HEALTH ASSESSMENT

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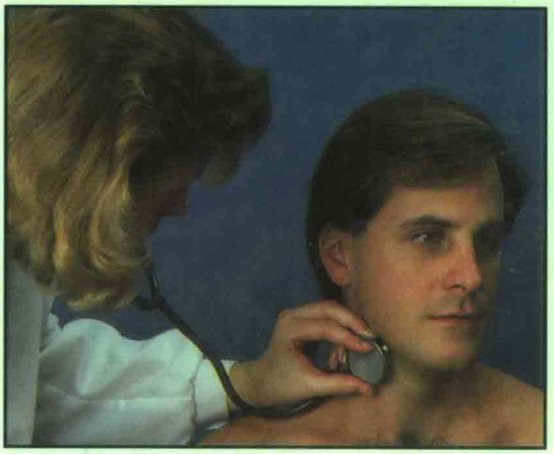
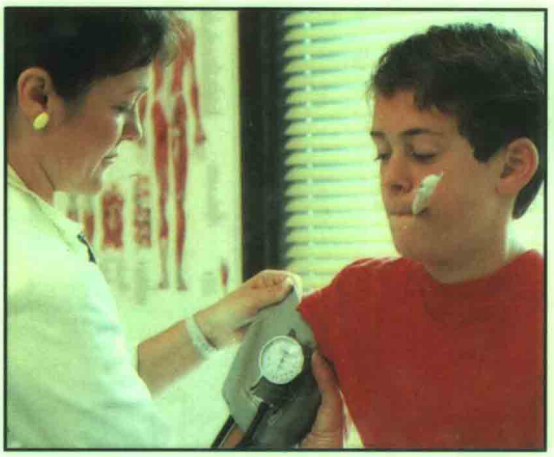
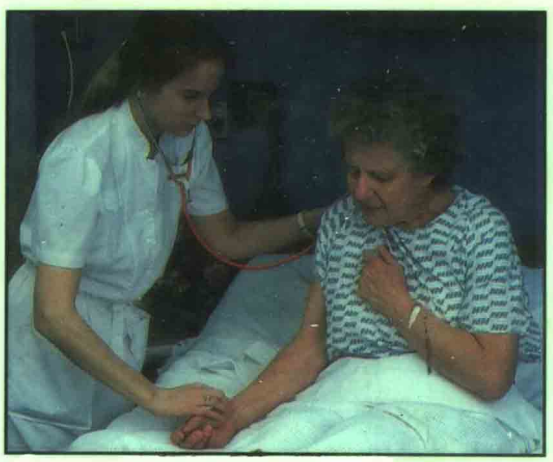
FOURTH EDITION







HEALTH ASSESSMENT

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Preface

Reorganized, redesigned, and considerably rewritten, the fourth edition of *Health Assessment* has been reconceived to reflect recent changes in the practice of health assessment by nurses. Like its previous editions, this book continues to reflect the authors' belief in holistic health assessment, taking into account the client's environment, health practices and beliefs, and physical status. In this edition, assessment is placed into its larger decision-making context. Health assessment is presented as the systematic collection of data that health professionals can use to begin making decisions about how they will intervene to restore or promote health.

The text is designed for students and beginning practitioners. It contains the theory and skills necessary to collect a comprehensive health history and to perform a complete physical examination. These skills can be most effectively mastered when the text is used in conjunction with a structured learning environment, such as a skills lab or a clinical setting in which learners can practice techniques on one another or on properly informed clients. Because the book contains a great deal of substantive detail on examination techniques and findings, the student is not expected to outgrow the text but utilize it as a valuable reference in clinical practice.

A new system of units elucidates the organization of the book. Unit I consists of a series of short chapters on the elements of the health history, capped by an overview chapter that pulls the disparate elements together in a cogent format. The health history, often neglected, is arguably the most important aspect of health assessment, since it alerts the examiner to potential problems and directs the focus of the examination itself. A sensitively gathered health history requires astute communication and observation skills, which are given careful attention in this text. We believe it is the most comprehensive discussion of the health history available to health professionals.

The bulk of the book consists of a body systems approach to the physical examination, Unit II. After short introductory chapters on equipment and techniques and taking vital signs, the physical examination is presented by body systems, a time-honored organizational method conducive to learning. To the extent possible, these chapters follow a consistent format. After a brief review of relevant anatomy and physiology, the examination techniques are presented in depth and carefully illustrated, emphasizing normal findings in the well adult. Then, common abnormal findings are presented that alert the learner to the types of pathology. Finally, by way of summary, the relevant health history, including suggested questions, is reviewed in a boxed format. To facilitate the student's laboratory or clinical experience, perforated cards are bound into the back of the book summarizing the physical examination in both a body systems and a head-to-toe format. These cards are designed to be torn out and carried into the structured practice area to reinforce the habit of an orderly examination. An orderly approach to the examination is indispensible to good technique.

Although the book focuses on the general care of the healthy adult client, no comprehensive text on health assessment can ignore the special assessment techniques required by clients of other age groups. Thus Unit III includes chapters that present assessment techniques unique to pregnant women, children, and older adults.

Other techniques are presented in Unit IV on special populations. Sensitivity to the cultural dimensions of clients has always been a hallmark of this book, and cultural considerations continue to be interwoven throughout the text where appropriate. Nonetheless, be-

cause of the multicultural society in the United States and Canada, we have developed a separate chapter that brings cultural considerations into a unified presentation. A functional assessment chapter has been added. Although any client can benefit from a functional assessment, the degree of adaptation to one's environment is especially important for the frail elderly and for disabled clients.

The purpose of performing an assessment is to use the data in clinical decision making. Unit V discusses the use of assessment data. It includes a new chapter on decision making that places assessment in its nursing process context. Emphasis is placed on how the information derived from the assessment is organized. There is little value in obtaining information that is unclear to the practitioner or other members of the health team at a future time when it may be of critical importance as part of an overall data base from which problems are identified and actions planned.

Throughout this text, the consumer of health care is referred to as the *client* because the term implies the ability of a person, whether well or sick, to contract for health care as a responsible participant, with the providers, in the health care process. Health-care providers can no longer expect consumers of health care to accept advice or treatment unless they have been included in the decision-making process. The term *client* also connotes the wide variety of settings in which health care is provided.

The authors are grateful for the wide acceptance of this book over its first three editions. We recognize the obligations that accompany the book's acceptance. It is our goal, once again, to offer a new edition of *Health Assessment* and to provide an innovative product, one which reflects and anticipates the ways in which health care is delivered. The many comments made by students and educators have been instrumental to the revision process and the realization of our goal.

It is also our pleasure to express gratitude to a number of individuals who helped us prepare this edition. Without their support and assistance it would not have been possible. Carrie Schopf, M.D., was our reviewer, supporter, and teacher for the first edition. We are also grateful for the assistance provided by Betsy Perry, R.N., M.P.H., and Lawrence Allen, M.D. The excellent photography of Patricia Urbanus, R.N., M.S.N., C.N.M., continues to serve this book well. Our thanks are also extended to Scott Thorn Barrows, William R. Schwarz, Robert Parshall, Christo Popoff, Marion Howard, and Mary Ann Olson for their outstanding artwork.

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The interview

OBJECTIVES

Upon successful review of this chapter, learners will be able to identify:

- Communication techniques that help fulfill interview purposes
- Purposes and components of a contract between a client and a practitioner
- Methods for facilitating an interview
- Methods of questioning that affect the interview process
- Methods for assuring understanding between client and practitioner
- Nonverbal patterns that communicate data
- Appropriate use of intimate distance, personal, social, and public spaces
- Use of empathy and acceptance in a therapeutic relationship
- Guidelines for obtaining a complete description of a symptom
- Common problems that occur during interviews

The major purpose of the interview conducted before the physical examination is to obtain a health history and to elicit symptoms and the time course of their development. The goal of an effective interview is to obtain a complete and accurate database. However, although assessment may be the main emphasis of a given exchange, the health care provider must use skillful communication techniques to establish the rapport necessary for a full sharing of the client's relevant life experiences. A climate of trust must be established that will allow a full expression of the client's needs. Furthermore, an analysis of the client's reactions during the interview will allow the examiner to predict the client's ability and willingness to comprehend and therefore carry out the directions given as part of the therapeutic plan.

The students of the health care professions have had many years of interacting with fellow human beings and have practiced establishing relationships in many settings. Therefore, the practitioner performs the examination within the context of a professional experience. Most students have learned which communication techniques work well for them, particularly in social settings. The focus of this discussion will be the characteristics of information exchange that will allow the client and health care professional to work toward the mutual goal of establishing a database.

As the interview begins with introductions, a mutual assessment of client and interviewer takes place. The interviewer generally has the advantage of knowing the client's name and may greet him or her warmly, respectfully, and by name. A handshake is appropriate if the examiner is comfortable in reaching out in the initial encounter and the client appears receptive to this.

The interview process is enhanced and facilitated by the client's communication skills and sensitivity to

the examiner. To this end, the practitioner must develop a flexible framework for obtaining the information or behavior needed in the assessment that will also facilitate the interaction necessary for a therapeutic relationship.

The most effective place to learn how to interview is at the bedside and in the clinic while dealing with actual clients. Initial interviews should be supervised by a skilled professional who will provide support and suggestions for modification during and after the client session.

It is helpful to have videotapes of practice sessions made so that students may more objectively analyze their own interviewing skills and maximize those special talents made evident by direct viewing. The goal of the effective communicator is to demonstrate concern and sincere desire to engage in tasks necessary to meet the client's health care needs.

The use of a written record of the interview, called a process recording, may be helpful in identifying communication problems. However, a tape recording (with the client's consent) of a verbal interchange between the client and the practitioner may serve the same end. Yet, tape recording may sometimes inhibit the client's willingness to communicate.

Particularly at the first interview, the client should be allowed to talk freely, describing his or her health condition. One frequently observed error is the monopoly of the interview by the practitioner. Frequently clients report that they did not mention symptoms because they did not have an opportunity or were not encouraged to do so—"He asked so many questions that I didn't get a chance to say anything." When one of the participants does most of the talking during the interview, the other may be silent for long periods. The practitioner should bear in mind that clients' perception of what is being said in conversation is often decreased when they are listening to a long presentation. The most effective communication exists when the client takes an active role in the interview. The interview might begin with a general invitation to the client to speak freely, such as "Tell me how do you feel," or " What health concern brings you here?"

CONTRACT

The interview is a verbal and nonverbal exchange that provides for the beginning and development of a relationship. Initially, the participants are strangers, each presenting a particular style of relating and adapting. Defining the terms of the relationship early in the interview allows for reduction of unnecessary stressors and provides goals for the participants. Common symbols (gestures and facial expressions) used between examiner and client should have the same meaning to both participants, since the quality of the communication will determine the value of the relationship. Unlike many other associations, the association between the health care professional and the client has a mutual concern, the client's well-being. This commonality of interest will facilitate progress toward the sharing of information, ideas, and emotions. A mutually understandable language and an understanding of the significance of body language, such as gestures and facial expressions, will increase the exchange of information between the client and the practitioner and enrich the data obtained.

Facial expressions are the most widely used nonverbal communication and the message most frequently observed by the client. Eye contact is frequently used. In most ethnic groups, people invite communication with others by looking directly at them. The person who looks another in the eye while talking is generally considered open and honest. However, should the person being gazed on decline the invitation, he or she generally does so by averting eye contact, most often looking downward. Although a short gaze may be interpreted as accessibility and interest on the examiner's part, it is important to avoid long periods of looking directly at the client because this may be interpreted as an invitation to an uncomfortably revealing relationship by the client or as a threatening behavior.

The contract or basic operating agreement between the client and the practitioner is usually a verbal commitment presented by the practitioner. This contract should include:

1. Time and place that the interview and subsequent examinations will occur
2. Duration of time involved in the present and future examinations
3. Number of sessions required
4. Expectations for participation by the client in the assessment process
5. Confidentiality of shared information and findings—responsibilities of each member
6. Rules regarding the presence of other professionals or of the client's relatives or other advocates
7. Cost to the client where applicable
8. Therapeutic goals subsequent to the assessment process

The advantage of the contract to the practitioner is that the client is relieved of misconceptions, fears, or fantasies concerning what might happen during the interview and examination. Thus, the contract establishes norms and role behavior. The practitioner and the client have expectations of each other, and confusion over roles threatens the relationship.

The expectation that there will be shared decision

making in the management of health care should be made very clear to the client. To this end, clients are encouraged to learn more about themselves to identify health needs and to recognize that they have an option in determining if and how health care needs are met.

In traditional health care relationships the health care professional is the authority figure whereas the client is, at least to some degree, the dependent.The client has initiated the interview by seeking help for a problem. In this effort to obtain aid from the professional, the client must determine the kind of information and behavior expected. The professional is obligated to analyze the client's communication pattern to explain to the client what is required for the professional to give the help that is needed. The interaction provides a kind of negotiation for the terms on which the relationship can continue, that is, a contract defining the participants' roles. The verbal and nonverbal dialogue that occurs in the first few minutes of this social exchange may well determine not only the reliability and amount of information the client will furnish to the interviewer but also the character of the relationship that follows.

SETTING

To promote the most effective attention to communication and therefore to build rapport, the practitioner should carefully construct the interview environment to avoid interruption, distraction, or discomfort as shown in the box opposite.

At the outset it should be determined if the time scheduled for the interview is mutually convenient to the client and interviewer. Although geographic privacy may not be obtainable in emergency rooms, large clinics, or multiple bed units in the hospital, psychological protection may be provided. Some of the assurances important to the client are that (1) the client is not being heard by other clients or personnel not concerned in care, (2) the practitioner is giving a high level of attention to the client, and (3) the information the client is sharing will be regarded as confidential or that the conditions of sharing will be defined.

In an ideal setting, the privacy of the client's thoughts and comfort can be guaranteed by conducting the interview in a private room where optimum temperature and lighting can be controlled. Indirect lighting is preferred so the client is not looking into a bright light or exposed to glare from a window.

The practitioner's physical position as related to the client can have implications in the control process. To suggest that the client has the option to control some of the interview, arrange the chairs or other furniture so that a face-to-face alignment to ensure eye contact is possible. The commonly used position of standing over and looking down at the client suggests that the practitioner has assumed leadership for the interchange. Leaning forward appropriately conveys alert attention. However, relaxed body posture should be maintained.

The Setting

1. Assure a comfortable temperature for both you and your client.
2. Do not seat yourself so the light source is behind you. This forces the client to look into the light. You will then be in a shadow, with your face and gestures difficult to see.
3. An elderly client may feel frightened sitting on an examination table due to altered perceptions of height and space. A child may feel similarly frightened by being up so high and separated from the parent.

Excessively long interviews are tiring to the client. More than one session may be needed to complete the database, particularly if the health history is complex or the client is critically ill or debilitated.

The client should obtain a sense of the interviewer's full involvement in the process. It is important to be aware of body language that could convey boredom or restlessness, such as shifting from one foot to another, sighing, or edging toward the door.

COMMUNICATION PROCESS

Anxiety may be an anticipated element in an initial interview for both the health care professional and the client. Some of the indications of acute anxiety that may be observed include a furrowed brow, squinting, dilated pupils, tensed facial muscles, distended neck vessels, rapid talk, a dry mouth, frequent hand gestures, a tense posture, an increased heart rate and blood pressure, sweaty palms and axillae, and a sweaty pubic area. Shuffling of feet may indicate the client's desire to escape the interview. The client's anxieties may be associated with the symptoms of illness, with the practitioner's reaction, with fees, or with expectations of future appointments. These anxieties may also be evidence of problems external to the interview. Clues that interview items are producing anxiety include long pauses, nervous laughter, dry coughing, and sighing.

Practitioners are concerned with clients' responses to the interview, with their ability to obtain appropriate information, and with their ability to synthesize the data provided so that the problems can be correctly defined.

To facilitate the development of rapport, health care professionals must use communication skills to project to clients that they are interested and concerned with providing necessary support. A practitioner might convey support by assuring a client, "I want to work with you to find out what is making you feel this way." To demonstrate interest and the willingness to listen, the practitioner must also be aware of the message conveyed nonverbally.

Particular attention is given the remarks made as the client is entering or leaving the room, since these comments frequently have special significance. The client may reveal the chief complaint at these times and avoid mentioning it during the formal interview.

The amount of structure that is brought to bear in the interview depends on the level of organization of ego functioning the client exhibits. In general, the client with the lesser degree of organization needs more structure in the interview to increase the amount of data obtained in a given time and to decrease anxiety.

The communication process involves feedback in that each message sent involves a response. This response affects the next message sent and its reaction. With practice, the examiner will settle in the communication mode that is most effective for the individual client. This is particularly important in the choice of the type of questions used to obtain the health history.

A common communication error that occurs in industrialized nations is that of thinking of the next remark, thereby not fully perceiving what is being said. This is a particular hazard for the student who is not yet fully comfortable with the interview pattern. Such an individual may perceive little of valuable data being given by the client, since that individual must concentrate on the format of questioning and on how best to word the next query.

Types of Questions

Multiple answer questions

Questions should be carefully designed to deal with one issue at a time. Questions should not demand two or more rejoinders, particularly conflicting answers.

Examples of questions to avoid are "Did you have measles, mumps, or whooping cough?" or "Did you have pain in your shoulder or in your chest?"

Open-ended questions

Although the interview is aimed at getting specific answers concerning the events surrounding the client's signs and symptoms, each point should be developed by the client in his or her own words. An open-ended question or suggestion is one aimed at eliciting a response that is more than one or two words long. This type of question is effective in stimulating descriptive or comparative responses. Observation of the client who is describing a symptom may give valuable information concerning attitudes and beliefs. In addition, it allows the client to provide information at a self-determined pace rather than feel forced to divulge information when sharing it may be troublesome. This description may also provide clues to the client's alertness, or level of mental abilities, and to the organization of ego functioning, revealed through the organization of thoughts and vocabulary. Furthermore, rapport is strengthened through the demonstration that the practitioner wants to invest time in hearing the client's thoughts. Examples of open-ended questions or suggestions are "How have you been feeling lately?" and "Tell me about your problem."

The disadvantage of this type of question is that it may result in responses that are not relevant to a specific point being assessed. The client may use the opportunity provided by an open-ended question to digress to avoid discussing relevant data because it is distressing. Although this technique might yield important information, there are times when the examiner needs data quickly and must sacrifice to get it. This is particularly true in emergency care. When the drug overdose victim rouses, the only piece of important data may be elicited by a closed question ("What did you take?")

Closed questions

The closed question is a type of inquiry that requires no more than a one- or two-word answer. This might be agreement or disagreement. The response may be a yes or no and may be answered nonverbally by a nod of the head. This is the kind of question most appropriate for eliciting age, sex, marital status, and other forced-choice responses. Examples of closed questions are "What did you eat for dinner last night?" and "What medication did you take?"

The educationally impoverished or those who lack culturally enriching experiences are often more comfortable with this type of question because they know what is expected. The open-ended question may pose anxiety to the client with poor articulation, who may fear that a display of lack of verbal skill will be a disadvantage with the practitioner. On the other hand, the closed question by its nature limits the amount of information that is obtained in the health history and may convey to the client that the practitioner is too busy or disinterested to listen. It has been observed that practitioners use more closed questions in initial interviews and when the process is stressful, as well as when time is limited.

Directive questions

Questions that lead the client to focus on one set of thoughts are called directive questions. This type of questioning is most often used in reviewing systems or in evaluating client functional levels. Although they are very effective for obtaining information, directive questions should be used with caution. If used in rapid succession, the client may feel rushed into giving information and may not develop a thought fully. The provider should allow the client time for reflection during the use of directive questions.

Leading questions

Questions that carry a suggestion of the kind of information that should be included in the response are called leading questions. The client is presented with an expectation by the practitioner. This kind of question may seriously limit the value of the health history. For example, the question "You haven't ever had venereal disease, have you?" implies that the possibility that the client *has had* venereal disease would be outside the limits of acceptability for the practitioner. The client who has experienced the disease may not say so to avoid disappointing the questioner.

The presence of emotionally charged words in a given question may make the question a biased one. For example, there is one in the question, "You haven't been masturbating, have you?" Since the Judeo-Christian ethic defines masturbating as "bad," bias has been inflicted. In this case the practitioner has suggested that the answer should be no. The client may well avoid all matters dealing with sexuality to avoid losing the practitioner's approval.

The practitioner must balance the goals of efficiency and effectiveness in the interviews. In obtaining a historical database, the practitioner asks the client many questions to obtain thorough, relevant information. However, a comprehensive interview is time-consuming, and practitioners often attempt to save time by asking closed questions. More information is gained by open-ended questions that may supply much relevant and extraneous data. Therefore, the interviewer must consider the relative importance of the interview questions in the gathering of the database to obtain the most useful information within a reasonable time.

Use of Silence

Periods of silence during the interview are helpful in making observations, such as: Is the client comfortable? Angry? Confused? Silence provides an opportunity to assess the level of anxiety in both the practitioner and the client. Also, the client is provided with sufficient time to carefully organize thoughts for a coherent explanation in response to questions. The rapid presentation of questions may not allow the client sufficient time for thought or reflection. Silence is also useful as an indicator of the amount of anxiety the client is experiencing. The client's silence may indicate absorbing thought, boredom, or grief. Silence by the practitioner usually encourages communication by the client.

Facilitation

Facilitation is the act that stimulates the client to continue talking, no matter what the topic. Silence may be facilitative, as are encouraging words such as "Go on", "Mm-hm", and "Yes, I see." The provider who uses facilitation effectively will convey a feeling of caring and empathy to the client.

Methods for Ensuring Understanding

The practitioner must use maneuvers to determine if both participants understand what has been said. A clear understanding of what the client is trying to say is essential to establishing an accurate database. The health history should not contain assumptions of what the client meant but a clear accounting of exactly what was said. Many techniques provide for encouragement of the client to expand on a description or to clarify the explanation that has been given. A workable example might be "Tell me more about it."

Use of a common language

The practitioner must carefully plan questions and give particular care in selecting the vocabulary to be used so that the client perceives the question in the same sense that it is intended by the practitioner. The practitioner is aided in processing the client's language and behavior for what is usual or "normal" by having an understanding of cultural and ethnic differences. Medical terminology or *jargon* should not be used excessively. When medical diagnoses are employed, the meaning should be explained to the client when the words are first used.

Use of jargon or terminology by the provider may serve to build barriers between the two participants. Indeed, the provider may purposely use these terms to avoid communication or to terminate conversations. This practice should be avoided.

If the client uses jargon or terminology, the provider must determine the client's understanding of the word(s). The provider and the client should then agree

on the use of the word(s). For example, many lay people use the terms coronary, heart attack, and angina interchangeably.

Planning the questions

The client is asked one question at a time. For the client to give the information needed for the health history, the questions must be phrased so that the client knows what kind of answers are expected. When the client's response is not appropriate, a reordering of the question or a more explicit choice of vocabulary may be indicated. It may be helpful to emphasize the key words in the question. In designing questions, one should avoid the use of ambiguous terms, medical language, or words with more than one meaning.

Use of an example

Comparison with a common experience, that is, a concrete happening, may help to clarify an abstract concept or hazy terminology. The practitioner may use an example as part of the questioning process when the meaning is not clear. For example, the practitioner may ask the client, "Was it as large as a cherry?"

Restatement

Restatement is the formulation of what the client has said in words that are more specific; it provides an opportunity to validate the practitioner's conception. The client is cued to give attention to the thought by phrases such as "Do you mean . . . ," "In other words . . . ," or "If I understand you correctly. . . ."

Reflection

Reflection means repeating a phrase or a sentence the client has just said. The suggestion to the client that the practitioner is still involved in that part of the communication may focus further attention or rumination on that thought. The strategy is aimed toward further elaboration in the form of the recall of facts or feelings that surrounded the circumstance. The technique should allow clarification or expansion of the information just given by the client. Examples are as follows:

Client: My mother has been drinking a fifth a day for 6 years. She's an alcoholic.

Interviewer response: You say your mother is an alcoholic?

Client: The spot on my arm is painful, you know.

Interviewer response: Painful?

Clarification

Questions designed to obtain information to more clearly understand conflicting, abstract, vague, or ambiguous statements are requests for clarification.

You say you felt depressed? Tell me what you mean.
You had constant headaches? Tell me what you remember about them.

Summary

Summary is a technique that allows for the condensation of facts into a well-ordered review. It is particularly useful following a rambling, detailed description. The summary further signals the client that this particular segment of the interview is terminating and suggests that further input is required immediately, since closure is imminent.

Confrontation

Telling clients something about themselves is known as confrontation. This may be a helpful technique to use when inconsistencies are noticed, for example, "When you tell me how painful your arm is, I notice that you are smiling. Why is this?" Confrontation may also be of use in helping the client to discuss emotions, for example, "You say you are not uncomfortable, but you are frowning and your muscles appear very tense." Confrontation is also used to seek further information when the client has presented unrealistic ideas.

Interpretation

The examiner may arrive at a conclusion from the data the client has given. Sharing the interpretation with the client allows the individual to confirm, deny, or offer an interpretation. Making an interpretation involves the risk of being wrong, and the examiner should be prepared to deal with this eventuality. The interpretation may also constitute an act of empathy or confrontation.

Filling in Omitted Data

Clinical impressions reached by the practitioner must be regarded as fluid because in further conversation with the client, new information may be provided. The client may withhold information through fear that sensitive information may be shared indiscriminately or through distrust of the practitioner. Furthermore, the client may regard certain facts as unimportant or irrelevant to the focus of the interview. In many instances when clients are so eager to comply with questions that they give a hurried accounting and leave out significant data. In ordering the data the practitioner may note that information is missing or that there are inconsistencies. Further interviews