In The Name of God

(A PROJECT OF NEW LIFE COLLEGE OF NURSING KARACHI)

UNIT I A.
HEALTH ASSESSMENT

INTRODUCTION TO HEALTH ASSESSMENT CONCEPTS

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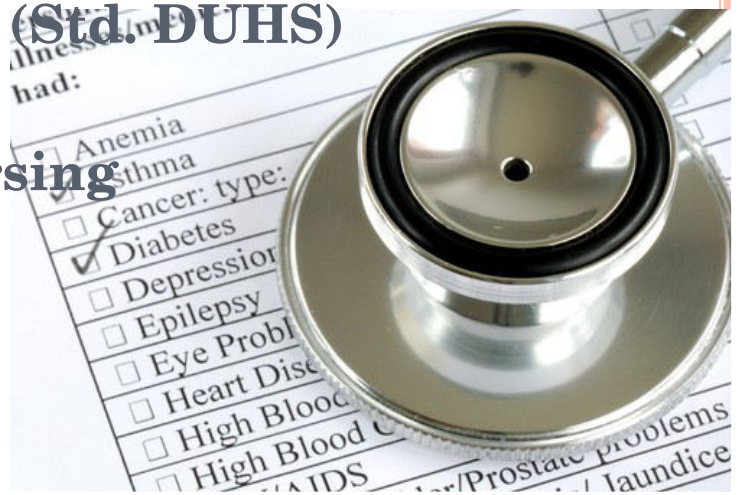


OBJECTIVES

- **By the end of the unit, learners will be able to:**
- Discuss the need for health assessment in general nursing practice.
- Explain the concepts of health assessment, data collection, and diagnosis.
- Identify types of health assessments.
- Document health assessment data using a problem oriented approach.

Need of Health Assessment in Nursing

- Accurate physical assessment requires an organized and systematic approach using the techniques of inspection, palpation, percussion, and auscultation.
- It also requires a trusting relationship and rapport between the nurse and the patient to decrease the stress the patient may have from being physically exposed and vulnerable.
- The patient will be much more relaxed and cooperative if you explain what will be done and the reason for doing it.
- While the findings of a nursing assessment do sometimes contribute to the identification of a medical diagnosis, the unique focus of a nursing assessment is on the patient's responses to actual or potential problems.

Nursing Assessment

- Is a major component of nursing care.
- Is a process which includes both physical and psychological aspect to evaluate client's condition.
- Enables the nurse to make a judgment about the client's health status , ability to manage his/her health care and need for nursing.

BASIC CONCEPTS

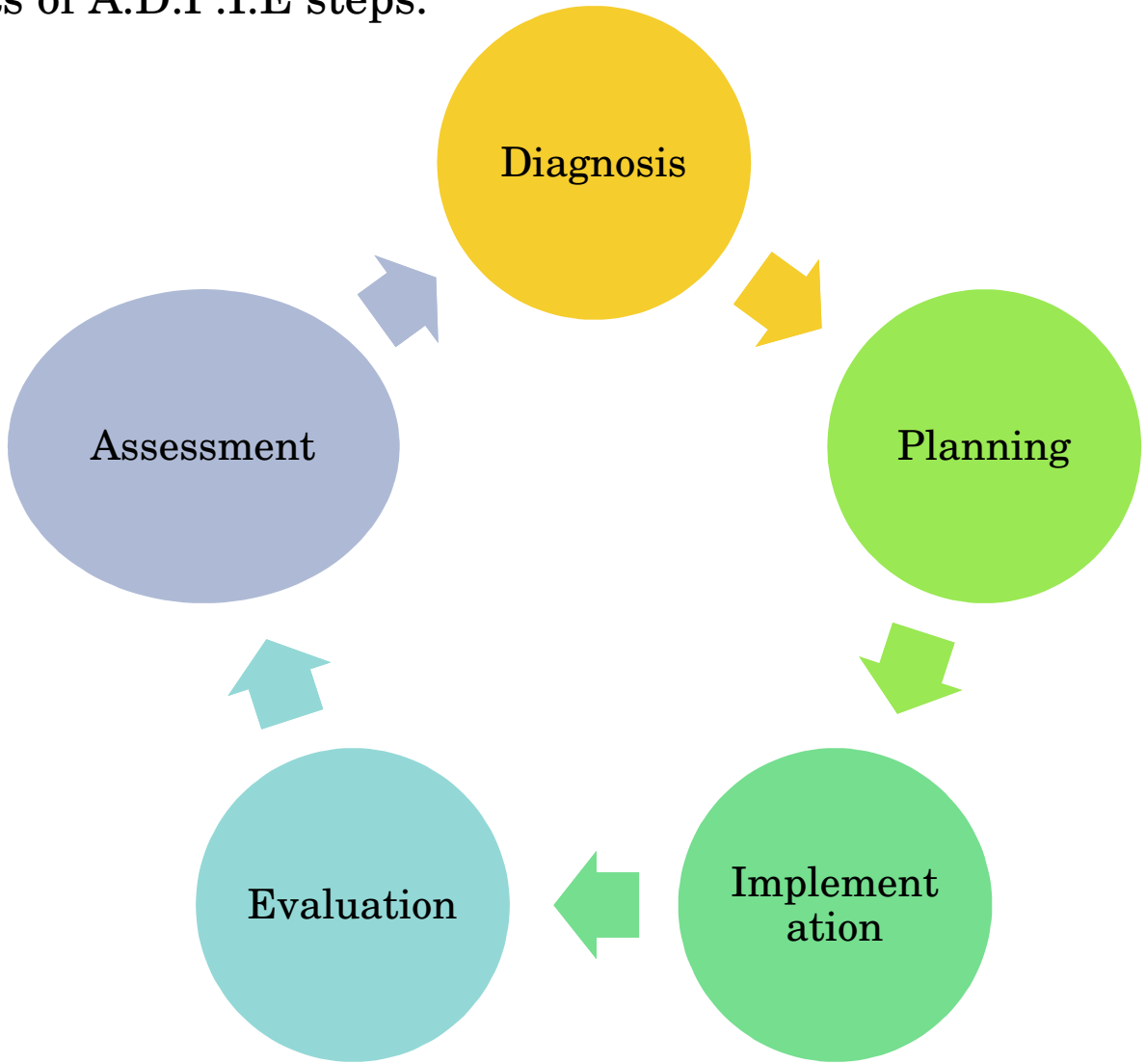
- **Health: (WHO)** a state of complete physic**al,** mental & social Wellbeing, not merely the absence of disease.
- **Wellness:** Level of wellbeing, a person perceives of being healthy.
- **Disease:** Alteration of structure and function of body. Disease or discomfort.
- **Illness:** A response a person has to an illness.

CONT…

- The new definition, considers health as a dynamic state of well being with different levels of functional abilities at different point in time. So a diabetic patient no doubt has a disease, but there are times when the client feels well and can be called healthy.
- **Illness** is a response to a disease and **sickness** is the individual perception of its illness. Thus it is possible that a person has a disease DM, has hypoglycemia sometimes, but still feels that he is normal so thus does not feel sick.

PHASES OF THE NURSING PROCESS

It is systematic, deliberate, problem solving, decision making process that nurses use to achieve a certain result.
It consists of A.D.P.I.E steps.



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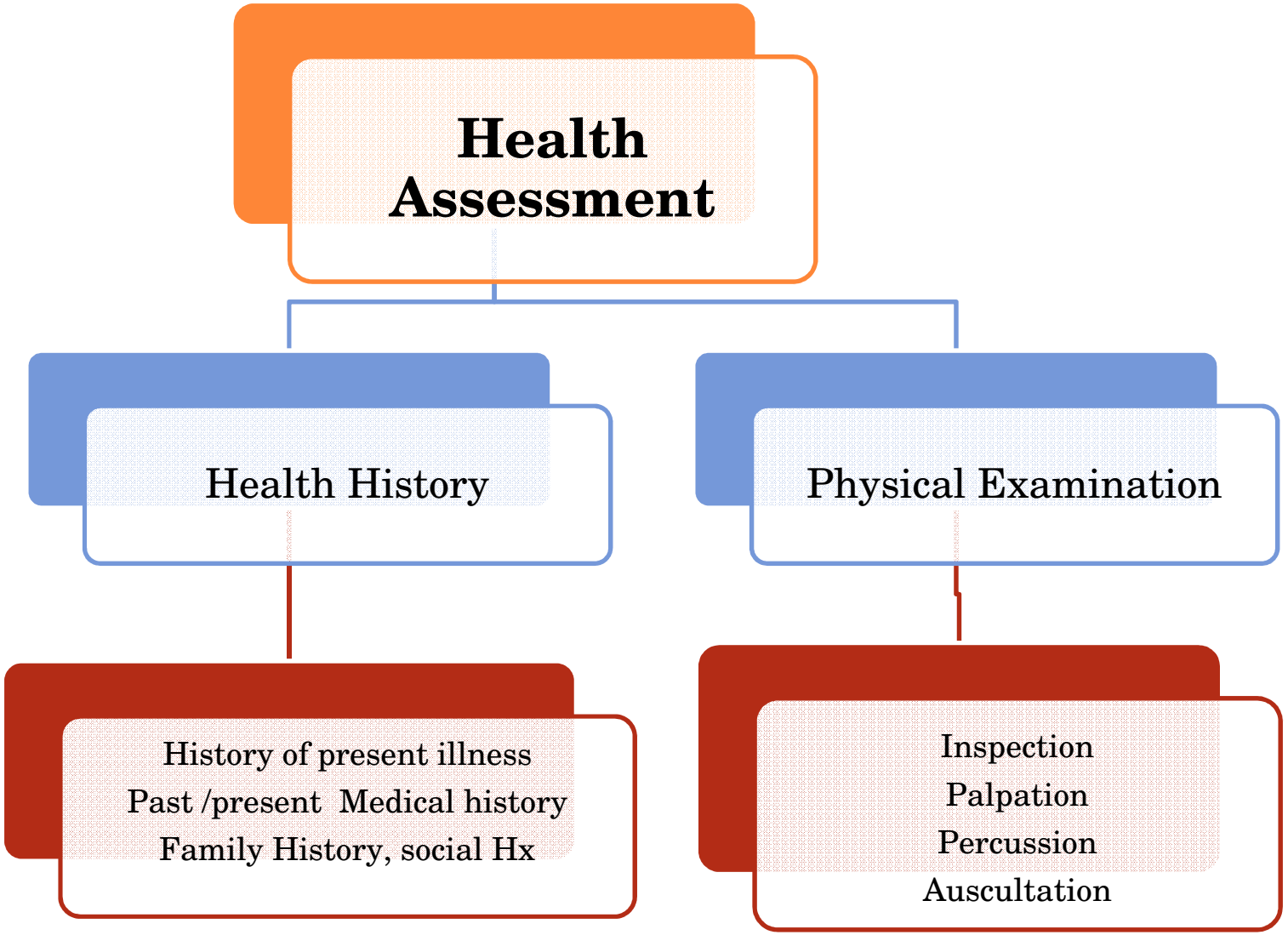
Phase	Title	Description
I	Assessment	Collecting subjective and objective data
II	Diagnosis	Analyzing subjective and objective data to make a professional nursing judgment (nursing diagnosis, collaborative problem, or referral.
III	Planning	Determining outcome criteria and developing a plan
IV	Implementation	Carry ing out the plan
V	Evaluation	Assessing whether outcome criteria have been met and revising the plan as necessary

Components of Health Assessment



FACTS ABOUT PHYSICAL ASSESSMENT:

- **a.** Physical assessment is an organized systemic process of collecting objective data based upon a health history and head-to-toe or general systems examination. A physical assessment should be adjusted to the patient, based on his needs. It can be a complete physical assessment, an assessment of a body system, or an assessment of a body part.

- **b.** The physical assessment is the first step in the nursing process. It provides the foundation for he nursing care plan in which your observations play an integral part in the assessment, intervention, and evaluation phases.

- **c.** The chances of overlooking important data are greatly reduced because the physical assessment is performed in an organized, systematic manner, instead of a random manner.

PURPOSES OF A PHYSICAL ASSESSMENT:

A. A comprehensive patient assessment yields both subjective and objective findings. Subjective findings are obtained from the health history and body systems review. Objective findings are collected from the physical examination.

- (1) **Subjective data: A**re apparent only to the person affected and can be described or verified only by that person. Pain, itching, and worrying are examples of subjective data.

- (2) **Objective data: A**re detectable by an observer or can be tested by using an accepted standard.
  - A blood pressure reading, discoloration of the skin, and seeing the patient in the act of crying are examples of objective data.

CONTI….

- (3) Objective data are sometimes called **signs**, and subjective data are sometimes called **symptoms.**
- (4) Data means more than signs or symptoms; it also includes demographics, or patient information that is not related to a disease process.

CONTI….

B. The **purposes for a physical assessment** are:

- (1) To obtain baseline physical and mental data on the patient.
- (2) To supplement, confirm, or question data obtained in the nursing history.
- (3) To obtain data that will help the nurse establish nursing diagnoses and plan patient care.
- (4) To evaluate the appropriateness of the nursing interventions in resolving the patient's identified pathophysiology problems
- (5) To evaluate the physiological outcome of care.

Importance of Physical Assessment:

1. To early detect and treat diseases and disorders.
2. To identify actual and potential health problems.
3. To establish a data based from which the subsequent phases of the nursing evolve.
4. To assess the client's impact of activity and exercise on the client's overall level of health.
5. To assess the client's routine exercise pattern and observe how the client's body system response to activity and exercise.
6. To establish the client-nurse relationship
7. To obtain information about the client's health including, physiologic, psychologic, sociocultural, cognitive, developmental and spiritual aspects.
8. To identify the client's strength and weaknesses.

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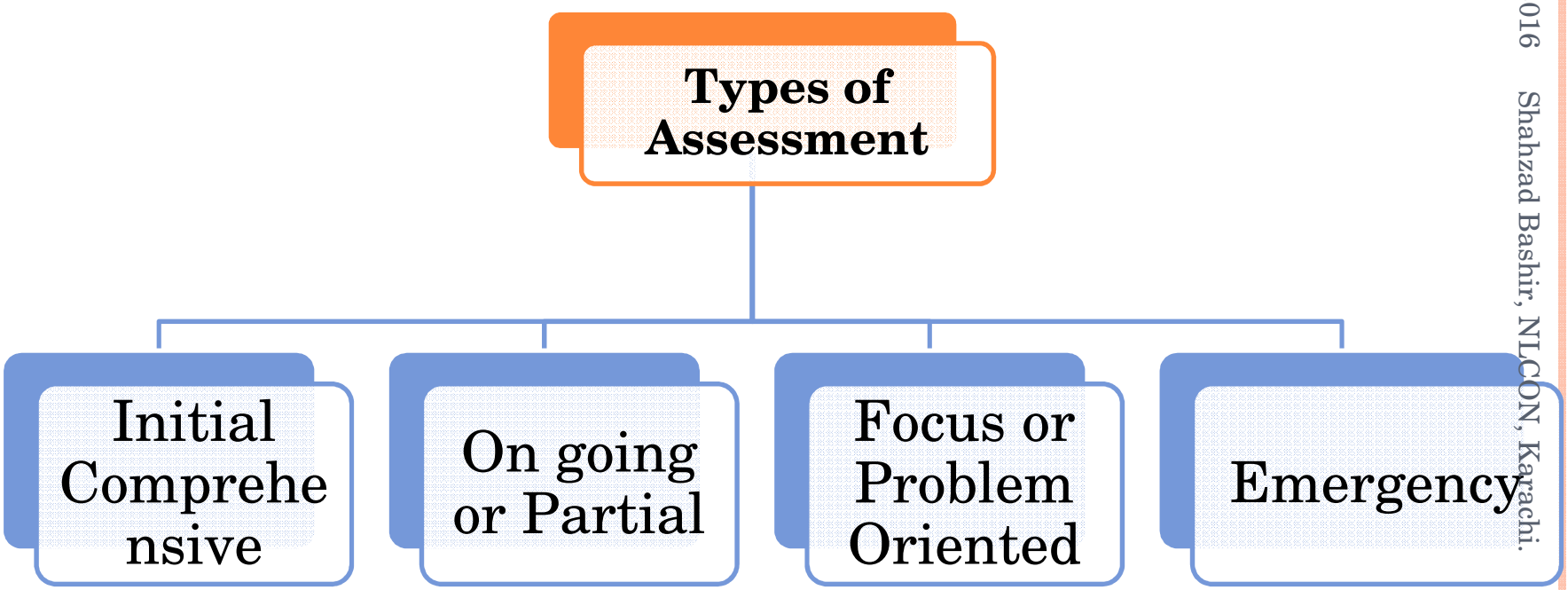
COMPARING SUBJECTIVE AND OBJECTIVE DATA

	Subjective	Objective
Description	▪Data elicited and verified by the client	▪Data directly or indirectly observed through measurement
Sources	•Client •Family and significant others •Client record •Other health care professionals	▪Observations and physical assessment findings of the nurse or other health care professionals. ▪Documentation of assessments made in client record. ▪Observations made by the client's family or significant others.
Methods used to obtain data	•Client interview	▪Observation and physical examination
Skills needed to obtain data	▪Interview and therapeutic communication skills ▪Caring ability and empathy ▪Listening skills	▪Inspection ▪Palpation ▪Percussion ▪Auscultation
Examples.	▪"I have a headache." ▪"It frightens me." ▪"I am not hungry."	▪Respirations 16 per minute ▪BP 180/100, apical pulse 80 and irregular ▪X-ray til in reveals fractured pelvis

Types of Assessment



Initial Comprehensive Assessment

- Also called an **admission assessment**, it is performed when client enter health care system.

- Involves collection of subjective data about the client's perception of health of all body parts or systems, past health history, family history, and lifestyle and health practices (which includes information related to the client's overall function) as well as objective data gathered during a step-by-step physical examination.

- The purposes are to evaluates client's health status, to identify functional health pattern that are problematic, & to provide in an- depth, comprehensive data base which is critical for evaluating changes in the client's health status in subsequent assessment.

Ongoing or Partial Assessment

- Consists of data collection that occurs after the comprehensive database is established. This consists of a mini-overview of the client's body systems and holistic health patterns as a follow-up on his health status.

- Any problems that were initially detected in the client's body system or holistic health patterns are reassessed in less depth to determine any major changes (deterioration or improvement) from the baseline data.

- This type of assessment is usually performed whenever the nurse or another health care professional has an encounter with the client. This type of assessment may be performed in the hospital, community, or home setting.
  - For example, a client admitted to the hospital with lung cancer requires frequent assessment of lung sounds. A total assessment of skin would be performed less frequently, with the nurse focusing on the color and temperature of the extremities to determine level of oxygenation.

Focused or Problem Oriented Assessment

- It is performed when a comprehensive database exists for a client and he/she comes to the health care agency with a specific health concern.

- Consists of a thorough assessment of a particular client problem and does not cover areas not related to the problem. For example, if your client, John P.. tells you that he has ear pain, you would ask him questions about the pain, possible hearing loss, dizziness, ringing in his ears, and personal ear care. Sexual functioning & bowel habits would be unnecessary and inappropriate.

- The physical examination should focus on his ears, nose, mouth, and throat. At this time, it would not be appropriate to repeat all system examinations such as the heart and neck vessel or abdominal assessment.

Emergency Assessment

- An emergency assessment is a very rapid assessment performed in life-threatening situations. In such situations (choking, cardiac arrest, drowning), an immediate diagnosis is needed to provide prompt treatment.

- An example of an emergency assessment is the evaluation of the client's airway, breathing, and circulation (known as the ABCs) when cardiac arrest is suspected.

- The major and only concern during this type of assessment is to determine the status of the client's life-sustaining physical functions.

Problem Oriented Recording (POR)

Type of format for documentation where a data base leads to a problem list and plan for some interventions i.e. diagnostic, therapeutic, educational.

S Subjective
O Objective
A Assumption / Diagnosis
P Planning
I Intervention
E Evaluation
R Revision

Documentation of PE findings

- Specific – avoid vague terms
- Concise – use short simple words
- Complete entry with date & sign
- Describe observation clearly
- Use standard abbreviations only
- Record exact size, position of lesions
- Use illustration
- Use black pen

REFERENCES BOOKS

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- Jarvis, Carolyn. (2011). *Physical Examination and Health Assessment - Text + Mosby's Nursing Video Skills: Physical Examination & Health Assessment Package. W B Saunders Co.*