Assessment

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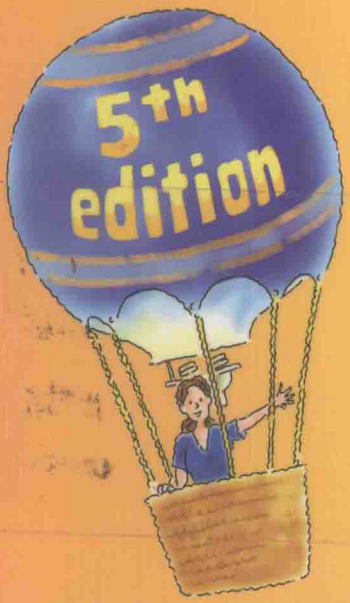

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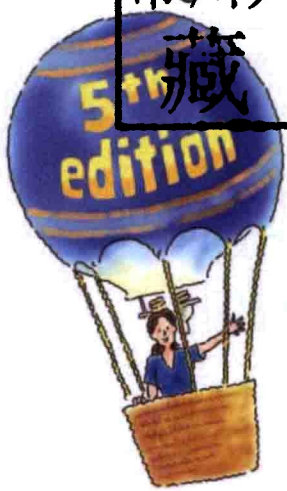

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Not another boring foreword

If you're like me, you're too busy to wade through a foreword that uses pretentious terms and umpteen dull paragraphs to get to the point. So let's cut right to the chase! Here's why this book is so terrific:

- It will teach you all the important things you need to know about assessment. (And it will leave out all the fluff that wastes your time.)
- It will help you remember what you've learned.
- It will make you smile as it enhances your knowledge and skills.

Don't believe me? Try these recurring logos on for size:

Peak technique illustrates and describes the best ways to perform specific physical examination techniques.

Bridging the gap explains cultural variables that may influence the health assessment.

Handle with care pinpoints age-related variations in assessment findings.

Interpretation station provides surefire guidelines for interpreting assessment findings quickly and easily.

Memory jogger helps the reader remember important points.

Just for fun—provides quick-study information in a gamelike format.

See? I told you! And that's not all. Look for me and my friends in the margins throughout this book. We'll be there to explain key concepts, provide important care reminders, and offer reassurance. Oh, and if you don't mind, we'll be spicing up the

pages with a bit of humor along the way, to teach and entertain in a way that no other resource can.

I hope you find this book helpful. Best of luck throughout your career!

Joy

Contents

Part I Beginning the assessment

1

Health history

Just the facts

In this chapter, you'll learn:

- reasons for performing a health history
- techniques for communicating effectively during a health history assessment
- essential steps in a complete health history
- questions specific to each step of a health history.

A look at the health history

Knowing how to complete an accurate and thorough assessment—from taking the health history to performing the physical examination—can help you uncover significant problems and develop an appropriate care plan.

Any assessment involves collecting two kinds of data: objective and subjective. *Objective data* are obtained through observation and are verifiable. For instance, a red, swollen arm in a patient who's complaining of arm pain is an example of data that can be seen and verified by someone other than the patient. *Subjective data* can't be verified by anyone other than the patient; they're gathered solely from the patient's own account—for example, "My head hurts" or "I have trouble sleeping at night."

Here's a way to remember the two types of data: you "observe" objective data, whereas only the "subject" provides subjective data.

Exploring past and present

You'll use a health history to gather subjective data about the patient and explore past and current problems. To begin, ask the patient about his general physical and emotional health; then ask him about specific body systems and structures.

Skills for getting the scoop

Keep in mind that the accuracy and completeness of your patient's answers largely depend on your skill as an interviewer. Therefore,

before you start asking questions, review the following communication guidelines.

Beginning the interview

To get the most out of your patient interview, before you begin, you'll need to create an environment in which the patient feels comfortable. During the interview, you'll want to use various communication strategies to make sure you communicate effectively.

Create the proper environment

Before asking your first question, try to establish a rapport with the patient and explain what you'll cover during the interview. Consider the following guidelines when selecting a location for the interview.

Settling in

- Choose a quiet, private, well-lit interview setting. Such a setting makes it easier for you and your patient to interact and helps the patient feel more at ease.
- Make sure that the patient is comfortable. Sit facing him, 3′ to 4′ (1 to 1.5 m) away.
- Introduce yourself and explain that the purpose of the health history and assessment is to identify key problems and gather information to aid in planning care.
- Reassure the patient that everything he says will be kept confidential.
- Tell the patient how long the interview will last and ask him what he expects from the interview.
- Use touch sparingly. Many people aren't comfortable with strangers hugging, patting, or touching them.

Take a moment to set the stage. A supportive, encouraging approach will make your patient much more forthcoming and will enable you to provide optimal care.

Watch what you say

- Assess the patient to see if language barriers exist. For example, does he speak and understand English? Can he hear you? (See *Overcoming interview obstacles.*)
- Speak slowly and clearly, using easy-to-understand language. Avoid using medical terms and jargon.
- Address the patient by a formal name such as "Mr. Jones." Don't call him by his first name unless he asks you to. Avoid using terms of endearment, such as "honey" or "sweetie." Treating the patient with respect encourages him to trust you and provide more accurate and complete information.

Bridging the gap

Overcoming interview obstacles

With a little creativity, you can overcome barriers to interviewing. For example, if a patient doesn't speak English, your facility may have a list of interpreters you can call on for help. A trained medical interpreter—one who's familiar with medical terminology, knows interpreting techniques, and understands the patient's rights—would be ideal. Be sure to tell the interpreter to translate the patient's speech verbatim.

Avoid using one of the patient's family members or friends as an interpreter. Doing so violates the patient's right to confidentiality.

Breaking the sound barrier

Is your patient hearing impaired? You can overcome this barrier, too. First, make sure the light is bright enough for him to see your lips move. Then face him and speak slowly and clearly but not loudly. If necessary, have the patient use an assistive device, such as a hearing aid or an amplifier. You can also write your questions on paper and have the patient answer by either speaking or writing back. If the patient uses sign language, see if your facility has a sign-language interpreter.

Communicate effectively

Realize that you and the patient communicate nonverbally as well as verbally. Being aware of these forms of communication will aid you in the interview process.

Nonverbal communication strategies

To make the most of nonverbal communication, follow these guidelines:

- Listen attentively and make eye contact frequently. (See *Overcoming cultural barriers.*)
- Use reassuring gestures, such as nodding your head, to encourage the patient to keep talking.
- Watch for nonverbal clues that indicate the patient is uncomfortable or unsure about how to answer a question. For example, he might lower his voice or glance around uneasily.
- Be aware of your own nonverbal behaviors that might cause the patient to stop talking or become defensive. For example, if you cross your arms, you might appear closed off from him. If you stand while he's sitting, you might appear superior. If you glance at your watch, you might appear to be bored or rushed, which could keep the patient from answering questions completely.
- Observe the patient closely to see if he understands each question. If he doesn't appear to understand, repeat the question using

Bridging the gap

Overcoming cultural barriers

To maintain a good relationship with your patient, remember that his behaviors and beliefs may differ from your own because of his cultural background. For example, most people in the United States make eye contact when talking with others. However, people from different cultural backgrounds—including Native Americans, Asians, and people from Arabic-speaking countries—may find eye contact disrespectful or aggressive. Be aware of these differences and respond appropriately.

different words or familiar examples. For instance, instead of asking, "Do you have respiratory difficulty after exercising?" ask, "Do you have to sit down after walking around the block?"

Verbal communication strategies

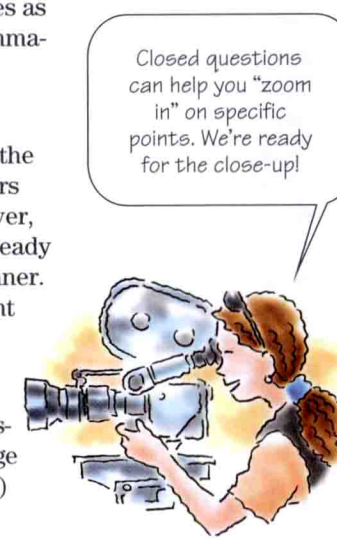
Verbal communication strategies range from alternating between open-ended and closed questions to employing such techniques as silence, facilitation, confirmation, reflection, clarification, summarization, and conclusion.

An open...

Asking open-ended questions such as "How did you fall?" lets the patient respond more freely. His response may provide answers to many other questions. For instance, from the patient's answer, you might learn that he has previously fallen, that he was unsteady on his feet before he fell, and that he fell just before eating dinner. Armed with this information, you might deduce that the patient had a syncopal episode caused by hypoglycemia.

...and shut case

You may also choose to ask closed questions. Although these questions are unlikely to provide extra information, they may encourage the patient to give clear, concise feedback. (See *Two ways to ask.*)



Peak technique

Two ways to ask

You can ask your patient two types of questions: open-ended and closed.

Open-ended questions

Open-ended questions prompt the patient to express feelings, opinions, and ideas. They also help you gather more information than closed questions do. Open-ended questions facilitate nurse-patient rapport because they show that you're interested in what the patient has to say. Examples of such questions include:

- What caused you to come to the hospital tonight?
- How would you describe the problems you're having with your breathing?
- What lung problems, if any, do other members of your family have?

Closed questions

Closed questions elicit yes-or-no answers or one- to two-word responses. They limit the development of nurse-patient rapport. Closed questions can help you "zoom in" on specific points, but they don't provide the patient the opportunity to elaborate. Examples of closed questions include:

- Do you ever get short of breath?
- Are you the only one in your family with lung problems?

Silence is golden

Another communication technique is to allow moments of *silence* during the interview. Besides encouraging the patient to continue talking, silence gives you a chance to assess his ability to organize thoughts. You may find this technique difficult (most people are uncomfortable with silence), but the more often you use it, the more comfortable you'll become.

Give 'em a boost

Using such phrases as "please continue," "go on," and even "uh-huh" encourages the patient to continue with his story. Known as *facilitation*, this communication technique shows the patient that you're interested in what he's saying.

Confirmation conversation

Confirmation helps ensure that you and the patient are on the same track. For example, you might say, "If I understand you correctly, you said..." and then repeat the information the patient gave. This communication technique helps to clear misconceptions that you or the patient might have.

Check and reflect

Try using *reflection* (repeating something the patient has just said) to help you obtain more-specific information. For example, a patient with a stomachache might say, "I know I have an ulcer." If so, you can repeat the statement as a question, "You know you have an ulcer?" Then the patient might say, "Yes. I had one before and the pain is the same."

Use reflection—repeating something the patient has just said—to obtain more-specific information.

Clear skies

When information is vague or confusing, use the communication technique of *clarification*. For example, if your patient says, "I can't stand this," you might respond, "What can't you stand?" or "What do you mean by 'I can't stand this'?" Doing so gives the patient an opportunity to explain his statement.

Put the landing gear down...

Get in the habit of summarizing the information the patient gave you. Known as *summarization*, this communication technique ensures that the data you've collected are accurate and complete. Summarization also signals that the interview is about to end.

...and come in for a safe landing

Signal the patient when you're ready to end the interview. Known as *conclusion*, this signal gives him the opportunity to gather his thoughts and make any pertinent final statements. You can do this

by saying, "I think I have all the information I need now. Is there anything you would like to add?"

Reviewing general health

You've just learned how to ask questions. Now it's time to learn the right questions to ask when reviewing the patient's general physical and emotional health. Also, remember to maintain a professional attitude throughout this process.

Asking the right questions

A complete health history requires information from each of the following categories, optimally obtained in this order:

- biographic data
- chief complaint
- medical history (past and current)
- family history
- psychosocial history
- activities of daily living.

Many facilities have a health history form or computer program that prompts the interviewer to gather specific required information. (See *Components of a complete health history.*)

Memory jogger

To remember the categories you should cover in your health history, think: **B**eing **C**omplete **M**akes **F**or **P**roper **A**ssessment:

- **B**iographic data
- **C**hief complaint
- **M**edical history
- **F**amily history
- **P**sychosocial history
- **A**ctivities of daily living.

Biographic data

Start the health history by obtaining biographic information from the patient. Do this first so you don't forget to gather this information after you become involved in details of the patient's health. Ask the patient for his name, address, telephone number, birth date, age, marital status, religion, and nationality. Find out with whom he lives and get the name and telephone number of a person to contact in case of an emergency.

Also, ask the patient about his health care, including who his primary doctor is and how he gets to the doctor's office. Ask if he has ever been treated for his current problem and, if so, when he received treatment. Finally, ask if he has an advance directive in place. If he does, request a copy to place in his chart. (See *Advance directives*, page 10.)

Components of a complete health history

You can use this health history form as a guide when gathering a patient's health history information.

BIOGRAPHICAL DATA

Name _____
Address _____
Date of birth _____
Advance directive explained: ☐ Yes ☐ No
Living will on chart: ☐ Yes ☐ No

Name and phone of two people to call if necessary:
NAME RELATIONSHIP PHONE #

CHIEF COMPLAINT

History of present illness

CURRENT MEDICATIONS

DRUG AND DOSE FREQUENCY LAST DOSE

MEDICAL HISTORY

Allergies

☐ Tape ☐ Iodine ☐ Latex ☐ No known allergies
☐ M Drug: _____
☐ Food: _____
☐ Environmental: _____
☐ Blood reaction: _____
☐ Other: _____

Childhood illnesses

DATE

Previous hospitalizations

(Illness, accident or injury, surgery, blood transfusion) DATE

Health problems

	Yes	No		Yes	No
Arthritis	☐	☐	Hypertension	☐	☐
Blood problem (anemia, sickle cell, clotting, bleeding)	☐	☐	Kidney problem	☐	☐
Cancer	☐	☐	Liver problem	☐	☐
Diabetes mellitus	☐	☐	Lung problem (asthma, bronchitis, emphysema, pneumonia, TB, shortness of breath)	☐	☐
Eye problem (cataracts, glaucoma)	☐	☐	Stroke	☐	☐
Heart disease (heart failure, MI, valve disease)	☐	☐	Thyroid problem	☐	☐
Hiatal hernia	☐	☐	Ulcers (duodenal, peptic)	☐	☐
HIV/AIDS	☐	☐	Psychological disorder	☐	☐

Be sure to include prescription drugs, over-the-counter drugs, herbal preparations, and vitamins and supplements.

Obstetric history (females)

Last menstrual period _____
Gravida _____ Para _____
Menopause ☐ Yes ☐ No

Psychosocial history

Coping strategies _____
Feelings of safety _____

Ask about the patient's feelings of safety to help identify physical, psychological, emotional, and sexual abuse issues.

Social history

Smoker ☐ No ☐ Yes (# packs/day_____ # years_____)
Alcohol ☐ No ☐ Yes (type _____ amount/day_____)
Illicit drug use ☐ No ☐ Yes (type _____)

Religious and cultural observations

Activities of daily living

Diet and exercise regimen _____
Elimination patterns _____
Sleep patterns _____
Work and leisure activities _____
Use of safety measures (seat belt, bike helmet, sunscreen) _____

Ask about the patient's family medical history, including history of diabetes or heart disease.

Health maintenance history DATE

Colonoscopy _____
Dental examination _____
Eye examination _____
Immunizations _____
Mammography _____

FAMILY MEDICAL HISTORY

	Yes	No	Who (parent, grandparent, sibling)
Arthritis	☐	☐	
Cancer	☐	☐	
Diabetes mellitus	☐	☐	
Heart disease (heart failure, MI, valve disease)	☐	☐	
Hypertension	☐	☐	
Stroke	☐	☐	

Handle with care

Advance directives

The Patient Self-Determination Act allows patients to prepare advance directives—written documents that state their wishes regarding health care in the event they become incapacitated or unable to make decisions. Elderly patients in particular may have interest in advance directives because they tend to be concerned with end-of-life issues.

Direction for directives

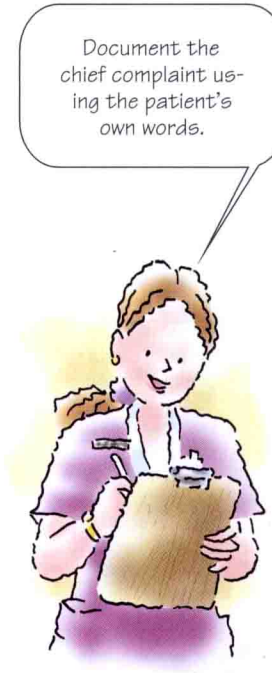
If a patient doesn't have an advance directive in place, the health care facility must provide him with information about it, including how to establish one.

An advance directive may include:

- power of attorney for health care that authorizes a specific person to make medical decisions if the patient can no longer do so
- specific medical treatment the patient wants or doesn't want
- instructions regarding pain medication and comfort—specifically, whether the patient wishes to receive certain treatment even if the treatment may hasten his death
- information the patient wants to relay to his loved ones
- name of the patient's primary health care provider
- any other wishes.

Take a hint

Your patient's answers to basic questions can provide important clues about his personality, medical problems, and reliability. If he can't furnish accurate information, ask him for the name of a friend or relative who can. Document the source of the information and whether an interpreter was used to obtain the information.



Chief complaint

Try to pinpoint why the patient is seeking health care, or his *chief complaint*. Document this information in the patient's exact words to avoid misinterpretation. Ask how and when the symptoms developed, what led the patient to seek medical attention, and how the problem has affected his life and ability to function.

Alphabet soup

To ensure that you don't omit pertinent data, use the PQRSTU mnemonic device, which provides a systematic approach to obtaining information. (See *PQRSTU: What's the story?*)

Medical history

Ask the patient about past and current medical problems, such as hypertension, diabetes, and back pain. Typical questions include:

- Have you ever been hospitalized? If so, when and why?
- What childhood illnesses did you have?