HEALTH ASSESSMENT

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Health Assessment

- Is Data Collection and Data Analysis
- Utilizes the Nursing process
- Is essential in diagnosing medical and nursing problems, provides insight into beliefs and perceptions.

Health Assessment

- Incorporates critical thinking
- Includes knowledge of developmental stages through the life cycle
- Health assessment includes, physical & mental along with assessment for domestic violence and child abuse

Health Assessment

- Requires proficient communication skills and interviewing techniques
- Considers cultural aspects
  - Cultural Competency

Cultural Assessment

- Brief History of the cultural group patient identifies with
- Communication
- Values
- Cultural Sanctions/Restrictions and Health related beliefs/practices
  (Include nutrition, socioeconomic considerations, educational background and religious affiliation)

Cross-Cultural Communication

- Cultural perspectives on professional interactions
- Etiquette
- Space and distance
- Cultural considerations on gender and sexual orientation
Techniques of Communication (cont.)
- Nonverbal skills
  - Physical appearance
  - Posture
  - Gestures
  - Facial expression
  - Eye contact
  - Voice
  - Touch

Health Assessment
- Begins with reason for seeking care (chief complaint is previously used term) & health history
- Document using the patient’s own words
- Elicit a complete description from patient
- Document duration of complaint
- What aggravates condition, what may alleviate it?

Types of Health Histories
- Complete
- Interval
- Problem focused or chief complaint

History Taking
- Well developed interview skills and careful documentation
- Environment conducive to privacy and comfort
- Is the client a good historian?
- Reasons for seeking health care
- Interview- intro, working, termination phases

Complete Health History
- Biographical
- Reason for seeking health care
- Present health/ Illness
- Past health
- Family health
- Review of systems
- Psychological
- Functional Assessment
- Perception of health

Reason for Seeking Care
- Symptom
  - Subjective sensation
- Sign
  - Objective abnormality
  - Detectable on physical exam or in laboratory reports
**Present Health/Illness**
- Onset, duration, precipitating factors.
- Frequency, duration...
- Associated symptoms i.e. N/V
- Alleviating/ aggravating factors
- ROS re: CC
- Relevant family, occupational or recreational history.

**Past Health History**
- Past general health
- Childhood illnesses
- Accidents/ injuries
- Hospitalizations/surgeries
- Acute and chronic illnesses
- Immunizations
- Allergies, medications, transfusions

**Current Health**
- Allergies
- Habits
- Meds (including OTC/Herbal/ Vitamins)
- Exercise
- Sleep

**Family History**
- Important to know to determine risks
- Spouse/significant other
- Children
- Cultural considerations

**Genogram:** see also page 813

**Review of Systems: ROS**
- Reviews past and present health status of each body system.
- Reviews health maintenance.
- Head to toe
- May elicit new information
Psychological Function
- Cognitive – memory, comprehension
- Response to illness and health
- Psych history, meds, anxiety?
- Cultural considerations

Functional Assessment
- ADLs
- Sleep/rest
- Nutrition/problems with diet, weight
- Alcohol problems /Substance abuse
- Coping difficulties
- Domestic/child abuse

Perception of Health
- How one defines health
- Views on one’s health status
- What are one’s expectations pertaining to health and health care

Physical Examination (PE)
- Goal is to identify variations form normal.
- Explain procedure first
- Head to Toe
- Unaffected areas before affected

Techniques of PE
- Four components used in specific order:
  - Inspection
  - Palpation
  - Percussion
  - Auscultation

Techniques of PE
- **Inspection** - First techniques used. What examiner sees, hears and smells. Observe symmetry.
- **Palpation** - Second technique using fingers and hands to touch. Light palpation first then deep palpation
Palpation Technique

The RN must utilize different parts of the hand
One hand or bimanual (2 hands)
- fingertips - assess texture, swelling, pulse or lumps
- Fingers and thumb in a grasp - assess position and shape of organs
- Dorsa (back) of hands - assess temperature
- Base of hand - assess vibration

Techniques of PE

- **Percussion**: Third techniques...tapping on skin surface which creates a vibration of underlying structures. The vibration produces a sound, may aid in diagnosis.
- **Resonant**: normal lung.
- **Hyperresonant**: Child’s lung or emphysema.
- **Tympany**: Air filled organ, e.g., stomach or intestine.
- **Dull**: Dense organ, e.g., liver or spleen.
- **Flat**: No air present, e.g., bone.

Techniques of PE

- **Methods of Percussion**
  - **Direct**: used over sinuses.
  - **Indirect**: used over thorax and abdomen.
  - **Fist Percussion**: used over kidneys

Techniques of PE

- **Uses for Percussion**: Mapping out location and size of an organ
- **Determining density**: air, fluid, solid) of a structure
- **Detecting superficial mass**: (up to 5 cm deep)
- **Eliciting pain**: if underlying structure is inflamed
- **Eliciting a DTR**: using a percussion hammer

Techniques of PE

- **Auscultation**: Usually last technique during PE (*exception – abdomen, it’s the 2nd technique after inspection*)
- **Use stethoscope** to block sounds not magnify
- **Diaphragm**: firmly against skin
- **Bell**: lightly against skin

Techniques of PE

- **Description of sounds heard**
  - **Pitch**: frequency of sound vibrations, high or low.
  - **Intensity**: loudness of sound: loud or soft (amplitude)
  - **Duration**: length of sound: short, long
  - **Quality**: subjective terms- harsh, tinkling, etc...
Physical Exam

- Utilize 4 techniques
- Proper setting
- Equipment
- Clean/ safe environment
- Remember client comfort

Summary

- Health assessment includes:
  - Complete health history
  - ROS
  - Physical Exam

SOAP note

- Subjective - info given by pt (health history)
- Objective - PE finding using IPPA
- Assessment - therapeutic ideas, nsg dx
- Plan - diagnostic, therapeutic or educational interventions to work toward problem solving.

Subjective Data

- "Statements" made by patient
- "Their feelings" about symptomatology

- Patient denies any history of skin disease or problems. States he has a "receding hairline" since his mid 30’s. Admits to nail biting "only when studying for nursing exams."

Objective data

- What the RN observes
- As the PE is performed you must identify the normal and abnormal findings
  - Pertinent positives and
  - Significant negatives

Assessment

- After you collect the data then you must interpret the results
- Written as a NANDA diagnosis
  - Actual health problem
  - Risk diagnosis
  - Wellness diagnosis
- Remember the 2 and 3 part statements
- PES format
- Problem r/t etiology AEB S&S
Plan

- List of interventions that will aim to resolve the problem(s)
  - Educational
  - Therapeutic
  - Diagnostic
  - Referral to specialist
- Use of *active verbs* to state nursing interventions
  - Instruct
  - Discourage
  - Encourage
  - Advise
  - Teach
- But never... TELL !!!!!