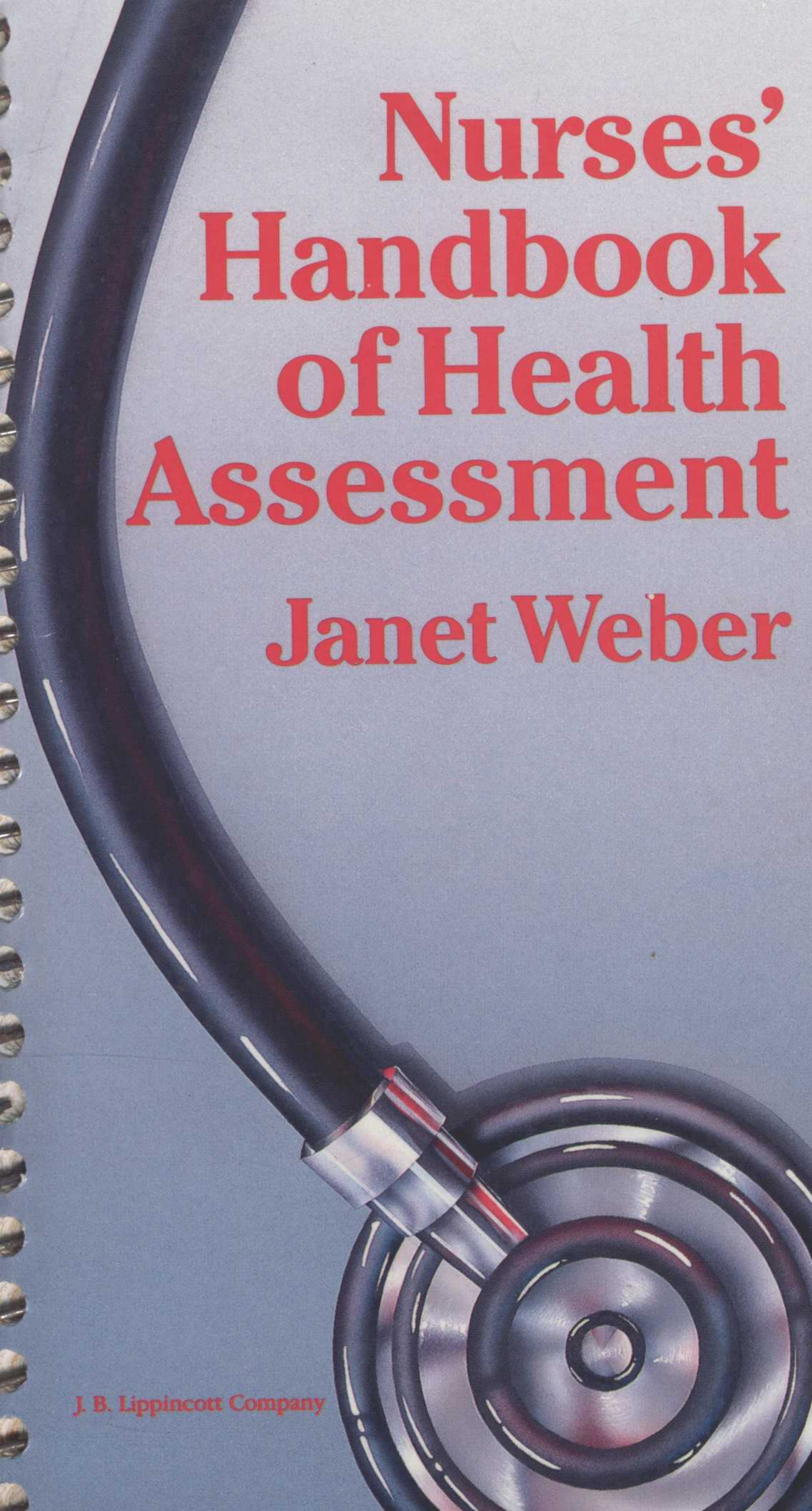
Nurses' Handbook of Health Assessment

Janet Weber



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Nurses' Handbook of
Health Assessment

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6 5

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Any procedure or practice described in this book should be applied by the health-care practitioner under appropriate supervision in accordance with professional standards of care used with regard to the unique circumstances that apply in each practice situation. Care has been taken to confirm the accuracy of information presented and to describe generally accepted practices. However, the authors, editors and publisher cannot accept any responsibility for errors or omissions or for consequences from application of the information in this book and make no warranty, express or implied, with respect to the contents of the book.

Every effort has been made to ensure drug selections and dosages are in accordance with current recommendations and practice. Because of ongoing research, changes in government regulations and the constant flow of information on drug therapy, reactions and interactions, the reader is cautioned to check the package insert for each drug for indications, dosages, warnings and precautions, particularly if the drug is new or infrequently used.

To Bill, my husband, and Joey, my son,
for all your encouragement and patience

To my parents for all your support

To my students for those special
insights you gave me

To the nursing staff at Southeast Missouri Hospital
for your encouragement

NOT FOR RESALE

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Preface

The purpose of *Nurses' Handbook of Health Assessment,* a pocket-size nursing history and physical assessment guide, is to provide the student or practicing nurse with a ready reference to assist with collection of subjective and objective client data. This handbook is not intended to contain detailed anatomy and physiology, or an in-depth explanation of how to do the health history and physical assessment. Many textbooks are available with specific in-depth information. Instead, this guide is intended to remind the student or nurse of information needed when assessing the client, including normal and abnormal findings. Illustrations are given to highlight parts of the physical assessment that are easily forgotten.

The guide is divided into 18 chapters. Chapter 1 gives an overview of the nursing history. Chapter 2 consists of guideline questions necessary to elicit subjective data for a complete nursing health history. The chapter begins with questions for a client profile and developmental history, followed by health history questions organized according to Gordon's 11 functional health patterns (Gordon, 1982). The reader is referred to specific physical assessment chapters for related objective data as appropriate. A list of associated nursing diagnostic categories that may be identified by client responses follows each section. The nursing diagnoses used are based on the North American Nursing Diagnoses Association's (NANDA's) accepted list of diagnostic categories. This functional health pattern format focuses the health history within the independent domain of professional nursing.

Chapter 3 consists of guidelines for performing the physical assessment. This is followed by 15 chapters consisting of procedures for assessment of each body system. Focus questions specific to assessment of each body system are found at the beginning of each of these chapters.

The nurse must be aware of signs and symptoms appropriate to each body system in order to collaborate with the physician in monitoring the client's health status. A list of associated collaborative problems follows each of the physical assessment chapters. Each physical assessment chapter contains pediatric variations, geriatric variations, and teaching tips for selected nursing diagnoses and collaborative problems that may be incorporated into the physical assessment. Chapter 18 explains maternal health assessment, a normal variation.

In the appendices at the end of the guide are tables and charts

containing common laboratory values, developmental norms, growth charts, immunization tables, recommended dietary allowances, sample history and physical assessment, height and weight charts, and an eye chart.

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Contents

1. The Nursing Health History

馆藏专用章

Definition and Purpose

A nursing health history is the systematic collection of subjective data (stated by the client) and objective data (observed by the examiner) used to determine the client's health status or human response in relation to developmental, psychological, physiological, sociocultural, and spiritual life processes (Carpenito, 1987). This data assists the nurse in identifying nursing diagnoses and collaborative health problems. A *nursing diagnosis* is a statement that describes an actual or potential altered human response of a client to life processes. Such a nursing diagnosis can be legally identified and primarily treated by the nurse (Carpenito, 1987). A *collaborative problem* is a client problem that the nurse responds to in collabo-

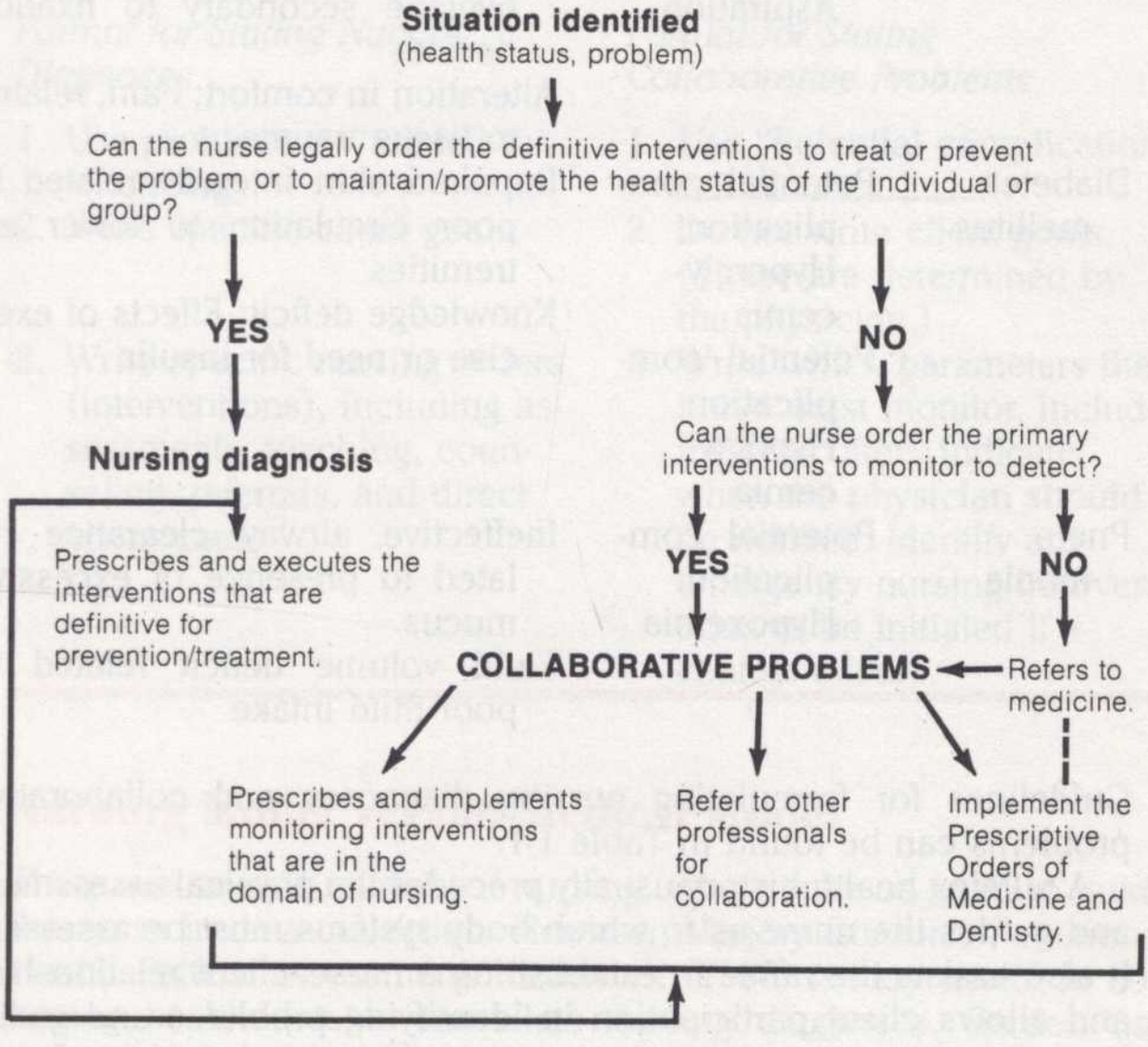

Figure 1-1. Dimensions of professional nursing: A bifocal framework. (Copyright © 1985 by Lynda Juall Carpenito)

ration with other health care professionals. A collaborative problem requires nursing assessment and monitoring, but primary orders to treat the problem must be provided by a physician. Collaborative problems are equivalent in importance to nursing diagnoses, but represent the interdependent or collaborative role of nursing, whereas nursing diagnoses represent the independent role of the nurse (Carpenito, 1987). Figure 1-1 illustrates the decision-making process involved in distinguishing a nursing diagnosis from a collaborative health problem. The nurse can use this model to decide whether the identified problem can be treated independently as a nursing diagnosis, or whether the nurse can only monitor the problem as a collaborative problem. If the nurse can neither treat nor monitor, the problem is probably a medical diagnosis. The difference between a medical diagnosis, a collaborative problem, and a nursing diagnosis is explained with the following examples:

Medical Diagnosis	*Collaborative Problem*	*Nursing Diagnoses*
Fractured jaw	Potential complication: Aspiration	Alteration in oral mucous membrane related to difficulty with hygiene secondary to fixation devices Alteration in comfort: Pain, related to tissue trauma
Diabetes mellitus	Potential complication: Hyperglycemia Potential complication: Hypoglycemia	Impaired skin integrity related to poor circulation to lower extremities Knowledge deficit: Effects of exercise or need for insulin
Pneumonia	Potential complication: Hypoxemia	Ineffective airway clearance related to presence of excessive mucus Fluid volume deficit related to poor fluid intake

Guidelines for formulating nursing diagnoses and collaborative problems can be found in Table 1-1.

A nursing health history usually precedes the physical assessment and guides the nurse as to which body systems must be assessed. It also assists the nurse in establishing a nurse–client relationship, and allows client participation in identifying problems and goals. The primary source of data is the client. Valuable information may also be obtained from the family, other health team members, and the client record.

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Table 1-1. Comparison of Nursing Diagnoses and Collaborative Problems

Identifying Criteria of a Nursing Diagnosis	*Identifying Criteria of a Collaborative Problem*
1. The client problem is physiological, psychosocial, or spiritual.	1. The client problem is usually physiological.
2. The nurse monitors and treats.	2. The nurse monitors the problem and notifies the physician if a change occurs. (In some cases the nurse may initiate emergency interventions.)
3. The nurse independently orders and implements the primary nursing interventions.	3. The physician orders the primary treatment and the nurse collaborates to implement those treatments he or she is licensed to implement.
Format for Stating Nursing Diagnoses	*Format for Stating Collaborative Problems*
1. Use problem + "related to" + etiology.	1. Use "Potential complication: _____."
2. Write specific client goals.	2. Do not write client goals. (These are determined by the physician.)
3. Write specific nursing orders (interventions), including assessments, teaching, counseling, referrals, and direct client care.	3. Write which parameters the nurse must monitor, including how often. Indicate when the physician should be notified. Identify any emergency nursing interventions to be initiated if a change occurs.

Nursing Model versus Medical Model

There are several models of nursing, which may be used to guide the nurse in data collection. However, Marjory Gordon's Functional Health Pattern assessment framework (1987) is very useful in collecting health data to formulate nursing diagnoses. Gordon has defined 11 functional health patterns that provide for a holistic client data base. A pattern is a sequence of related behaviors that assists the nurse in collecting and categorizing data. These 11 functional

health patterns can be used for nursing assessment in all practice areas for clients of all ages, and in the assessment of families and communities. For the purpose of this handbook, assessment is focused on the individual. The North American Nursing Diagnoses Association (NANDA) list of accepted nursing diagnoses has been grouped according to the appropriate functional health patterns. These diagnoses are listed at the end of each of the functional health pattern sections in Chapter 2. Following is a brief overview of the subjective and objective assessment focus for each functional health pattern.*

1. Health Perception–Health Management Pattern
   Subjective data: Perception of health status and health practices used by client to maintain health
   Objective data: Appearance, grooming, posture, expression, vital signs, height, weight
2. Nutrition–Metabolic Pattern
   Subjective data: Dietary habits, including food and fluid intake
   Objective data: General physical survey, including examination of skin, mouth, abdomen, and cranial nerves (CN V, IX, X, and XII)
3. Elimination Pattern
   Subjective data: Regularity and control of bowel, and bladder habits
   Objective data: Skin examination, rectal examination
4. Activity–Exercise Pattern
   Subjective data: Activities of daily living that require expenditure of energy
   Objective data: Examination of musculoskeletal system including gait, posture, range of motion (ROM) of joints, muscle tone, and strength; cardiovascular examination, peripheral vascular examination, and thoracic examination
5. Sexuality–Reproduction Pattern
   Subjective data: Sexual identity, activities, and relationships; expression of sexuality and level of satisfaction with sexual patterns; reproduction patterns
   Objective data: Male and female genitalia examination, breast examination
6. Sleep–Rest Pattern
   Subjective data: Perception of effectiveness of sleep and rest habits
   Objective data: Appearance and attention span
7. Cognitive–Perceptual Pattern
   For the purpose of this handbook the cognitive–perceptual pattern has been divided into two parts: (a) the sensory–perceptual pattern, to include the senses of hearing, vision, smell, taste,

* Adapted from Gordon M. Nursing Diagnosis: Process and Application, 2nd ed. New York, McGraw-Hill, 1987.

and touch, and (b) the cognitive pattern, to include knowledge, thought perception, and language.

a. Sensory–Perceptual Pattern
   Subjective data: Perception of ability to hear, see, smell, taste, and feel (including light touch, pain, and vibratory sensation)
   Objective data: Visual and hearing examinations, pain perception, cranial nerve examination; testing for taste, smell, and touch
b. Cognitive Pattern
   Subjective data: Perception of messages, decision-making, thought processes
   Objective data: Mental status examination

8. Role–Relationship Pattern
   Subjective data: Perception and level of satisfaction with family, work, and social roles
   Objective data: Communication with significant others, and visits from significant others and family; family genogram
9. Self-Perception–Self-Concept Pattern
   Subjective data: Perception of self-worth, personal identity, feelings
   Objective data: Body posture, movement, eye contact, voice and speech pattern, emotions, moods, and thought content
10. Coping–Stress Tolerance Pattern
    Subjective data: Perception of stressful life events and ability to cope
    Objective data: Behavior, thought processes
11. Value–Belief Pattern
    Subjective data: Perception of what is good, correct, proper, and meaningful; philosophical beliefs; values and beliefs that guide choices
    Objective data: Presence of religious articles, religious actions/routines, and visits from clergy

Using a nursing functional pattern framework assists the nurse with collecting data necessary to identify and validate nursing diagnoses. This approach eliminates repetition of medical data already obtained by physicians and other members of the health care team. The medical systems history model (biographical data, chief complaint, present health history, past health history, family history, psychosocial history, and review of systems) is more useful for the physician in making medical diagnoses. Patients often complain that the same information is asked by both nurses and physicians. A nursing history, based on functional health patterns, will help eliminate this problem by assisting the nurse to assess client responses associated with nursing diagnoses and collaborative problems.

It is important for the nurse to assess each of the functional health patterns with clients because alterations in health can affect func-

tioning in any of these areas, and alterations in functional health patterns can in turn affect health. See Appendix I for a sample nursing assessment form based on functional health patterns.

Guidelines for Obtaining a Nursing Health History

Professional interpersonal and interviewing skills are necessary to obtain a valid nursing health history. The nursing interview is a communication process that focuses on the client's developmental, psychological, physiological, sociocultural, and spiritual responses that can be treated with nursing and collaborative interventions. The nursing interview has three basic phases; these phases are briefly explained below by describing the roles of the nurse and the client during each phase.

1. Introductory Phase
   The nurse introduces self and explains the purpose of the interview to the client. An explanation of note-taking, confidentiality, and type of questions to be asked should be given. Comfort, privacy, and confidentiality are provided.
2. Working Phase
   The nurse facilitates the client's comments about major biographical data, reason for seeking health care, and functional health pattern responses. The nurse must listen and observe cues in addition to using critical thinking skills to interpret and validate information received from the client. The nurse and client collaborate to identify client problems and goals. The approach used for facilitation may be either free-flowing or more structured with specific questions, depending on time available and the type of data needed.
3. Summary and Closure Phase
   The nurse summarizes information obtained during the working phase and validates problems and goals with the client. Possible plans to resolve the problems (nursing diagnoses and collaborative problems) are identified and discussed with the client.

There are specific communication techniques used to facilitate the interview. Following are some specific guidelines for phrasing statements and questions to promote an effective and productive interview.

1. Types of Questions to Use
   a. Use open-ended questions to elicit the client's feelings and perceptions. These questions begin with "what," "how," or "which," because they require more than a one-word response.
   b. Use closed-ended questions to obtain facts and to zero in on specific information. The client can respond with one or two words. These questions begin with "how," "when," or "did"; they help to avoid rambling by the client.

   c. Use a "laundry list" (scrambled words) approach to obtain specific answers. For example, "Is pain severe, dull, sharp, mild, cutting, piercing? Does pain occur once every year, day, month, hour?" This reduces the likelihood of the client's perceiving and providing an expected answer.
   d. Explore all data that deviates from normal with the following questions: What alleviates or aggravates the problem? How long has it occurred? How severe is it? Does it radiate? When does it occur? Is its onset gradual or sudden?
2. Types of Statements to Use
   a. Rephrase or repeat your perception of client's response in order to reflect or clarify information shared. For example, "You feel you have a serious illness?"
   b. Encourage verbalization of client by "um hum," "yes," "I agree," or nodding.
   c. Describe what you observe in the client. For example, "It seems you have difficulty on the right side."
3. Additional Helpful Hints
   a. Accept the client; display a nonjudgmental attitude.
   b. Use silence to help the client and yourself reflect and reorganize thoughts.
   c. Provide the client with information during the interview as questions and concerns arise.
4. Communication Styles to Avoid
   a. Excessive or not enough eye contact (varies with cultures).
   b. Doing other things while getting the history, and being mentally distant or physically far away from client (more than 2–3 ft).
   c. Biased or leading questions; for example, "You don't feel bad, do you?"
   d. Relying on memory to recall all the information, or recording all the details.
   e. Rushing the patient.
   f. Reading questions from the history form, distracting attention from the client.
5. Specific Age Variations
   a. Interviewing the pediatric client: Birth–early adolescence (through age 14). All information from the history should be validated for reliability with the responsible significant other (*i.e.*, parent, grandparent).
   b. Interviewing the geriatric patient
      (1) Use simple, straightforward questions in lay terms.
      (2) Establish and maintain privacy (especially important).
      (3) Assess hearing acuity; with loss, speak slowly, face the client, and speak on the side on which hearing is the most adequate.
      (4) *Remember:* Age affects and often slows all body systems within an individual to varying degrees.

2. Components of the Nursing Health History

Following are the components of a nursing health history incorporating a functional health pattern approach (Gordon, 1987). Prior to data collection for each functional health pattern, a client profile and developmental history are obtained.

1. Client Profile
2. Developmental History
3. Health Perception–Health Management Pattern
4. Nutritional–Metabolic Pattern
5. Elimination Pattern
6. Activity–Exercise Pattern
7. Sexuality–Reproduction Pattern
8. Sleep–Rest Pattern
9. Sensory–Perceptual Pattern
10. Cognitive Pattern
11. Role–Relationship Pattern
12. Self-Perception–Self-Concept Pattern
13. Coping–Stress Tolerance Pattern
14. Value–Belief Pattern

The purpose of each nursing health history component will be explained, followed by guideline statements and questions to elicit subjective data from the client. Guideline questions should be preceded by open-ended statements to encourage the client to verbalize freely. Then specific questions are asked to obtain specific information. It is important to remember that not every question will apply to every client. Common sense and professional judgment must be used to determine which questions are a priority and are appropriate for each individual client.

Certain factors such as comfort level, level of anxiety, age, and current health status influence the client's ability to fully participate in the interview and must be considered. The guideline questions are guidelines only and should be altered to meet the individual client's needs and the examiner's purpose in each interview. When appropriate, an objective data outline follows the subjective data questions and refers the examiner to the section where the specific examination technique, normal findings, and deviations from nor-

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