discuss which type of medications are particularly likely to affect the stay of an acute patient.
6. Identify the role of nursing staff in the acute care admission process.

7. Identify some issues that you may need to have addressed upon discharge after an abdominal surgery.

Research Topic

Investigate which complementary medications are likely to affect an acute patient's stay and how.

Further Reading

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