



## Data collection

### Introduction

When you meet the patient it can be very challenging to get an overview of the nursing of the particular patient. The study method “Data collection” can help you with this challenge. You can use the method alone or together with other students and/or together with a counselor.

The nursing assessment is based on systematic collection of data on the patient’s condition, needs, wishes, habits, experiences, problems and resources.

You can collect data from

- the patient, relatives and the patient’s network
- mono- and cross-disciplinary collaborators e.g. the primary care nurse and the general practitioner
- the nursing record, medical record and other notes on nursing.

Data can be collected on both conscious and unconscious patients through verbal and nonverbal communication. You continuously listen and observe the patient’s signs constantly, consciously and unconsciously. These data must subsequently be systematized.

Data collection can also be planned at specific points in time. This will be a more systematic data collection from the beginning.

The result of these collections of data constitutes the foundation of the nursing professional assessment.

A nursing professional assessment must identify the patient’s needs for nursing

- in acute and planned situations
- in shorter and longer periods of time.

The nursing professional assessment primarily takes its starting point in the first phase of “the nursing process” (1): *the assessment phase* which consists of data collection, analysis and identification of nursing needs.

### Purpose

The purposes of the study method are

- to practice relevant and systematic data collection
- to practice communication with the patient
- to practice nursing professional assessment to identify the patient’s need for nursing
- to practice documentation of nursing

## Approach in relation to the planned conversation

### Preparation of the conversation

- you establish contact to the patient and make him feel secure and you explain the intention with the conversation
- you plan in collaboration<sup>1</sup> with the patient where and when the conversation takes place
- in the course of the conversation you practice being present as a professional and an active listener. You practice structuring the conversation using your professional knowledge and questioning technique
- consider which data are relevant possibly in collaboration with a counselor

### The conversation

- you collect data according to the key words in the electronic patient file (Appendix 1)
- you use your senses (hearing, seeing, smelling, touching) to collect data during the conversation
- you may make use of instrumental measurements of e.g. blood pressure, pulse, temperature, weight, height, blood glucose
- you practice understanding the patient's symptoms, needs and problems in the course of the conversation to collect more relevant data. Remember to include the patient's resources and wishes in your assessment.

### Literature:

1. Bydam, Jens; Hansen Janet M. (2005). *Sygeplejens fundament 1*. København, Nyt Nordisk Forlag. ISBN: 87-17-03718-2 side 73-102

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<sup>1</sup> Data collection takes place in accordance with the Danish Health Act and Nursing Ethical Guidelines

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## Appendix I

Patient:

Cause of admission:

Key words used in the electronic nursing file at Odense University Hospital	Collected data
<b>Activity</b> Personal hygiene, mobilisation, use of medical aids. The patient's physical, social and intellectual activities.	
<b>Respiration and circulation</b> Respiratory distress, cough, aspiration risk, blood pressure, pulse, temperature.	
<b>Nutrition</b> Under- and over-nourishment. Eating habits, nausea vomiting.	
<b>Discharge of waste matter</b> Constipation, diarrhoea, incontinence, cystitis.	
<b>Skin and mucosa</b> Skin, mucous membranes, hair, nails.	
<b>Pain and sensory perception</b> Acute and chronic pain Sensory disturbances in relation to vision, hearing, balance, touching	
<b>Sleep and rest</b> Tiredness, insomnia, restlessness, ability to concentrate	
<b>Communication</b> Ability to communicate, understand and make oneself understandable	
<b>Psycho-social conditions</b> Mental conditions related to mental and bodily conditions. Loneliness, abuse, coping, stress	
<b>Sexuality</b> Sexual or other problems related to cohabitation as a result of disease, nursing and treatment	
<b>Knowledge and development</b> Need for information and education, prerequisites for learning	