# Chapter 6: Clinical Judgement and APIE

This chapter contains information by Jennifer Lapum; Oona St-Amant; Charlene Ronquillo; Michelle Hughes; and Joy Garmaise-Yee’s book titled “Documentation in Nursing” and is available under CC BY-NC license.

### Vocabulary List

### **clinical reasoning [noun]** process that uses formal and informal thinking strategies to analyze patient information to make good judgments about patient care

### Critical Thinking and Clinical Reasoning

(Christman & Ernstmeyer, 2021)

Nurses make decisions while providing patient care by using critical thinking and clinical reasoning. Critical thinking is a broad term used in nursing that includes “reasoning about clinical issues such as teamwork, collaboration, and streamlining workflow.” Using critical thinking means that nurses take extra steps to maintain patient safety and don’t just “follow orders.” It also means the accuracy of patient information is validated and plans for caring for patients are based on their needs, current clinical practice, and research.

Critical thinkers possess certain attitudes that foster rational thinking. These attitudes are as follows:

* Independence of thought: Thinking on your own
* Fair-mindedness: Treating every viewpoint in an unbiased, unprejudiced way
* Insight into egocentricity and sociocentricity: Thinking of the greater good and not just thinking of yourself. Knowing when you are thinking of yourself (egocentricity) and when you are thinking or acting for the greater good (sociocentricity)
* Intellectual humility: Recognizing your intellectual limitations and abilities
* Nonjudgmental: Using professional ethical standards and not basing your judgments on your own personal or moral standards
* Integrity: Being honest and demonstrating strong moral principles
* Perseverance: Persisting in doing something despite it being difficult
* Confidence: Believing in your ability to complete a task or activity
* Interest in exploring thoughts and feelings: Wanting to explore different ways of knowing
* Curiosity: Asking “why” and wanting to know more

Clinical reasoning is defined as “[a] complex cognitive process that uses formal and informal thinking strategies to gather and analyze patient information, evaluate the significance of this information, and weigh alternative actions.” To make sound judgments about patient care, nurses must generate alternatives, weigh them against the evidence, and choose the best course of action. The ability to clinically reason develops over time and is based on knowledge and experience.

### Inductive and Deductive Reasoning and Clinical Judgment

Inductive and deductive reasoning are important critical thinking skills. They help the nurse use clinical judgment when implementing the nursing process.

Inductive reasoning involves noticing cues, making generalizations, and creating hypotheses. Cues are data that fall outside of expected findings that give the nurse a hint or indication of a patient’s potential problem or condition. The nurse organizes these cues into patterns and creates a generalization. A generalization is a judgment formed from a set of facts, cues, and observations and is similar to gathering pieces of a jigsaw puzzle into patterns until the whole picture becomes more clear. Based on generalizations created from patterns of data, the nurse creates a hypothesis regarding a patient problem. A hypothesis is a proposed explanation for a situation. It attempts to explain the “why” behind the problem that is occurring. If a “why” is identified, then a solution can begin to be explored.

No one can draw conclusions without first noticing cues. Paying close attention to a patient, the environment, and interactions with family members is critical for inductive reasoning. As you work to improve your inductive reasoning, begin by first noticing details about the things around you. A nurse is similar to the detective looking for cues in Figure 4.1.Be mindful of your five primary senses: the things that you hear, feel, smell, taste, and see. Nurses need strong inductive reasoning patterns and be able to take action quickly, especially in emergency situations. They can see how certain objects or events form a pattern (generalization) that indicates a common problem (hypothesis).

Example: A nurse assesses a patient and finds the surgical incision site is red, warm, and tender to the touch. The nurse recognizes these cues form a pattern of signs of infection and creates a hypothesis that the incision has become infected. The provider is notified of the patient’s change in condition, and a new prescription is received for an antibiotic. This is an example of the use of inductive reasoning in nursing practice.

Figure 4.1 Inductive Reasoning Includes Looking for Cues

Deductive reasoning is another type of critical thinking that is referred to as “top-down thinking.” Deductive reasoning relies on using a general standard or rule to create a strategy. Nurses use standards set by their state’s Nurse Practice Act, federal regulations, the American Nursing Association, professional organizations, and their employer to make decisions about patient care and solve problems.

Example: Based on research findings, hospital leaders determine patients recover more quickly if they receive adequate rest. The hospital creates a policy for quiet zones at night by initiating no overhead paging, promoting low-speaking voices by staff, and reducing lighting in the hallways. (See Figure 4.2). The nurse further implements this policy by organizing care for patients that promotes periods of uninterrupted rest at night. This is an example of deductive thinking because the intervention is applied to all patients regardless if they have difficulty sleeping or not.

Figure 4.2 Deductive Reasoning Example: Implementing Interventions for a Quiet Zone Policy

Clinical judgment is the result of critical thinking and clinical reasoning using inductive and deductive reasoning. Clinical judgment is defined by the National Council of State Boards of Nursing (NCSBN) as, “The observed outcome of critical thinking and decision-making. It uses nursing knowledge to observe and assess presenting situations, identify a prioritized patient concern, and generate the best possible evidence-based solutions in order to deliver safe patient care.” The NCSBN administers the national licensure exam (NCLEX) that measures nursing clinical judgment and decision-making ability of prospective entry-level nurses to assure safe and competent nursing care by licensed nurses.

**Evidence-based practice (EBP)**is defined by the American Nurses Association (ANA) as, “A lifelong problem-solving approach that integrates the best evidence from well-designed research studies and evidence-based theories; clinical expertise and evidence from assessment of the health care consumer’s history and condition, as well as health care resources; and patient, family, group, community, and population preferences and values.”

### Methods of Documentation

This chapter contains information by Jennifer Lapum; Oona St-Amant; Charlene Ronquillo; Michelle Hughes; and Joy Garmaise-Yee’s book titled “Documentation in Nursing” and is available under CC BY-NC license. (Lapum et al., n.d.)

Several **methods of documentation** are used to organize a nurse’s notes, sometimes referred to as progress notes. Decisions about which method to use may depend on the organization where you work, which sometimes specify certain methods. Otherwise, it is usually a matter of personal preference.

In this section, three main documentation methods are presented: charting by exception, narrative, and nursing process. Another method that is sometimes used to inform documentation is SBAR (Situation, Background, Assessment, and Recommendation), as discussed in a previous chapter, but this was typically designed to inform verbal communication.

**Charting by exception**. This method is not commonly used, but some specific units find it helpful. Typically, it involves charting when a finding is not normal. A specific setting will provide a list of normal ranges or normal activities, and you will only document a note if the client’s activities or your assessment findings are outside of the norms. For example, a normal finding might be that there are no signs of infection on an incision: you would only document if the client exhibits signs of infection such as redness, swelling, or discharge.

**Narrative** involves **chronological** documentation that follows a **storied** format and **sequential order**. For example, you would document when the client’s symptoms first started, what they did to treat them, and how they responded to the treatment. A storied format involves attending to ‘what,’ ‘when,’ ‘who,’ and ‘how’ – what happened, when did it happen, who was involved, how the client responded, etc. For example: “An 8-year-old client fell off bike. Client’s mother indicated that he experienced a loss of consciousness for about 20 seconds, was confused when he awoke, and got a headache within 20 minutes. She brought him to the emergency room and arrived within 30–40 minutes of the fall.” As you can see, this documentation note is both chronological and storied.

The **nursing process** is used to inform documentation in which the nurse focuses on the client’s **issue/concern/problem,** followed by the plan and action to address the issue, and an evaluation of how the client responded. This method is also called problem-focused documentation. Several approaches are used for this kind of documentation:

* DAR (data, action, response)
* APIE (assessment, plan, intervention, evaluation)
* SOAP (subjective, objective, assessment, plan) and its derivatives including
* SOAPIE (subjective, objective, assessment, plan, intervention, evaluation).

 These methods share commonalities; see Table 6.1.

|  |  |  |  |
| --- | --- | --- | --- |
| **DAR** | **APIE** | **SOAPIE** | **Comments** |
| Data | Assessment | Subjective and objective data assessment | Assessment refers to your analysis of the available data. For example, it may include the health problem/issue and nursing diagnosis (e.g., risk for falls, risk for infection).  Assessment guides the next steps in terms of planning and interventions. |
| Action | Plan and implementation/ intervention | Plan and intervention | Action refers to what you did to address the problem (e.g., repositioning the client, providing pain medication).  Planning and intervention are similar to action. They may be combined or separated into different items: planning refers to realistic and measurable interventions to be implemented (e.g., education, mobility, safety interventions, vital sign frequency); intervention refers to what was done. |
| Response | Evaluation | Evaluation | Response and evaluation refer to the outcome of the intervention (did it work? how did the patient respond?) |

### **Methods of Documentation - Examples**

Examples of four methods of documentation are included in this section. In each of the examples, the following is printed at the end “Nurse’s signature, designation”, but ensure that you sign your name and insert your specific designation.

#### **Narrative Method of Documentation – Loss of Consciousness**

**Case summary:** A 47-year-old client, identifies as trans female with pronoun they/their, came into the emergency department after losing consciousness from being struck in the head from a boating accident. According to the client’s partner, the client regained consciousness within one minute.

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| --- | --- | --- | --- |
| **Date (yyyy/ mm/dd)** | **Time** | **Discipline** | **Notes** |
| 2020/  10/14 | 1330 | nursing | Client stated it was their first sailing lesson and they were “hit square in the forehead with the mast and I was out.” The client was unconscious for less than one minute according to their partner who was in the boat. After the accident, they immediately sailed back and came to the ER. Client states “I have a headache.” Rates pain 3/10. No dizziness, nausea or vomiting. Vital signs are stable. Client is alert and oriented to person, place, time and self. No difficulty speaking, understanding or answering assessment questions. No weakness or incoordination. Gait is coordinated. Firm hand grasp bilaterally. No history of falls. Pupils are round, equal in size at 3mm, and reactive to light bilaterally. No change in vision. Glasgow coma score 15. The centre of the client's forehead has a red swollen lump approximately 4 cm in diameter. Discussed concussion protocols and critical finding signs and symptoms that need immediate medical attention. Encouraged to limit physical and cognitive activities that cause symptoms and to not engage in physical activities that are higher risk of another concussion while still having symptoms. Client and partner verbalized understanding of critical finding signs and symptoms and to seek care if symptoms get worse or additional symptoms appear. Clients will follow up with the primary care provider within 24 hours to discuss a gradual return to physical activity plan. Nurse’s signature, designation ——————— |

#### **DAR – Stress**

**Case summary:** A 17-year-old client, identifies as male with pronouns he/his, came into the clinic following a high school counselor’s suggestion after sharing that he is feeling worried about going to university.

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| **Date (yyyy/ mm/ dd)** | **Time** | **Discipline** | **Notes** |
| 2020/  10/19 | 1645 | nursing | **D:** Client stated, “I’m feeling really worried about starting university on my own.” Client asked questions about how to control a restless mind and how to manage his stress. Vital signs are stable.  Client restless, fidgeting legs during interview, and chewing on fingernails. **A:** Discussed client’s fears about transitioning to university. Collaborated with the client in identifying stress management techniques the client can do prior to going into university including developing a peer support network, positive self talk, and walking daily.  Discussed how to access potential resources at university sites including learning supports and mental health supports. Follow up appointment booked for three weeks. **R:** Client acknowledged resources provided and stated will try to increase his exercise to help focus their restless mind, continue to meet with the school counselor to discuss feelings, and will try to practice positive self-talk when feelings of fear begin to become overwhelming. Client noted that he will check out the university website for support. Client stated, “I think I will be able to follow these strategies and I will check out the support in the next couple of weeks.” Nurse’s signature, designation —————————————— |

#### **APIE – Nutrition**

**Case summary:** A 62-year-old client, identifies as male with pronouns of he/his, who is one month post cerebrovascular accident on a rehab unit. The client is on a thickened diet as a result of dysphagia.

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| **Date (yyyy/ mm/dd)** | **Time** | **Discipline** | **Notes** |
| 2020/  11/25 | 0930 | nursing | **A:** Client stated “I’m getting used to eating my new diet and I’ve not choked since starting it.” Added thickener to client’s coffee. Client ate 90% of the meal. **P:** Will reinforce dysphagia eating techniques with the client each day. **I:** Reviewed dysphagia eating techniques with the client: tilting chin down, small bites, placing food on unaffected side of mouth, eating slowly, and avoiding talking while eating. Gave praise to client for eating independently and using correct eating techniques: swallowing twice after each mouthful, using a teaspoon portion size of food to unaffected side of mouth. **E:** No signs of aspiration. Client practiced head tilt and placement of food towards the unaffected side. Documented meal intake. Ordered additional thickener package for client’s meal tray. Left phone message for speech language therapist and occupational therapist to re-assess client’s progress. Nurse’s signature, designation — |

#### **SOAP or SOAPIE – Elimination**

**Case summary:** A 41-year-old client, identifies as female with pronouns she/her, on a postpartum unit 2 days after having a cesarean section (C/S). The client delivered a healthy 8 lb baby.

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| --- | --- | --- | --- |
| **Date (yyyy/ mm/ dd)** | **Time** | **Discipline** | **Notes** |
| 2020/  11/02 | 1030 | nursing | **S:** Client commented feeling abdominal discomfort in the left lower quadrant, rated 5/10, stating “I’m getting worried because I still have not had a bowel movement, it’s been four days” and is “worried it will hurt because of my hemorrhoids.” Client stated she drank 500cc of water today and ate  about half of her meals. **O:** Bowel sounds audible in all four quadrants. Tympany predominates throughout, with slight dullness over LLQ. Abdomen is firm and tender on touch. No nausea or  vomiting. **A:** Constipation related to medication during C/S, limited mobility, low fiber diet and minimal water intake. **P:** Will assess client’s knowledge. **I:** Educated the client on the importance of increasing water intake to 6 to 8 glasses, eating the high fiber diet provided by the hospital, and walking around the unit once an hour to assist with peristalsis and bowel movements. Demonstrated how to support the incision area when getting up to go for a walk to decrease discomfort or pulling of incision. Provided teaching resources on postpartum constipation and cesarean sections. Provided the client 500cc of water. Assisted client out of bed to go for a walk with family. **E:** Client drank water and stated will record fluid intake. Client had 400mg of Ibuprofen for abdominal discomfort. Will monitor diet and follow up to determine if constipation continues and further interventions are needed. Nurse’s signature, designation — |

#### **ADOPIE vs APIE**

In week 3 we learned about ADOPIE (assessment, diagnosis, outcome identification, planning, interventions, and evaluation). In week 6, you will see the term APIE. APIE is a shortened variation of ADOPIE and includes assessment, planning, interventions, and evaluation.

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