Identifying Health Problems

LEARNING OUTCOMES
After completing the chapter, the learner should be able to accomplish the following:

1. Describe the term health problem
2. Distinguish between identified health problems and medical diagnoses
3. Describe the phases involved in assessment data interpretation and analysis
4. Describe means to validate identified health problems
5. Describe the complexity of identifying health problems

KEY TERMS

- collaborative problems
- collated information
- cue
- current health problems
- data cluster
- health problem
- identified health problem
- medical diagnoses
- standard
IDENTIFYING HEALTH PROBLEMS is the second phase in the process of planning, delivering and evaluating person-centred care (Fig. 16-1). A health problem is identified as a result of synthesising, analysing and interpreting the data collected during the assessment phase. A health problem is a condition that necessitates intervention to prevent or resolve disease or illness or to promote coping and wellness. This chapter will build on the assessment phase outlined in the previous chapter. This process of identifying health problems is explored throughout the chapter in the context of person-centred care.

Throughout this chapter you will be asked to build on the skills you have been learning to apply in Chapters 14 and 15. Using more of the scenario you will be asked to consider the next phase in the planning of person-centred care for Claire, the 18-year-old with Type 1 diabetes who is admitted to your unit with a diagnosis of ketoacidosis and requiring stabilisation. Critical thinking questions will be posed and reflective cues included, encouraging you to focus on the planning of care to address Claire’s health problems. Through this activity you will continue to strengthen your clinical reasoning and reflection skills as the basis for thoughtful practice.

In Chapter 15, Claire was attending the community centre and was assessed for problems relating to maintaining stable blood glucose levels. Claire’s attitude was despondent and angry, and she admitted to feeling stressed and finding it difficult to adhere to her diabetes regime. In this chapter, it is three weeks later and Claire is admitted to your unit with a diagnosis of ketoacidosis requiring stabilisation. You have undertaken a health assessment in order to gather data. You now have to analyse this data so that you can identify Claire’s health problems and needs.

After you have collected and recorded information gained from the person during the initial interview, the work of identifying the health problems begins. The analysis and interpretation of this information helps to identify:

- The person’s resources and strengths
- Risk factors
- Current health problems
- Potential problems and complications (see Fig. 16-1).

The answers to the following questions may help you to identify a health problem:

- What did the person tell you?
- What did the family or significant other tell you?
- What did you observe in the person?
- What did you find on physical examination?
- What did you read in the medical history?
- What was said at team meetings and at handover?

An example of using this type of analysis framework for data from the health assessment is demonstrated with the case of a person with chronic obstructive pulmonary disease (COPD). This type of systematic approach may identify the issue of problems with breathing. The data collected as evidence of the problem may include the following:

- What did you observe in the person?
  - Was he using accessory muscles, pursed lip breathing or struggling for air?
- What did the person tell you?
  - ‘I cannot breathe properly’; ‘I cannot even eat without struggling for air.’

Figure 16-1 The interpretation and analysis of data is used to identify a person’s strengths and health problems that nursing and midwifery intervention can prevent or resolve. The problems identified may change from day to day as the person’s responses to health and illness change.
What did the family or significant other tell you?
‘Since the chest infection he has to sit upright in bed with four or five pillows to help his breathing.’

What did you find on physical examination?
The person has a barrel chest, diminished breath sounds on examination, and respiration rate of 28 breaths per minute.

What did you read in the medical history?
Medical diagnosis of COPD; admission for chest infection

What was said at team meetings and at handover?
This is the fourth admission this year and he has lost weight since last admission.

When a health problem is identified, a decision is made as to which healthcare providers should be involved in the team to treat the problem. Current or potential health problems can be prevented or resolved by encouraging participation of the person in care interventions, medical activities and collaborative actions. Together with the person you formulate, validate and list the health problems and this provides the basis for selecting care interventions that will achieve outcomes valued by the person (Fig. 16-2). The person is also encouraged to use his or her identified strengths when selecting the care interventions. Care interventions are discussed and jointly implemented as part of the person’s daily activities.

The initial step of assessment leads to the identification of the person’s health problems, resources and strengths, which in turn forms the basis for developing, implementing and evaluating care. Without the assessment and problem identification the other phases of the process cannot be developed.

Figure 16-2 shows how the activities of assessment lead to a pivotal point in the process of person-centred care—identifying health problems from which care will be planned.

THE PROCESS OF IDENTIFYING HEALTH PROBLEMS

During the phase of identifying a health problem you should, wherever possible, include the person and family or significant others in all aspects of the process. To ensure that the identification of the health problem is accurate and person-centred, feedback is sought from the person to encourage participation in the decision-making process relating to his or her care. Health problems cannot be reliably identified without the person’s input. In certain circumstances a person being cared for will not be able to participate in this process; due to unconsciousness, critical illness or an illness that impairs cognitive abilities. When this situation occurs,
family or significant others will need to be consulted. Minors such as children have the right to participate in the decision making at the level of their cognition. However, parents and guardians remain the primary caregivers when a child is in hospital and have the responsibility and rights to be involved in the child’s care.

In order for all potential health problems to be identified, it is imperative that the health assessment process described in Chapter 15 be as rigorous as possible as not all health problems are immediately obvious. Conducting a review of the assessment findings will help to ensure all possible health problems are identified (Box 16-1).

The focus of the problem identification phase of the process of person-centred care, is the nurse or midwife’s unique concern for the person (i.e. what it is about the person that gives rise to the need for care, as opposed to the need for medicine or for physiotherapy). The identified health problem is defined to help create care strategies that will be implemented to address the problem. Interpretation and analysis of health data may identify a health problem that is better treated by a doctor (medical diagnosis) or in conjunction with other healthcare providers (collaborative problem). In such a case the findings are reported to the doctor or other appropriate healthcare providers and you will work collaboratively with them to resolve the issues. Box 16-2 outlines key nursing and midwifery responsibilities within a collaborative framework.

Clinical Reasoning and an Identified Health Problem

Clinical reasoning is explained in Chapter 14. The clinical reasoning process includes a focus on identifying a health problem and the reason for the problem. This hypothesis driven process is the initial step in the clinical decision making process. In this instance, it is directed towards identifying and naming a clinical state. It is important that it is done correctly as interventions are dependent on correct problem identification or the person may experience the progression of a problem or develop a complication (Szaflarski, 1997). Clinical reasoning is founded on clinical knowledge and experience so that the nurse or midwife is able to recognise patterns, generate a hypothesis that determines the action to be taken. Systematic collection of data (explained in Chapter 15) is imperative for correct clinical reasoning.

Clinical reasoning is used in all health disciplines and an effective healthcare team uses a collaborative approach to person-centred care. Working in partnership, a doctor may make a medical approach to diagnosis that identifies diseases and their underlying pathology; nurses and midwives may take a more holistic approach to a person’s responses to

### BOX 16-1 Reviewing the Assessment Data

A review of the assessment process and findings is conducted before the commencement of the process of analysing the assessment data. The assessment review provides the opportunity to explore any additional data that may not have become apparent during the initial interview. The review which may take place some time after the initial interview, will help to ensure that all possible health problems are identified and appropriate care planned.

Consider the following questions as you conduct an assessment review.

- Did I listen attentively to ensure that I fully understood what the person was telling me about his or her health concerns?
- Did I maintain the person’s identity by providing sufficient opportunities for the expression of his or her values, beliefs and culture? Did I incorporate this knowledge into the assessment findings?
- Did I identify and acknowledge the person’s abilities, strengths and resources? Did I incorporate this knowledge into the assessment findings?
- Did I include the person’s family or significant others in the assessment process?
- Did I collaborate with other members of the healthcare team to ensure their input into the assessment?
- Can I identify any further family- or community-related issues that need to be considered?
- Can I involve the person more in decision making throughout the ongoing assessment process?
- Have I clarified all of the issues and asked for the person’s feedback at each stage of the initial and continuing assessment?

After reviewing the assessment process and ensuring that all data have been collected, you are ready to begin the process of analysing the data and identifying the health problems.

### BOX 16-2 Key Nursing and Midwifery Responsibilities Within a Collaborative Framework

- Promoting a safe environment
- Working within a legal and ethical framework
- Monitoring for changes in health status
- Preventing harm
- Identifying and meeting the person’s learning needs
- Individualising care strategies
- Ensuring medication regimes are within accepted practices
- Promoting comfort and managing pain
- Promoting health and a sense of wellbeing
- Identifying problems that impede the ability to be independent
- Determining how individuals, families and communities respond to health problems or life changes

Source: Adapted from Alfaro-LeFevre, 2004.
health and illness and an allied health worker such as a physiotherapist may take a focused approach on a particular function. Midwives in particular focus on the well women and do not see childbirth as an illness.

An example of this holistic approach might be identifying that a person has constipation, which is evidenced by the person saying ‘I am feeling bloated’ and/or ‘I have not had a bowel movement’; and the reason is that the person has been on bed rest or may not be taking sufficient fluid or fibre in their diet. The medical diagnosis may concentrate on restoring bowel motility through pharmaceutical treatments by prescribing medications to assist the person with the constipation. A holistic medical approach may also include preventative measures and recommendations such as suggesting increasing fluid intake and increasing fibre in the person’s diet. The clinical reasoning may identify the same health problems but other additional problems that relate to specific resolution of the constipation that falls within the scope of practice of a nurse or midwife. The nurse or midwife may identify issues related to embarrassment, fear of loss of control or increased need for privacy as a result of care interventions such as an enema or laxative. A medical diagnosis remains the same for as long as the disease is present, whereas the health problems identified by nurses and midwives may change from day to day as the person’s responses change. As previously stated, often, the medical diagnosis and health problems have the same underlying cause and the care of the person is collaboratively managed by all members of the healthcare team. This means that you are required to have a comprehensive knowledge of medical terminology (see Appendix B) and disease pathologies if you are to work effectively as a valued member of the healthcare team.

Table 16-1 shows how nurses and midwives successfully interpret different clusters of data to identify the health problems, while doctors use other data to develop a medical diagnosis and order treatment. In the first column a health problem is identified by a nurse and successfully treated. In the second column data is presented which leads a doctor to make a medical diagnosis and order investigations and treatment. This example demonstrates how members of the healthcare team work in collaboration; with the early detection and reporting of the problem to the doctor leading to the doctor’s prompt medical diagnosis of cystitis and successful antibiotic therapy.

**TABLE 16-1 A Collaborative Approach to an Identified Health Problem and Medical Diagnosis**

<table>
<thead>
<tr>
<th>Identified Health Problem</th>
<th>Medical Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>A problem identified by a nurse or midwife is a clinical judgment about individual, family or community responses to current or potential health problems or life processes. Identification of the health problem provides the basis for selection of care interventions to achieve outcomes for which they are accountable</td>
<td>Traumatic or disease condition or syndrome validated by medical diagnostic studies</td>
</tr>
<tr>
<td>Focus</td>
<td>Monitoring human responses to current and potential health problems</td>
</tr>
<tr>
<td>Sample data cluster</td>
<td>56-year-old mother of seven; 162cm, 76 kg; ‘Whenever I sneeze lately, I dribble urine. This is embarrassing.’</td>
</tr>
<tr>
<td>Problem statement</td>
<td>Stress urinary incontinence related to weakness in pelvic muscles due to advanced age and obesity</td>
</tr>
<tr>
<td>Care interventions</td>
<td>You obtain urine culture; report signs, symptoms and results to the doctor who is part of the team. The doctor reviews the results, conducts an examination and orders antibiotic therapy. You administer the prescribed antibiotics to treat the cystitis. You work with the woman to teach pelvic floor exercises to increase muscle tone; explore her willingness and motivation to pursue weight reduction and an exercise program and evaluate the need for a bladder-training program. You discuss referral to a continence advisor for advice re continence products. You make another appointment for the doctor to review her short term goals (resolution of her cystitis) and for yourself to review her long-term goals (improvement in and prevention of further deterioration in urinary continence).</td>
</tr>
<tr>
<td></td>
<td>‘Lately it has got worse and now whenever I have to urinate it burns terribly. I also feel like I have to go all the time—real bad.’ Small, frequent voidings, cloudy urine; T—38°C</td>
</tr>
<tr>
<td></td>
<td>Cystitis</td>
</tr>
</tbody>
</table>
Clinical Reasoning Skills for Identifying a Health Problem

Successful implementation of each phase of the process of person-centred care requires high level skills in critical thinking and clinical reasoning. To correctly identify health problems:

- Be familiar with health problems and read professional literature.
- Trust clinical experience and judgment, but be willing to ask for help when the situation demands more than your qualifications and experience can provide.
- Respect your clinical intuitions, but before writing an identified health problem without evidence, increase the frequency of your observations and assessments and continue to search for cues to verify your intuition.
- Recognise personal biases and keep an open mind.

Questions to facilitate critical thinking when identifying problems include:

- Is the information accurate and complete?
- Has the person or family validated that these are important health issues?
- Has the person and family been given an opportunity to identify health problems that may have been missed?
- Is each identified problem supported by evidence? Might these cues signify a different health problem?
- Has the cause of the current or potential problem been identified and what strengths and resources does the person use to avoid or resolve them?
- Have healthcare facility guidelines and protocols been used to correctly document identified health problems in a way that clearly communicates the person’s problems to other health professionals?

INTERPRETATION AND ANALYSIS OF ASSESSMENT DATA

As explored in Chapters 14 and 15, most experienced nurses and midwives begin the work of interpreting and analysing information while they are still collecting (assessing) it. The term cue is often used to denote significant information that influences this interpretation and analysis of collected data. This information should ‘raise a red flag’ to look for patterns or collated information that signals a current or potential health problem.

Recognising Significant Information

Distinguishing healthy responses from unhealthy ones is not as clear-cut as it may seem. It is important to avoid mistakenly labelling some health patterns as unhealthy.

A standard, or a norm, is a generally accepted rule, measure, pattern or model to which information can be compared in the same class or category. For example, when determining the significance of a patient’s blood-pressure reading, appropriate standards include knowledge of the normal values for age, group, race and illness. The normal range for the patient, if known, is an important standard. A pressure of 150/90 mm Hg may be high for someone whose blood pressure normally is 120/70 mm Hg, but it may be normal for a person with hypertension. Examples of how standards can be used to identify significant cues include the following (Gordon, 1997):

1. Changes in usual health patterns that cannot be explained by expected norms for growth and development: Example—An infant who has breastfed well as a newborn suddenly stops feeding when put to the breast and begins to lose weight.

2. Deviation from an appropriate population norm: Example—a first-year university student begins to accelerate her exercise habits dramatically and starts inducing vomiting after binge eating. She rapidly loses weight.

3. Behaviour that is non-productive in the whole-person context: Example—A young woman breaks up with her boyfriend and begins to believe that she is ‘unfit’ for any other relationship, withdrawing from her friends and social activities.

4. Behaviour that indicates a developmental lag or evolving dysfunctional pattern: Example—A 16-year-old single mother with a 6-month-old infant continues to ‘party hard’ with her friends, binge drink and shows no interest in caring for her son, who is repeatedly left with concerned family members.

Recognising Patterns of Illness

A data cluster is the grouping of data, cues and information that has been gathered as evidence during the assessment process and that points to the existence of a health problem. The assessment information is collated and placed in groupings that show relationships between significant data and may indicate that the person has a health problem. See Table 16-2. Identified health problems should always be derived from the collation of assessment information rather than from a single cue. The danger of deriving a health problem from a single cue may be misleading and cause care to be initiated that is not required or will not address the correct health problem. This can be illustrated in the following example. Identifying a health problem for a woman recovering from gallbladder surgery as limited coping skills, based solely on her tears, may be a misinterpretation the woman’s crying, which may in fact be a healthy release of emotion. If the same woman begins to exhibit a number of significant cues, such as refusing to eat, preferring bed rest to being out of bed and walking around, and complaining of increasing discomfort, an unhealthy pattern is emerging.
### TABLE 16-2 Clustering Assessment Data to Identify the Problem

<table>
<thead>
<tr>
<th>Assessment Data Gathered during the Interview/Physical Assessment</th>
<th>Clustering of Data</th>
<th>Identified Health Problems</th>
</tr>
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</table>
| 35-year-old mother of 4-year-old twin boys; returned to work (executive secretary) for first time 7 months ago. Admitted for anaemia for investigation. ‘I guess I lost about 9–12 kilos over the last 6 months—I think I’ve just been too busy and stressed to eat properly.’ Asked questions relating to her admission diagnosis and what it means  
- Pale, lethargic. Height: 173 cm; weight: 52 kg  
- Blood pressure low, pulse and respirations raised | Tired, lethargic and stressed  
Weight height ratio decreased  
States she has lost weight  
States she does not eat properly and is stressed  
No knowledge about reasons for her admission | 1. Poor diet and weight loss  
2. Lack of knowledge relating to condition  
3. Unrelieved stress |
| 87-year-old male admitted to a residential care facility. He mobilises with aid of a wheely frame and has a longstanding history of chronic obstructive pulmonary disease. ‘I need a urinal all the time as I can’t walk as far as the toilet.’  
‘Can I get my oxygen connected and have it on all the time as I get nervous when it’s not on?’  
‘I just can’t eat much as I get puffed out.’  
- Pulse: 92; respirations: 28, shallow; blood pressure: 128/84; temperature 36.9°C  
- Weight: 45 kg. | New admission to aged care facility  
Past history of chronic respiratory illness  
Verbalises that he is not able to walk far, states he gets ‘puffed out’ when eating  
Needs oxygen continuously  
Respiration/pulse rates altered  
Decreased weight | 1. Adjustment to new surroundings  
2. Requires assistance with mobilisation  
3. Shortness of breath on exertion  
4. Weight loss related to breathing patterns |

### Identifying Strengths and Limitations

The next phase in analysing information is to determine the person’s strengths and limitations. Using a person-centred approach during this phase will help you to explore whether the person agrees with the strengths and limitations you have identified; and to discuss the person’s motivation to work towards their resolution.

### Determining Strengths and Limitations

The nurse or midwife works in collaboration with the person, family (significant others) or the community to identify strengths and limitations. This is undertaken to help build upon the individual’s personal strengths and to provide support where there are perceived limitations, in order to address the identified health problems. Personal strengths might include being physically healthy, emotional healthy, having good cognitive abilities, coping skills, interpersonal strengths and spiritual strengths. Resources such as the presence of support people, adequate finances and a healthy environment may all contribute to personal strengths. Limitations can include inadequate finances, poor social environment, poor coping skills, social isolation and limited access to health resources.

### Reaching Conclusions

You may reach one of the following conclusions after interpreting and analysing the assessment data and information: there is no health problem, there is a possible health problem or there is an identified health problem. If you are unable to treat the health problem because the person denies its existence and refuses treatment, make sure the person understands the possible outcomes of this stance.
By applying what you have learnt so far, you are developing your skills in identifying a health problem. Practise this now by thinking back to Claire, our 18-year-old with Type 1 diabetes mellitus, who has rebelled against the control that diabetes is having on her life. Three weeks after attending the community clinic she presents at the emergency department with ketoacidosis and is admitted for blood glucose stabilisation to the medical ward where you work as a recently graduated registered nurse. Your assessment shows Claire:

- Is avoiding testing her blood glucose levels
- Frequently misses taking her insulin
- Has been admitted three times in the past two years with ketoacidosis
- On examination is sleepy but rousable
- Has blood glucose levels currently at 27 mmoL
- Is vague when questioned about diet, glucose testing and insulin doses
- Is undertaking her final year at high school and is planning on going to university
- She and her girlfriends enjoy a social drink at parties (every weekend)
- Has an intravenous drip with insulin running through a pump.

Claire verbalises that she would like to ‘get back on track’ and admits that she needs help with her diet, exercise and insulin regimes.

1. From the assessment data you have gathered create a list that clusters the data. Group the data into areas that link together. Use Table 16-2 as a guide.

2. Why it is important to cluster the assessment data?

Classification of Identified Health Problems

As you interpret and analyse personal data, you will identify health problems that may require immediate care interventions or planning needs to occur for future interventions for those that may occur in the future. Identified health problems can be classified into two main areas: current health problems and potential health problems.

Current Health Problems

Current health problems are those that can be validated by the evidence and the presence of major defining characteristics. These are health problems that are actually occurring and adversely affecting the person’s health status. Such health problems are identifiable and quantifiable.

Potential Health Problems

Potential health problems are statements describing suspected health problems for which additional data is needed or that may occur as a result of a further decline in their health status. Additional data is used to confirm or rule out the suspected health problem.

For example a health problem identified for a person who has experienced vomiting, diarrhoea and excessive diaphoresis for three days is described as ‘excessive fluid loss due to vomiting, diarrhoea and sweating’. If the diarrhoea persists and weakness interferes with the person’s normal perineal hygiene, there may be risk for skin breakdown. This is the potential health problem, which is described as ‘possible skin breakdown due to persistent vomiting, diarrhoea and sweating’.

Describing a Health Problem

The purpose of describing a health problem is to clearly and concisely identify it. It is a process of uncovering the person’s strengths and limitations and what he or she would like to change relating to his or her health status. When describing a health problem it is important to use simple language that will convey the exact nature of the problem and ensure that others will understand. Words commonly used in descriptions of health problems include: compromised, decreased, deficient, delayed, depleted, disturbed, dysfunctional, excessive, imbalanced and impaired. Box 16-3 provides examples of descriptors that may assist in describing a health problem.

Factors to Be Considered

When describing the health problem it is important to consider other factors that may have an impact on or be the cause of the problem. Examples of causative factors include:

- Physiological
- Psychological
- Sociological
- Cultural
- Spiritual
- Environmental.

BOX 16-3 Examples of Health Problem Descriptors

- Inability to perform activities of daily living due to a stroke
- Altered breathing due to condition of COPD
- Excessive mucous production as a result of inflammation of the lungs
- Compromised cardiac output related to heart failure
- Decreased oxygenation due to poor respiratory effort
- Disturbed thought processes due to mental health status
- Delayed fetal growth due to placental insufficiency
If the underlying causative factors are not correctly identified, nursing or midwifery actions might be inefficient and ineffective. For example, a problem of non-adherence is identified for a person with diabetes who is frequently admitted to the hospital with hyperglycaemia and who has a poor history of dietary and pharmacological management. Assuming that the non-adherence is related to a lack of knowledge and then channelling all activities and energies into teaching the person how to manage the diabetes is useless, if the problem is actually a result of a decreased will to live, which would necessitate a different group of care interventions. For instance, Claire’s lack of adherence was being influenced by her not wanting to be different from her friends.

The following example illustrates the process of clustering the data and examining the evidence to identify the health problem. Acute pain has been chosen as the example as it is the cause of many of the problems that are identified through the assessment process and is applicable across the life span.

In this example John a 28-year old male has been admitted to the emergency department with suspected appendicitis. One of the presenting symptoms is acute abdominal pain. By working through the following section, you can see how this health problem is identified.

### Identifying a Health Problem: Acute Pain as the Problem

Assessment data may reveal acute pain to be the problem or the cause of a problem. Pain is a common problem that is often identified during health assessments. Pain is often exacerbated by underlying causes or may be heightened by emotional causes and distress.

### Examples of the underlying issues that may increase pain include:
- Changes to an individual’s health status
- Increased anxiety related to social or financial situations
- Inability to cope with the current situation
- A chronic illness
- Environmental issues (e.g. working in the city).

The outcomes of the identified health problem of pain can manifest themselves as the inability to sleep, mobilise, concentrate, having feelings of hopelessness and despair, crying or anorexia. These are the behaviours that the person may exhibit or complain about during the health assessment process.

For each problem identified evidence must be provided so that the problem can be validated and be free from error, bias or misinterpretation. Evidence can be ascertained through a series of questions that you ask yourself during the assessment process. It is important to include both the subjective and objective data.

The questions that should be considered are:
1. What behaviour is the person displaying?
2. What is the person’s mood?
3. What physical characteristics is the person displaying?
4. What thought processes does the person exhibit?

The answers to these questions will allow you to gather evidence that will validate the identified problem and ensure that the planned care will address that problem. See the Identified Health Problem box below.

As you can see from this example, the problem can be validated from the evidence gathered as part of the assessment process. The objective and subjective data is considered when identifying the problem and the problem statement reflects what the problem is, how the problem affects the person and why he or she has the problem.

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### IDENTIFIED HEALTH PROBLEM: ACUTE PAIN

<table>
<thead>
<tr>
<th>Problem Statement: Inability to perform activities of daily living due to acute pain related to appendicitis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Validation of the Health Problem</strong></td>
</tr>
<tr>
<td>What behaviour is John displaying?</td>
</tr>
<tr>
<td>What is John’s mood?</td>
</tr>
<tr>
<td>What physical characteristics is John displaying?</td>
</tr>
<tr>
<td>What thought processes does John exhibit?</td>
</tr>
</tbody>
</table>
DOCUMENTING A HEALTH PROBLEM

When you recognise significant information indicating a health problem it must be documented. This is further explained in Chapter 20. When using a person-centred focus the identified problem should be written in language that is easily understood by the healthcare team, can be validated through assessment data and places the person at the centre of the problem. The identified health problems may be current or potential in nature; this should also be documented as it can indicate that the person-centred assessment process is completed or ongoing.

You document the identified problem in the patient record. Depending on the documentation system in use, identified problems might be recorded in the plan of care or in the patient record. Some healthcare facilities have pro formas with specific headings that you record the identified health problems under.

Throughout this and the previous chapter you have been assessing Claire you are now in a position to identify her health problems. You have undertaken the assessment of Claire, which has included a health history and physical assessment, and gathered your subjective and objective data. Earlier in this chapter you organised the data into meaningful groups or clusters and from these groupings of data conclusions can be made that will lead to the identification of the problems relating to Claire’s health. Now refer to the data clusters and then attempt to write a problem statement in the same way that is demonstrated in the Identified Health Problem box on p. 302. The problem statement should be clear and you should be able to validate it. See the preceding text for an outline of how to construct a problem statement.

1. Write down the health problems you have identified for Claire and show them to a colleague, then construct the table to include the problem statement.

2. Why it is important to write the health problems in simple, understandable language?

2. Interview two people with the same medical diagnosis. Develop a prioritised list of identified health problems for both, and reflect on the differences. Compare and contrast the strengths of both people. If you can do this exercise with another student, it would be helpful to explore why there are differences in your lists of the person’s identified health problems and strengths.

Review questions

1. Not able to bath or dress independently is an example of:
   a. Collaborative problem
   b. Interdisciplinary problem
   c. Medical problem
   d. Nursing/midwifery problem

2. To determine the significance of a blood pressure reading of 148/100 mm Hg, it is first necessary to:
   a. Compare this information to standards.
   b. Check the taxonomy of nursing diagnoses for a pertinent label.
   c. Check a medical text for the signs and symptoms of high blood pressure.
   d. Consult with colleagues.

3. When the initial assessment revealed that the person had not had a bowel movement for two days, the student wrote down ‘constipation’. Which of the following comments is she most likely to hear from her facilitator?
   a. ‘Wait a minute ... An identified health problem should always be derived from collated significant information rather than from a single cue.’
b. ‘Job well done … You’ve identified this problem early and we can manage it before it becomes more acute.’

c. ‘Is this an actual or a possible identified health problem?’

d. ‘This is a medical, not a nursing/midwifery problem.’

4. A clinical judgment that an individual, family or community is more vulnerable to develop the problem than others in the same or similar situation is what type of identified health problem?

a. Actual

b. Risk

c. Possible

d. Wellness

e. Syndrome

Answers with rationale

1. The correct answer is d, nursing/midwifery problem, because it describes a problem that can be treated by nurses/midwives within the scope of independent nursing practice.

2. The correct answer is a. A standard, or a norm, is a generally accepted rule, measure and pattern. For example, when determining the significance of a person’s blood pressure reading, appropriate standards include normative values for the person’s age group, race and illness. Deviation from an appropriate norm may be the basis for writing an identified issue.

3. The correct answer is a. Collated information is a grouping of the person’s information or cues that points to the existence of a health problem. Identified health problems should always be derived from collated significant information rather than from a single cue. There may be a reason for the lack of a bowel movement for two days, or it might be this individual’s normal pattern.

4. The correct answer is b. A clinical judgment that an individual, family or community is more vulnerable to develop the problem than others in the same or similar situation is an identified issue that the person may be at risk of developing that particular health problem.

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