Health Assessment Status

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Objectives

- States the purpose of nursing health assessment.
- Explains the components of a nursing health history.
- Describes techniques for collecting assessment data
- Identifies the purpose of the physical health examination.
- Explains the techniques and/or methods of examination.
- Describes the equipment needed to perform a physical examination.
- Discusses the significance of selected physical findings.
- Explains expected outcomes of the health assessment.
- Summarizes the suggested sequencing to conduct a physical health assessment.
- Enumerates differences in assessment techniques appropriate for the young, middle and older adult.

Purpose of Assessment

- To make a judgment or a diagnosis
- Making reliable observations
- Distinguishing data
  - Relevant vs. irrelevant
- Validating data
- Organizing data
- Categorizing data according to a framework
- Recognizing assumptions
- Identify gaps in data

Nursing Health History

- Biographical data
  - Name, address, sex, marital status, occupation, religious preference, where client gets medical care
- Chief complaint
  - Reason for the visit - What brought them to the hospital
  - Use the client's words
- History of present illness (OLD CART format)
- Past history
  - Illnesses, allergies, immunizations, accidents, hospitalizations, surgeries, medications
- Family history
- Lifestyle
- Social data
- Psychological data
- Patterns of health care
- Spiritual needs

History of Present Illness: OLDCART format

- **O**nset
- **L**ocation
- **D**uration
- **C**haracteristics
- **A**ggravating factors
- **R**elieving factors
- **T**reatments

- OLDCART pertains to treatment prior to arriving at the hospital
- Can be written out in narrative form to tell the client's story
- Using specific client quotes makes for a stronger statement

Past Medical History

- Illnesses
- Allergies
- Immunizations
- Accidents/injuries
- Hospitalizations
- Surgeries
- Medications

Family History of Illness

- Include only direct blood relations
  - Parents
  - Grandparents
  - Siblings
  - First cousins
- Include ages of individuals or cause of death with age at the time of death

Lifestyle

- Personal/Social habits – Alcohol, Tobacco, Caffeine, illegal or recreational drugs w/ amount, frequency, and duration of use for each
- Diet
- Sleep patterns
- Activities of Daily Living (ADL's)
  - Basic activities of functional mobility and personal care
  - Eating, grooming, dressing, elimination, locomotion
- Instrumental ADL's (IADL's)
  - Complex activities required for independent living
  - Transportation, food prep, finances, cleaning, meds

Social Data

- Family relationships/friendships
- Ethnic Affiliations
- Educational History
- Occupational History
- Economic Status
- Home and Neighborhood Conditions

Psychological Data

- Major stressors
- Coping patterns or strategies
- Communication style
  - Should include both verbal and nonverbal expression

Patterns of Health Care

- All health care resources the client is currently using and has used in the past.
  - Primary care provider (PCP)
  - Specialists
  - Dentist
  - Health clinic
  - Folk/Traditional health healers

Data Collection

- To collect data accurately, both the client and nurse must actively participate
- Sources of Data
  - Primary= patient
  - Secondary= family, labs, diagnostic tests, MD/nursing notes
- Types of Data
  - Subjective
    - Symptoms or covert data
      - Apparent only to the patient and described only by patient
  - Objective
    - Signs or overt data
      - Detected by nurse and/or can be measured or tested
      - Can be seen, heard, felt, or smelled

Data Collection Methods: Observing

- Gather data by using your senses
- Two aspects
  - Noticing data
  - Selecting, organizing & interpreting data
- Use vision, smell, hearing, & touch

Data Collection Methods: Interviewing

- A planned communication/conversation with a purpose often to get information
- Two approaches to interviewing
  - Directive – nurse controls interview seeking specific info
  - Nondirective – often client led and helps to establish rapport
- Types of questions
  - Closed questions
  - Open-ended questions
  - Neutral questions
  - Leading questions

Data Collection Methods: Examining

- Physical assessment utilizing a systematic approach
  - Inspection
  - Auscultation
  - Palpation
  - Percussion
- Styles
  - Cephalocaudal (Head-to-toe approach)
  - Body systems approach

Organizing Data

- Written
- Computerized/Electronic
  - County currently using ORCHID for charting
  - **O**nline **R**ealtime **C**entralized **H**ealth **I**nformation **D**atabase

Conceptual Models/Frameworks

- School of Nursing
  - Betty Neuman Systems Model
  - Used in Careplans
- Clinical Nursing Careplan assignment will also include Erikson's system of developmental stages
  - In Peds you may also include Piaget's stages of cognitive development

Validating Data

- Validation – Double-checking or Verifying
  - Data gathered during assessment must be complete, factual, & accurate because nursing diagnosis and interventions will be based on this information
- Cues
  - Subjective or objective data that can be directly observed by the nurse
- Inferences
  - Nurse's interpretation or conclusion made based on the cues

Documenting Data

- Nursing documentation (charting)
  - To complete the assessment phase the nurse records client data
  - Accurate documentation is essential and should include all data collected about the clients health status
  - All "charting" is a legal document. Any false entries make the nurse legally liable
- Record the physical findings
  - Data is collected in a factual manner and not interpreted by the nurse

Physical Assessment

- Purposes of the physical examination approach
  - To obtain baseline data
  - Supplement, confirm, refute data obtained in nursing history
  - Obtain data that will help establish nursing diagnosis and plan of care
  - Evaluate physiological outcomes
  - Make clinical judgments
  - Identify areas of health promotion & disease prevention
- Nurses use national guidelines and evidence-based practice to focus health assessment on specific conditions

Types of Physical Assessment

- Initial assessment
  - On admission to establish client's baseline
- Problem-focused assessment
  - Ongoing problem to determine status of a specific problem
- Emergency assessment
  - A crisis or change in status to identify a life-threatening problem
- Time-lapsed reassessment

Preparation for Assessment

- Prepare the patient
  - Age specific approach
- Health Insurance Portability and Accountability Act (HIPAA)
  - Make client is are aware of your confidentiality
- Prepare the environment
- Position the client
- Draping – privacy
- Instruments

Method of Examination

- Inspection
  - Includes visual exam (moisture, texture, shape, size, color, symmetry), olfactory, and auditory
- Palpation
  - Use pads of fingers to determine texture, temperature, vibration, masses, distention, pulsation, and tenderness
  - Light palpation (superficial) precedes deep palpation
- Percussion
  - Indirect – place middle finger of nondominant hand on client's skin and strike with the tip of middle finger from dominant hand
  - Direct – percusses an area of skin with 2-4 fingers typically only used for assessing sinuses
  - 5 types of sound – Flatness, Dullness, Resonance, Hyperresonance, Tympany
- Auscultation - Listening for sounds within the body
  - Direct (Using just your ear) & Indirect (Using stethoscope)
  - Pitch, Intensity, Duration, Quality

General Survey

- Appearance & Behavior
- Mental Status
- Vital signs
- Height and weight
- The actual of assessment
  - Focus on the rest of your "Assessment" lectures in N113

Physical Assessment Technique Variations

- Adapt to your specific patient's situation
  - Maybe they can't move, so you will have to change how you perform your assessment
- Gerontological differences that maybe abnormal for younger clients will be normal for more elderly clients
  - i.e., S4 heart sound in someone young can be a problem in elderly
  - Take age into consideration when assessing

Record Physical Exam Findings

- Document/record/chart your findings on patient's record in ORCHID
- The law says if you didn't chart it, you didn't do it