Chapter 1: Critical Thinking and the Nursing Process

KEY TERMS

assessment	the orderly collection of objective and subjective data on the patient's health status
clinical pathways	pathways or maps show the outcome of predetermined patient goals over a period of time; that is, they state what activity the patient should be capable of performing daily, on the basis of the patient's Diagnostic-Related Grouping (DRG)
clinical reasoning	a disciplined, creative, and reflective thinking used with critical thinking to establish potential strategies for patients to reach their health goals
clustering	placing similar or related data into meaningful groups
collaborative intervention	physician-prescribed orders that are implemented by nurses
collaborative patient problem	patient problem for which the nurse works jointly with the physician and other health care workers to monitor, plan, and implement treatment
critical pathway	map in the case management patient care delivery system that shows the outcome of predetermined patient goals over a period of time
critical thinking	a purposeful, goal-directed thinking process that strives to problem-solve patient care issues through clinical reasoning
defining characteristics	signs, symptoms, or statements made by the patient that validate the existence of the health problem or situation
evaluation	last step of the nursing process; the patient's progress in achieving the outcomes is determined
evidence-based practice	uses the outcomes of well-designed and executed scientific studies to guide clinical decision making and clinical care
functional health patterns	groups of human behaviour that facilitate nursing care; there are 11 patterns
implementation	fifth step of the nursing process; the execution of the nursing interventions that were devised during the planning stage to help the patient meet predetermined outcomes
independent nursing interventions	actions that the nurse is legally capable of implementing based on education and experience
intervention	nursing action designed to achieve patient outcomes
nursing care plan	patient care record that uses the nursing process as its framework
nursing process	dynamic, six-step process that incorporates information in a meaningful way in the use of problem-solving strategies to place the patient, family, or community in an optimal health state; includes assessment, nursing diagnosis, planning, outcome identification, implementation and evaluation
patient goal	broad, unmeasurable statement directed toward removal of related factors or patient response to an adverse condition
patient outcome	measureable statement of the expected change in patient behaviour
prioritise	ranking the patient's nursing diagnoses; most critical concerns should be dealt with first

CHAPTER SUMMARY

This chapter presents an overview of the nursing process, critical thinking and clinical reasoning. All of this information provides the foundation for nursing practice in the 21st century.

Critical thinking and clinical reasoning

Nursing is a profession requiring knowledge, research and care in clinical practice.

Professional intuition develops with experience, and influences clinical decision making. Critical thinking and clinical reasoning are essential to nursing practice. Critical thinking uses purposeful, goal-directed thinking processes to solve patient-care issues. The components of critical thinking are interpretation, analysis, inference, explanation, evaluation and self-regulation. Nurses solve complex patient-care problems using both critical thinking and clinical reasoning skills.

Critical thinking and the nursing process

The steps of the nursing process are presented in this chapter. Assessment is the first step in the nursing process. During the assessment phase, the nurse collects subjective and objective data. Subjective data are collected from the patient during the interview or while obtaining a health history. Objective data are collected from physical assessment and laboratory, and diagnostic findings. This assists with the problem being identified, which is going to be the focus.

Planning is the second step in the nursing process. Subjective data is evaluated and then consideration is given to objective data required to assist with the assessment.

The third step in the nursing process is implementation. During this stage the nurse utilises clinical reasoning to complete the physical assessment of the patient. Physical assessment involves collection of objective data with approaches such as Gordon's Functional Health Patterns. Objective data is also collected via diagnostic and laboratory findings such as x-rays and blood tests.

The fourth step or final phase of the nursing process is evaluation. The evaluation requires the nurse to be able to prioritise potential problems with their clinical reasoning and establish the nursing-related patient problem, which is the problem the nurse and patient are able to address. There is also the identification of the collaborative patient problem. This is a problem which requires a team approach from other healthcare disciplines such as a doctor.

Evidence-based practice

Evidence-based practice is a current trend in contemporary care. Clinical decisions are made on factual research rather than 'because they have always been done that way'. This has resulted in better patient outcomes.

Clinical (or critical) pathways

Clinical or critical pathways are used as a cost-effective system to provide high-quality patient care. They show predetermined patient goals and expectations of a patient's capability, therefore allowing early recognition if any variances should occur.

THEORY APPLICATION

- Scenario for students: Your patient is a 54-year-old Asian male who presents to your unit with a gastrointestinal (GI) bleed. He tells you that he has felt lightheaded for the last couple of days and has noticed that his stools have become black and tarry. He also complains of indigestion. His hematocrit is below the normal value, so he needs a blood transfusion. His nasogastric tube (NGT) reveals frank blood. The patient is also pale. He states that he has been under a lot of stress lately since his wife left him but that he is otherwise healthy. He relates to you that he read somewhere that an aspirin a day helps prevent heart attacks, so he takes 650 mg of aspirin every day. Your patient is a deliveryman who rotates shifts (he tells you that he sleeps anywhere from 5 to 10 hours a day, depending on the shift that he is working).
  A. Distinguish between the subjective and objective data.
  B. Have half the class organise the data presented using Gordon's Functional Health Patterns and the other half use a body systems approach. Compare data organisation.
  C. What further data do you need to collect to complete the assessment? Do additional data need to be gathered to assess the 11 functional health patterns?

  Answers:

  A. Subjective: Feeling faint, having indigestion, stating that he takes 650 mg of aspirin every day, and reporting black, tarry stools. Objective: Decreased hematocrit, frank blood via the NGT, and pallor.
  B. Health perception–health management pattern: The patient perceives his health as unremarkable. He states that he takes 650 mg of aspirin every day. Nutritional–metabolic pattern: No information. Elimination pattern: Black, tarry stools. Activity–exercise pattern: Need more information, but the patient probably gets some exercise in his profession as a deliveryman. Cognitive–perceptual pattern: No information. Sleep–rest pattern: Inconsistent sleep habits. Self-perception–self-concept pattern: No information. Role–relationship pattern: Recently separated. Sexuality–reproductive pattern: No information; however, one should not assume that this is not an active pattern just because the patient is separated from his wife. Coping–stress-tolerance pattern: Patient admits to being under stress. Value–belief pattern: No information.
  C. Ask questions pertaining to the 'no information' data above.

TEACHING EXERCISES

- Have each student present a brief patient history. Ask the students to identify the subjective and objective information contained in each patient history. Ask the students to identify whether any additional information should be collected. Have the group brainstorm on what patient problems may be applicable to each patient.
- If the students are exposed to critical pathways at their clinical agency, have them bring back their patients' specific pathways and have the group determine the aspects of assessment-based nursing interventions that have been laid out in the pathway.

INDIVIDUAL EXERCISE

- Ask the students to review the data collected for their patients' histories. Have the students identify whether the data are objective or subjective. Ask the students to use Gordon's

Functional Health Patterns or body systems to cluster the data. Have the students identify whether any further information should be collected.

GROUP DISCUSSION

- Discuss with the group the pros of standardised care plans (e.g., less paperwork and more time with a patient) versus the cons (e.g., limited individualisation of a patient's plan of care). Remember, care plan documentation can be a challenge when patient acuity is high or staffing is low.

CLINICAL APPLICATION

- Have students explore how their clinical agency documents the nursing process. Ask them to share copies of the documentation forms with their clinical group. Have them critique the documentation in regard to ease of finding pertinent information, readability, and completeness of documentation. Are the nursing care plans standardised or computerised? If they are standardised or computerised, is there a way to individualise the care plan? Have the students critique the care plan.
- Challenge the students to find an example of how evidence-based practice has changed clinical decision making or clinical care at their institution. Have them report the example to the class, including the evidence that prompted the change.

Chapter 2: The Patient Interview and Developmental Considerations

KEY TERMS

aphasia	impairment or absence of language function
code of ethics	codified beliefs and lists of mandatory or prohibited acts
colloquialism	word or phrase particular to a community and used in informal conversation and writing
conservation	the understanding that altering the physical state of an object does not change the basic properties of that object
development	patterned and predictable increases in the physical, cognitive, socioemotional, and moral capacities of individuals that enable them to successfully adapt to their environment
developmental stage	one of multiple sequential age periods during which individuals experience the same physical, cognitive, socioemotional, and moral changes
developmental task	specific physical or psychosocial skill that must be achieved during each developmental stage
egocentrism	viewing the world in terms of only the self and interpreting one's own actions and all other events in terms of the consequences for the self
growth	increase in body size and function to the point of optimum maturity
intermediary	individual who serves to assist with communication between the patient and another individual, usually a member of the health care team
joining stage	introduction or first stage of the interview process, during which the nurse and patient establish rapport
life event or transitional developmental theory	belief that development occurs in response to specific events, such as new roles (e.g., parenthood), and life transitions (e.g., career changes)
life review	reflection on the experiences, relationships, and events of one's life as a whole, viewing successes and failures from the perspective of age, and accepting one's life and accompanying life choices and outcomes in their entirety
listening response	attempt made by the nurse to accurately receive, process and respond to the patient's messages
menopause	cessation of menstruation
nonverbal communication	communicating a message without using words
object permanence	ability to form a mental image of an object and to recognise that, although removed from view, the object still exists
reversibility	the understanding that an action does not need to be experienced before one can anticipate the results or consequences of the action
stress	physiologically defined response to changes that disrupt the resting equilibrium of an individual
termination stage	last segment of the interview process during which information is

	summarised and validated
transitional developmental theories	based on the premise that development occurs in response to specific events, such as new roles (e.g. parenthood) and life transitions (e.g. career changes)
working stage	that segment of the interview process during which the majority of data are collected

CHAPTER SUMMARY

The patient interview

Patient interview focuses on assessment of physical, mental, emotional, developmental, social, cultural and spiritual aspects of the patient. Information is collected regarding past and present condition, family status, relationships, cultural background, lifestyle choices and developmental level. Consideration is also given to patient's self-concept, religious beliefs, social supports, burden of care, sexuality and reproduction processes.

The nurse

The nurse is pivotal in establishing therapeutic relationship with patient which facilitates the patient to effectively access the healthcare system. The initial interview is crucial for development of a therapeutic relationship.

The patient

The patient needs to feel actively involved and empowered in their care. The therapeutic relationship and the interview process provide an ideal opportunity for this to occur.

The interview

Factors which are crucial for an effective interview to occur include the approach, environment, ensuring confidentiality, the time, length and duration of the interview, and ensuring the nurse does not display any biases or prejudices during the interview.

Stages of the interview process

- **Stage 1:** JOINING STAGE – therapeutic relationship evolves from trust.
- **Stage 2:** WORKING STAGE – information collected and goals are developed and addressed.
- **Stage 3:** TERMINATION STAGE – information is summarised and validated and plans for future are developed.

Communication process

- **Listening** – via active listening which includes verbal (spoken word) and non-verbal communication (body language).
- **Distance and personal space** – consideration to appropriate distance in a given situation.

Effective interviewing techniques

Effective communication occurs when there is the use of open-ended questions, and closed questions. Verbal and non-verbal communication and particularly the use of silence are most effective techniques for communication to occur in the nurse–patient interview.

Communication techniques

Listening responses
Ensure messages are accurately received and understood by the nurse, and allow for empathy to be demonstrated by the nurse toward the patient's situation.

Action responses
These interviewing techniques assist the nurse to facilitate change in patient perception of situation and make decisions for changes which may need to occur.

Some interviewing techniques should be avoided
Certain techniques are detrimental to developing a therapeutic relationship and these skills may even damage or destroy a therapeutic relationship which has already been developed.

Interviewing patient with special needs

All patients are unique and the interview process will need to cater for the individual. However, there are some patients who will require the nurse to be more prepared and perhaps more patient. Such patient situations may include the hearing and visually impaired, patient with speech difficulties, patient from another culture, patient with a low level of understanding, an emotional patient, a patient who may be sexually threatening or aggressive, or a patient under the influence of alcohol or drugs.

Final consideration regarding successful interviewing with the patient involves careful consideration of the developmental stage of the individual patient as this will influence terminology and language used and responses by the patient during the interview process.

THEORY APPLICATION – THE PATIENT INTERVIEW

- Scenario for students: While observing your colleague conduct a patient interview, you notice that he is standing at a bedside table about 5 metres away from the patient and is yelling his questions from across the room. When the patient responds that she is being admitted for alcohol detoxification, your peer states, 'We've all been there before. You'll do fine'. When the patient becomes tearful and somewhat silent, your colleague tells her to 'get a hold of yourself and stop crying'. When the patient states that she is tired and wants to rest, the interviewer remarks that he has only a couple more questions he needs to ask her to complete his paperwork. The patient acquiesces, but it is obvious that she is upset.
  A. Analyse your colleague's interview technique and decide whether it is effective.
  B. What suggestions could you offer your colleague to show more support of the patient?
  C. How do you think you would feel if you were this patient?

Answers:

A. The interviewer's technique is ineffective. He is standing too far from the patient; he is not respecting her confidentiality when he yells questions across the room; his comment, 'We've all been there' belittles the patient's condition; he handles her emotional outburst in an unsupportive manner and he disregards her request to end the interview.

B. The student can pull the interviewer away and discuss the situation; the student can discuss the matter with the instructor; or the student may assume the role of patient advocate and state, 'The patient is tired. Can't we continue this interview after a break?'

C. Responses will be of a personal nature.

THEORY APPLICATION – DEVELOPMENTAL CONSIDERATIONS

- Scenario for students: Your patient is a 3-year-old boy who is the youngest of three siblings. His 3-year-old check-up is normal except that his mother states that he is still not potty trained. She states that she has tried everything. She has recently resorted to shaming him and to physically disciplining him when he has accidents. She tells you that she is at the end of her tether and doesn't know what to do.

  A. How would you respond?

  B. Identify this child's developmental stage according to Piaget, Freud, and Erikson. Discuss what you think each developmental theorist would say about this parent's dilemma.

  Answers:

  A. Every child is unique in toilet training. Remind the mother that boys tend to be ready to toilet train later than girls. Investigate, through your questions, the child's home environment (e.g., is the home conducive to toilet training? Have the parents invested in a non-threatening portable potty? Is the bathroom well lit, and can the child turn on the light? Have the parents spent some one-on-one time with the child?). Determine through questioning and observation the child's readiness to use the potty (e.g., can he unbutton and pull down his pants? Does he know what wet and dry feel like? Can he indicate when he is about to urinate or have a bowel movement?) Reinforce the fact that shame and corporal punishment will not make toilet training more successful.

  B. Piaget (Preoperational Stage); Freud (Anal Stage); Erikson (transitioning from Autonomy versus Shame and Doubt to Initiative versus Guilt Stage).

TEACHING EXERCISES – THE PATIENT INTERVIEW

- Simulate patient interviews in which one student plays a hostile, sexually aggressive, or angry patient and another student plays the interviewer. Have each participant critique the interviewer's approach and provide feedback to enhance interview techniques. Explore both participants' personal thoughts and feelings during the encounter.
- Pair students, and have each select a card containing instructions on how to act while being interviewed. Have the 'interviewer' take a brief (2–3 minutes) health history for the 'patient'. Some examples of patient behaviours are: exhibiting distracting nonverbal communication, supplying one-

or two-word replies to questions, and remaining silent. At the conclusion, have each student discuss perceptions.

- Pair students, and have each 'nurse' select a card with instructions on how to act while interviewing the 'patient'. Have them conduct a 2- to 3-minute interview. Some examples of nurse behaviours are: requesting an explanation, probing, supplying false reassurance, giving disapproval, advising, being talkative, and using medical jargon. At the conclusion, have each student discuss perceptions.

TEACHING EXERCISES – DEVELOPMENTAL CONSIDERATIONS

- Obtain a copy of the developmental assessment tools discussed in the text and have the students review them. Have them use one of the tools to assess children of different ages.
- Have the students compare and contrast the different developmental tools described in this chapter.

HELPFUL HINT

- When communicating with patients, it is important to be culturally sensitive. Have the students reflect upon cultural differences in communication and identify how they can implement effective communication techniques in these situations.
- Advise the group that when they are assessing their patients they need to be respectful of their patients' developmental stages and adjust their interview techniques and language appropriately. For example, they should get down at the child's eye level when speaking with a toddler. With adults, they should not assume that they can address them by first name; most patients want to be addressed at a professional level just as the students should be addressed. Students should ask patients how they prefer to be addressed (e.g., by first name, Mr/Mrs and last name, etc.)

INDIVIDUAL EXERCISES

- Have the students record a 5-minute conversation with their patients. Have the students analyse the communication techniques that were used and decide whether they were effective or ineffective. Also, have them identify an alternate communication technique for each ineffective technique used in the conversation.
- Have the students interview their family and friends and ask specifically about their hospital experiences and what they liked and disliked about the nursing care they received.
- Have the students explore their own feelings about the possibility of a significant other being disabled because of advancing age. If it is a parent, would the students be able to accommodate the parent in their own home, or would the parent go to a skilled facility? What criteria would they use to make this decision? What influence might cultural values have on this decision? Ask the students whether they have ever discussed with their families what their wishes are in the event of such a dilemma.

GROUP DISCUSSION

- Have the group members discuss their experiences watching patient interviews and identify the use of therapeutic and non-therapeutic interviewing techniques. For each non-therapeutic interviewing technique used, students should identify a therapeutic interviewing technique that could have been used in its place. Have them discuss whether the interviews were handled appropriately and debate what could have made the interviews more successful. Elicit student impressions as to which interview techniques were effective and which were ineffective.
- Ask students to describe the appropriate use of touch during the patient interview.
- Discuss the appropriate and inappropriate uses of humour with patients.
- Discuss the importance of remaining non-judgmental. Ask the group what they would say to a co-worker who was obviously prejudicial when he or she talked about the patient population in the clinical environment.
- Discuss the use of silence as an interview technique. Ask why this technique is difficult for some people to use.
- Have your students review the developmental tasks for their ages and then have them discuss whether they have achieved these tasks. Ask the older students whether they have any advice for the younger ones based on their achievement of the younger adults' developmental tasks.

CLINICAL APPLICATION

- Ask your students to accompany their preceptors or clinical facilitators to admission interviews while on clinical placement. Remind the students that they need to introduce themselves to the patients, explain why they are there, and ask the patients whether it is all right if the students stay.
- Have the students conduct a patient interview and analyse their use of effective and ineffective communication techniques. For each ineffective technique used, have the students identify an effective communication technique.

ANSWERS TO REVIEW QUESTIONS

1(c) 2(c) 3(d) 4(a) 5(b) 6(c) 7(c) 8(b) 9(d) 10(a)

Chapter 3: The Complete Health History Including Documentation

KEY TERMS

anaemia	decreased number of red blood cells
anaesthesia	absence of touch sensation
associated manifestations	signs and symptoms that accompany a patient's chief complaint
cephalocaudal	head-to-toe approach
characteristic patterns of daily living	patient's normal daily routines; includes meal, work, and sleeping schedules and patterns of social interactions
chief complaint	symptom or problem that causes the patient to seek health care
complete health history (CHH)	comprehensive history of the patient's past and present health status; includes physical, emotional, psychological, developmental, cultural, and spiritual data
descriptor or qualifier	adjective that describes or qualifies the human response
distress	negative stress that is harmful and unpleasant
electronic medical records (EMRs)	create a paperless system that can reduce charting/documentation time once the clinician is familiar with the system. EMRs enable the nurse to use voice recognition, narrative writing, and/or check boxes with drop-down menus to record patients' histories and assessment findings. Other advantages of EMRs are their legibility, easy accessibility, ability to be accessed by multiple users simultaneously at different work stations in different areas in real time, and capability of accessing real-time laboratory and diagnostic studies
emergency health history	history taken from the patient or other sources when the patient is experiencing a life-threatening state
episodic health history	history taken from the patient for a specific problem or need
epistaxis	nosebleed
eustress	positive stress that challenges, provides motivation, and prevents stagnation
focused history	shorter than the Complete Health History and is specific to the patient's current reason for seeking health care
functional health assessment	documents a person's ability to perform instrumental activities of daily living and physical self-maintenance activities
genomics	the study of the genetic makeup of the human cell
health maintenance activities	practices that a person incorporates into a lifestyle that can promote healthy living
hirsutism	excessive body hair
history of the present illness	chronological account of the patient's chief complaint and the events surrounding it
intimate partner violence (IPV)	involves more than physical abuse; it includes psychological, emotional, sexual, and financial abuse or coercion
midclavicular line	vertical line drawn from the midpoint of the clavicle

nocturia	excessive urination at night
palpitation	irregular and rapid heart beat, or sensation of fluttering of the heart
past health history (PHH)	history that covers the patient's health from birth to the present
past medical history (PMH)	history that covers the patient's health from birth to the present
patient profile	demographics that may be linked to health status
pertinent negatives	manifestations that are expected in the patient with a suspected pathology but that are denied or absent
positive findings	those associated manifestations that the patient has experienced along with the primary complaint
qualifier	see *descriptor*
race	classification of individuals based on shared inherited biological traits such as skin colour, facial features, and body build
rash	cutaneous skin eruption that may be localised or generalised
reason for seeking health care	problem or health care need that brought the patient to seek health care
review of systems (ROS)	the patient's subjective responses to a series of body system-related questions; serves as a double-check that vital information is not overlooked
sequelae	aftermath
social history	information related to the patient's lifestyle that can have an impact on his or her health
symptom	subjective finding
visual analog scale	numerical scale used to rate pain from 0 to 10

CHAPTER SUMMARY

The patient assessment involves the health history. The level of detail gathered in the health assessment is influenced by the patient's current health status. A complete health history is an in-depth, thorough interview from birth to present. A focused history is a specific assessment of the current situation in case of follow-up care, and an emergency health history obtains information in the emergency situation.

The complete health history assessment tool involves collating information regarding patient profile, reason for seeking help and present history of complaint. Characteristics of complaint include location, radiation, quality, quantity, associated manifestations, aggravating factors, setting, timing and meaning or impact on the patient.

In order to complete a health history assessment other relevant information required includes past medical history, past surgical history, allergies, medications currently taken, communicable disease history, injuries and accidents, special needs, blood transfusions, childhood illnesses and immunisation history.

Family health history is also required to complete a health assessment, to identify any familial or genetic diseases.

Social history involves assessment of following areas: alcohol, drug and tobacco use, domestic and intimate partner violence, sexual practice, travel history, work and home environment. Factors influencing psychosocial environment such as hobbies, leisure activities and stress also need to be assessed for thorough health assessment of the patient.

Following this the identification and assessment of the individual's health maintenance and promotion activities are explored. This allows for strengths and potential weaknesses to be identified which all contribute to a complete health assessment of the patient.

Finally, a review of the patient's body systems completes the health assessment of the patient.

On completion of all of these steps, the information and findings need to be accurately documented. General documentation guidelines include legible writing, using permanent blue or black ink, dating and timing each entry, not leaving space between entries, and signing each entry with full name and professional credentials. Thorough documentation ensures best possible communication, which results in improved patient care. From a legal perspective, actions not documented in the medical file were not undertaken.

THEORY APPLICATION

- Scenario for students: You are taking the health history of a 65-year-old male whose chief complaint is shortness of breath (SOB) while climbing stairs. Upon further questioning, you learn that his SOB has gotten progressively worse over the last 2 days and that he now requires two pillows to sleep at night. He also tells you that his house has two stories. He feels that his SOB gets better when he rests. You note that the patient is taking furosemide, a diuretic; yet when you ask him when he last took the furosemide, he tells you that he stopped taking it last week because he 'hated having to get up all night to pee'. The patient denies that he is having chest pain at present.

  A. Which of the nine characteristics of a chief complaint are applicable to this patient?

  Answer:

  A. Location, radiation, and quality do not apply. Dyspnoea can be quantified by relating it to exercise tolerance (e.g., 'How far can you walk?' 'How many pillows do you use to sleep at night?') Associated manifestations (negative at present); aggravating factors (climbing stairs, stopped taking diuretic); alleviating factors (two pillows to sleep); setting (a house with a lot of stairs); and timing (night-time) all are important.

TEACHING EXERCISES

- Have the students conduct and document a review of systems with a partner. Students should role-play using the following conditions: seizure disorder, diabetes mellitus, arthritis, low back pain, asthma, heartburn, and allergies.
- Have the students bring back a health history form from clinical placement to share with the group. Ask them to complete one on themselves to become familiar with the form before conducting their first patient interview.

- Have the students role-play history-taking using the following chief complaints: diarrhoea, impotence, urinary incontinence, increased sneezing, and moodiness. Ensure that the students use the nine characteristics of a chief complaint, including the PQRST mnemonic.

HELPFUL HINTS

- To probe a patient's use of alcohol, some clinicians use the CAGE questionnaire: 'Have you felt the need to *c*ut down on alcohol? When others comment on your intake, do you become *a*nnoyed? Do you feel *g*uilty about your use of alcohol? Have you ever taken an *e*ye opener (used alcohol for a hangover)?'
- Encourage students to take their time when completing a health history to ensure that they obtain a thorough history. It is important for the patient to not feel rushed during the health history interview.
- Most of the patient's demographic data (e.g., age, address, religion) and health insurance information are obtained by admitting personnel, not by nurses. However, it is important to review this information because it may help explain some of the patient's answers.
- Always verify the telephone number of the patient's next of kin in case you need to notify someone in an emergency.

INDIVIDUAL EXERCISES

- Nursing can be a stressful profession. Have the students explore how they manage their own stress. Have the students determine if their stress management techniques are effective or ineffective. For each ineffective technique, have students identify an effective technique that may be used in its place.
- Have the students keep a record of how long it takes for them to complete the nursing assessment forms. This exercise will help the students identify when they are becoming more efficient in gathering nursing assessment data.

GROUP DISCUSSION

- Have the group members discuss how they would guide a patient interview in the interest of time. What if the patient answers 'yes' to all of the questions? What if the patient is constantly talking and you, as the interviewer, can't get a question in? What if your preceptor is telling you to hurry up, yet you are not close to being finished with the interview? What if the physician interrupts your interview to perform a history and physical assessment? What if your interview is constantly interrupted; the admissions department needs to get your patient's insurance information; the radiology department needs to perform your patient's portable X-ray; and the phlebotomist needs to draw blood for the lab work?
- Have group members examine their clinical agencies' assessment forms and ask them whether they can identify the nursing assessment model used by each institution.
- Ask the students to identify their personal ways of managing stress. Have them compare their methods with those of others in the group. Impress on students the need for group confidentiality so that discussion can be frank and useful.

- Ask students to identify all of the possible alleviating factors patients might use to reduce the discomfort of their chief complaints. These may include various types of therapy, exercises, meditation, and other alternative and complementary disciplines.

CLINICAL APPLICATION

- In completing a patient's health history, it is imperative to identify possible discharge needs. Have the students explore the discharge planning process at their clinical placement site. Discuss nursing's role in the discharge planning process.
- Have the students obtain a complete health history from a patient and document it on the clinical agencies' forms or electronic medical record.

ANSWERS TO REVIEW QUESTIONS

1(b) 2(d) 3(c) 4(d) 5(b) 6(b) 7(c) 8(d) 9(b) 10(d)