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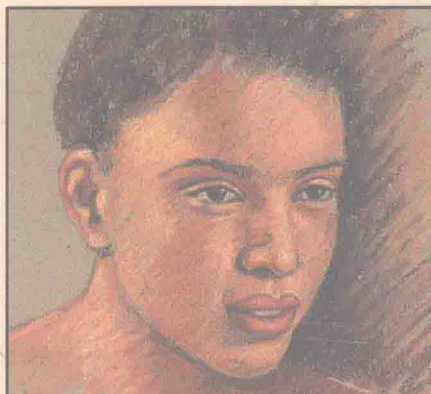
NURSING DIAGNOSIS REFERENCE MANUAL

THIRD EDITION

An indispensable guide
to better patient care

Sheila M. Sparks, RN, DNSc, CS

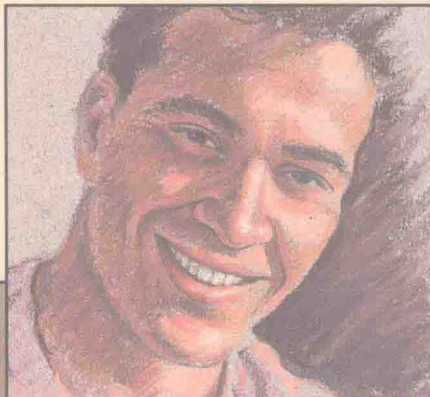
Cynthia M. Taylor, RN, MS, CS, CNAA



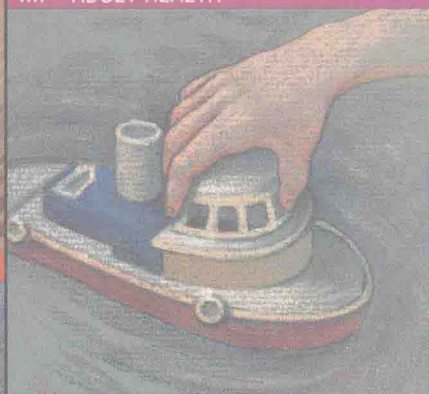
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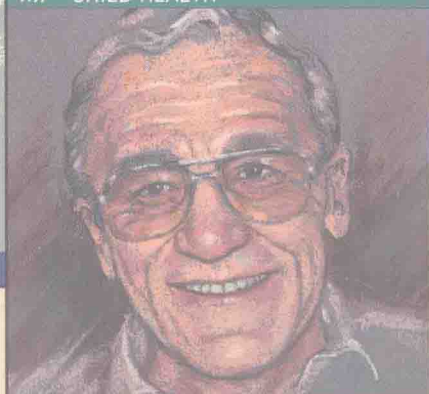
/// MATERNAL-NEONATAL HEALTH



/// ADULT HEALTH



/// CHILD HEALTH



/// GERIATRIC HEALTH

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NURSING DIAGNOSIS REFERENCE MANUAL

THIRD EDITION

Sheila M. Sparks, RN, DNSc, CS

Assistant Professor, School of Nursing
Georgetown University
Washington, D.C.

Cynthia M. Taylor, RN, MS, CS, CNAA

Independent Nurse Consultant
former Chief Operating Officer
Suburban Hospital
Bethesda, Md.

Springhouse Corporation
Springhouse, Pennsylvania

STAFF

Executive Director, Editorial

Stanley Loeb

Senior Publisher

Matthew Cahill

Art Director

John Hubbard

Senior Editor

Michael Shaw

Editors

Judd Howard, Richard Koreto

Copy Editors

Cynthia C. Breuninger (manager),
Lewis Adams, Lynette High, Doris
Weinstock

Designers

Stephanie Peters (associate art
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Facciolo (cover illustration), Laurie
Mirijanian

Typography

Diane Paluba (manager), Elizabeth
Bergman, Joyce Rossi Biletz, Phyllis
Marron, Robin Mayer, Valerie
Rosenberger

Manufacturing

Deborah Meiris (director), Pat
Dorshaw (manager), Anna Brindisi,
T.A. Landis

Production Coordination

Patricia McCloskey

Editorial Assistants

Maree DeRosa, Beverly Lane, Mary
Madden

Indexer

Janet Hodgson

The clinical procedures described and recommended in this publication are based on research and consultation with medical and nursing authorities. To the best of our knowledge, these procedures reflect currently accepted clinical practice; nevertheless, they can't be considered absolute and universal recommendations. For individual application, treatment recommendations must be considered in light of the patient's clinical condition and, before administration of new or infrequently used drugs, in light of latest package-insert information. The authors and the publisher disclaim responsibility for any adverse effects resulting directly or indirectly from the suggested procedures, from any undetected errors, or from the reader's misunderstanding of the text.


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CONTRIBUTORS

SECTION EDITORS

Adult Health

Sheila M. Sparks, RN, DNSc, CS,
Assistant Professor, School of Nursing,
Georgetown University, Washington, D.C.

Janyce G. Dyer, RN, DNSc, CS,
Assistant Professor, School of Nursing,
University of Pittsburgh

Child Health

Carole Logan Kuhns, RN, MS, Assistant
Professor, School of Nursing, Georgetown
University, Washington, D.C.

Maternal-Neonatal Health

Lynne Hutnik Conrad, RN, C, MSN,
Perinatal Clinical Nurse Specialist, Albert
Einstein Medical Center, Philadelphia

Geriatric Health

Marjorie A. Maddox, RN, EdD, CANP,
Associate Professor, School of Nursing,
University of Louisville

CONTRIBUTORS

Rosemary G. Ambroseo, RN, BSN,
Perinatal Nurse Specialist, Albert Einstein
Medical Center, Philadelphia

Patricia Anasiewicz, RN, MSN, Clinical
Nurse Specialist, Sacred Heart Hospital,
Norristown, Pa.

Billie Dixon Barringer, RN, BSN, MA,
Associate Professor, Northeast Louisiana
University, Monroe, La.

Barbara Walsh Clark, RN, MSN,
Professor of Nursing, Midway (Ky.)
College

Christine B. Clark, RN, BSN, Head
Nurse, MICU/CCU, Veterans Affairs
Medical Center, Atlanta

Linda Carman Copel, RN, C, PhD,
Assistant Professor, Villanova (Pa.)
University

Mary Coyle-Green, RN, MSN, ARNP,
Consultant, Southeastern Pain Clinic,
Jacksonville, Fla.

Susan B. Dickey, RN, C, MSN, Assistant
Professor, Temple University, Philadelphia

Jennifer Dooling, RN, Independent Nurse
Consultant, Columbia, Mo.

Louama K. Driscoll, RN, MSN,
Associate Chief, Nursing Service for
Education, Veterans Affairs Medical
Center, Ft. Lyon, Colo.

Teresa Eberhardt, RN, MS, Clinical
Nurse Specialist, Francis Scott Key
Medical Center, Baltimore

Nancy Endler, RN, MSN, Mental Health
Nurse Specialist, Suburban Hospital,
Bethesda, Md.

Susan Fitzgerald, RN, MBA, MS,
Administrative Director, Cardiovascular
Services, Suburban Hospital, Bethesda,
Md.

Denise M. Fitzpatrick, RN, C, MSN,
Perinatal Clinical Specialist-Educator,
Holy Family College, Philadelphia

Laurel S. Garzon, RN, DNSc, PNP,
Assistant Professor, School of Nursing,
Old Dominion University, Norfolk, Va.

Pauline McKinney Green, RN, MSN,
Assistant Professor, Howard University
College of Nursing, Washington, D.C.

Kathleen J. Gutierrez, RN, PhD, CS,
Associate Professor, Department of
Nursing, Regis University, Denver

Betty Glenn Harris, RN, PhD, Assistant
Professor, School of Nursing, University
of North Carolina at Chapel Hill

Teri J. Harrison, RN, MSN, CDE,
Pediatric Clinical Nurse Specialist,
Methodist Hospital of Indiana, Inc.,
Indianapolis

Kathryn VanDyke Hayes, RN, C, MSN,
Lecturer, Gwynedd-Mercy College,
Gwynedd Valley, Pa.

Frances M. Johnson, RN, MSN, Assistant Chief, Community Health Nursing, Veterans Affairs Medical Center, Washington, D.C.

Darlene S. Jones, RN, BSN, Lt. Comdr., Nurse Corps, U.S. Navy, National Naval Medical Center, Bethesda, Md.

Karen Kelleher, RN, MS, Administrative Director, Mental Health Services, Suburban Hospital, Bethesda, Md.

Susan L.W. Krupnick, RN, MSN, CCRN, CS, Psychiatric Consultation Liaison Nurse, University of Pennsylvania Hospital, Philadelphia

Janice K. Lavoie, RN, MSN, Clinical Instructor, School of Nursing, Georgetown University; Staff Nurse, Surgical Intensive Care Unit, Georgetown University Medical Center, Washington, D.C.

Teresa Lien-Gieschen, RN, C, MS, GNP, Gerontology Clinical Nurse Specialist, Medical College of Virginia Hospitals, Richmond, Va.

Margaret Lunney, RN, PhD, Associate Professor, Hunter-Bellevue School of Nursing, Hunter College of the City University of New York

Maxine Maher, RN, BSN, Head Nurse, Nursing Home Care Unit, Veterans Affairs Medical Center, Atlanta

Cynthia McCormack, RN, MS, Nurse Recruiter, Department of Nursing, Veterans Affairs Medical Center, Denver

Anne McCormick, RN, MSN, Doctoral Candidate, The Catholic University of America, Washington, D.C.

Carolyn D. Moore, RN, BSN, CNOR, Clinical Instructor, Operating Room, The Arlington (Va.) Hospital

Vimala R. Philapose, RN PhD, Geriatric Nurse Consultant, Senior Health Care Services, Presbyterian-St. Luke's Medical Center, Denver

Devamma Purushotham, RN, DED, Associate Professor, University of Windsor (Ont.), Canada

Kathleen Rhoades, RN, BSN, CCRN, Nurse Clinician IV, Critical Care Center, Suburban Hospital, Bethesda, Md.

Vanice W. Roberts, RN, DSN, Associate Professor of Nursing, Kennesaw State College, Marietta, Ga.

Patricia C. Seifert, RN, MSN, CNOR, Operating Room Coordinator, The Arlington (Va.) Hospital

Janice Ann Chaiken Sekelman, RN, DNSc, Associate Professor, Department of Nursing, College of Allied Health Sciences, Thomas Jefferson University, Philadelphia

Peggy Shedd, RN, MSN, CS, Psychiatric Liaison Clinical Nurse Specialist, Dartmouth-Hitchcock Medical Center, Hanover, N.H.

Kathleen C. Sheppard, RN, PhD, Director of Nursing, Continuity of Care, University of Texas M.D. Anderson Cancer Center, Houston

Carole J. Singer, RN, MSN, CS, Psychiatric Clinical Nurse Specialist, Private Health Care Systems Limited; Private Psychotherapy Practice, Sudbury, Mass.

Susan S. Thomason, RN, MN, CS, Clinical Nurse Specialist, Veterans Affairs Medical Center, Tampa, Fla.

Lynne Lear Tier, RN, MSN, Assistant Professor of Nursing, Manatee Community College, Bradenton, Fla.

Diane M. Wieland, RN, MSN, CS, Assistant Professor, Department of Nursing, College of Allied Health Sciences, Thomas Jefferson University, Philadelphia

Judith G. Winterhalter, RN, DNSc, Assistant Professor, Department of Nursing, College of Allied Health Sciences, Thomas Jefferson University, Philadelphia

Beryla Wolf, RN, PhD, Assistant Professor of Nursing, Department of Nursing, Regis University, Denver

Stephanie Wright, RN, PhD, Assistant Professor, School of Nursing, Georgetown University, Washington, D.C.

PREFACE

As nurses have come to realize, the nursing process is a powerful tool. It provides a framework for independent nursing action and promotes a consistent professional structure. What's more, it helps focus care on patients' actual needs. But how do you go about using the nursing process—actually applying it to patient care in a helpful, systematic, and efficient way? And how do you modify the nursing process to reflect the needs of different patients?

Well, now you have the answers to these and other questions at your fingertips with the *Nursing Diagnosis Reference Manual, Third Edition*. Incorporating all diagnoses approved by the North American Nursing Diagnosis Association (NANDA), this manual explains clearly and concisely how to apply the nursing process to patient care. It focuses on health problems that you diagnose legally and treat independently.

The manual begins with an explanation of each step of the nursing process—assessment, nursing diagnosis, outcome identification, planning, implementation, and evaluation. Included in this introductory section are clear guidelines for writing a clinically accurate diagnostic statement. This section also clarifies the distinction between a nursing diagnosis and a medical diagnosis.

After this section come the manual's five major parts: adult health, adolescent health, child health, maternal-neonatal health, and geriatric health. Together, these parts include comprehensive plans of care for 284 nursing diagnostic statements. Each plan of care has been written and reviewed by leading nursing clinicians, educators, and researchers. Each one is complete and can be used independently to avoid excessive cross-referencing.

Each plan of care uses a consistent format containing the following sections:

- **Diagnostic statement.** Each diagnostic statement includes a NANDA-approved label and, in most cases, a related etiology. This edition of the *Nursing Diagnosis Reference Manual* contains all the diagnostic labels approved by NANDA.

- **Definition.** This section offers a brief explanation of the diagnosis.
- **Assessment.** This section suggests parameters to use when collecting data to validate the diagnosis. Data may include health history, physical findings, psychosocial status, laboratory studies, patient statements, and other subjective and objective information.
- **Defining characteristics.** This section lists clinical findings that when grouped together confirm the diagnosis. For diagnoses expressing the possibility of a problem, such as "High risk for injury," this section is labeled *Risk factors*.
- **Associated medical diagnoses.** Here you'll find examples of medical problems that commonly relate to the nursing diagnosis.
- **Expected outcomes.** Here you'll find realistic goals for resolving or ameliorating the patient's health problem, written in measurable behavioral terms.

- *Interventions and rationales.* This section provides specific activities you can carry out to help attain expected outcomes. Each intervention contains a rationale, highlighted in *italic* type. Rationales receive typographic emphasis because they form the premise for every nursing action. You'll find it helpful to consider rationales before intervening. Understanding them can make repetitive or difficult interventions more interesting. And more important, it can improve critical thinking and help avoid mistakes.

- *Evaluations for expected outcomes.* Here you'll find evaluation criteria for the expected outcomes. These criteria will help you determine whether expected outcomes have been attained.

- *Documentation.* This section lists critical topics to include in your documentation—for example, patient perceptions, status, and response to treatment as well as nursing observations and interventions. Using the information provided in this section will enable you to write the careful, concise documentation required to meet professional nursing standards.

The manual includes several appendices that will help you select appropriate nursing diagnoses for virtually every clinical situation. The largest appendix lists nursing diagnoses for specific medical diagnoses. Other appendices group diagnoses by Gordon's functional health patterns, Maslow's hierarchy of needs, Orem's universal self-care demands, and Saba's home health care classification system.

As the nursing profession continues to advance, strengthening the nursing process remains an important challenge. We believe that the *Nursing Diagnosis Reference Manual, Third Edition*, will help both students and practicing nurses meet this challenge.

We would like to express our sincere appreciation to the nurses who contributed to the *Nursing Diagnosis Reference Manual, Third Edition*. Their expertise and commitment to quality patient care made this work possible. The section editors deserve special thanks for selecting excellent contributors and for writing, editing, and critiquing care plans.

We also extend special thanks to the Springhouse editorial staff—in particular, Michael Shaw, for his patience, good humor, and perseverance in helping us to complete what often seemed to be an insurmountable task. Thanks are also due to our typists, Gil Taylor and Greg Agostinelli, who proved themselves especially talented and made order out of chaos.

Finally, we dedicate this book to our nursing students and colleagues, who challenge us to think and work creatively.

Sheila M. Sparks, RN, DNSc, CS
Cynthia M. Taylor, RN, MS, CS, CNAA

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THE NURSING PROCESS

The cornerstone of clinical nursing, the nursing process is a systematic method for taking independent nursing action. Steps in the nursing process include:

- assessing the patient's problems
- forming a diagnostic statement
- identifying expected outcomes
- making a plan to achieve expected outcomes and solve the patient's problems
- implementing the plan or assigning others to implement it
- evaluating the plan's effectiveness.

The phases of the nursing process—assessment, nursing diagnosis, outcome identification, planning, implementation, and evaluation—are dynamic and flexible; they often overlap.

Becoming familiar with this process has many benefits. It will allow you to apply your knowledge and skills in an organized, goal-oriented manner. It will also enable you to communicate about professional topics with colleagues from all clinical specialties and practice settings.

The growing recognition of the nursing process is an important development in the struggle for greater professional autonomy. By clearly defining problems a nurse may treat independently, the nursing process has helped to dispel the notion that nursing practice is based solely on carrying out doctor's orders.

Despite recent advances, nursing is still in an embryonic state of professional evolution. In the years ahead, researchers and expert practitioners will continue to develop a body of knowledge specific to the field. A strong foundation in the nursing process will enable you to better assimilate emerging concepts and to incorporate these concepts into your practice (see *Nursing's approach to problem solving*, page 2).

ASSESSMENT

The vital first phase in the nursing process, assessment consists of the patient history, the physical examination, and laboratory studies. The other nursing process phases—nursing diagnosis formation, outcome identification, care planning, implementation, and evaluation—depend on the quality of the assessment data for their effectiveness.

A properly recorded initial assessment provides:

- a way to communicate patient information to other caregivers
- a method of documenting initial baseline data
- a foundation on which to build an effective plan of care.

Your initial patient assessment begins with the collection of data (patient history, physical examination findings, laboratory data) and ends with a statement of the patient's actual or potential problem—the nursing diagnosis.

Nursing's approach to problem solving

Dynamic and flexible, the phases of the nursing process resemble the steps that many other professions rely on to identify and correct problems. Here's how the nursing process phases correspond to the standard problem-solving method.

NURSING PROCESS	PROBLEM-SOLVING METHOD
Assessment <ul style="list-style-type: none">• Collect and analyze subjective and objective data about the patient's health problem.	<ul style="list-style-type: none">• Recognize that a problem exists.• Learn about the problem by obtaining facts.
Diagnosis <ul style="list-style-type: none">• State the health problems.	<ul style="list-style-type: none">• State the nature of the problem.
Outcome identification <ul style="list-style-type: none">• Identify expected outcomes.	<ul style="list-style-type: none">• Establish goals and a time frame for achieving them.
Planning <ul style="list-style-type: none">• Write a plan of care that includes the nursing interventions designed to achieve expected outcomes.	<ul style="list-style-type: none">• Think of and select ways to achieve goals and solve the problem.
Implementation <ul style="list-style-type: none">• Put the plan of care into action.• Document the actions taken and their results.	<ul style="list-style-type: none">• Act on ways to solve the problem.
Evaluation <ul style="list-style-type: none">• Critically examine the results achieved.• Review and revise the plan of care as needed.	<ul style="list-style-type: none">• Decide if the actions taken have effectively solved the problem.

Building a data base

The information you collect in taking your patient's history, performing a physical examination, and analyzing laboratory test results serves as your assessment data base. Your goal is to gather and record information that will be most helpful in assessing your patient. You can't collect or use *all* the information that exists about your patient. To limit your data base appropriately, ask yourself these questions: What data do I want to collect? How should I collect the information? How should I organize it to make care planning decisions?

Your answers will help you to be selective in collecting meaningful data during patient assessment.

The well-defined data base for a patient may begin with admission signs and symptoms, chief complaint, or medical diagnosis. It also may center on the type of patient care given in a specific nursing unit, such as the intensive

care unit or the emergency department (ED). For example, you wouldn't ask a trauma victim in the ED if she has a family history of breast cancer, nor would you perform a routine breast examination on her. You would, however, do these types of assessment during a comprehensive health checkup in an ambulatory care setting.

If you work in a setting where patients with similar diagnoses are treated, choose your data base from information pertinent to this specific patient population.

Subjective and objective data

The assessment data you collect and analyze fall into two important categories, subjective and objective.

The patient's history, embodying a *personal perspective* of problems, provides **subjective data**. It's your most important assessment data source. But because it's also the most subjective source of patient information, it must be interpreted carefully.

In the *physical examination* of a patient—involving inspection, palpation, percussion, and auscultation—you collect **objective data** about your patient's health status or about the pathologic processes that may be related to his illness or injury. Besides adding to your patient data base, this information helps you interpret the patient's history more accurately by providing a basis for comparison. Use it to validate and amplify the historical data. However, don't allow the physical examination of your patient to assume undue importance.

The most objective form of assessment data, *laboratory test results* provide another source for interpreting your history and physical examination findings. The advanced technology used in laboratory tests enables you to assess anatomic, physiologic, and chemical processes that neither your senses nor your patient's are capable of measuring. For example, if your patient complains of feeling tired (history) and you observe conjunctival pallor (physical examination), check his hemoglobin and hematocrit levels (laboratory data).

You need both subjective and objective data for comprehensive patient assessment. They validate each other and together provide more data than either could provide alone.

Consider all three types of assessment information—history, physical examination, and laboratory data—in their appropriate relationships to one another. Performing an accurate physical examination requires technical skill that in itself is valuable. It becomes even more valuable, however, when you place the examination findings in perspective as one aspect of total patient assessment.

Taking a complete health history

This portion of the assessment consists of the subjective data you collect from the patient. Use your interviewing skills to help the patient describe biological, social, and psychological responses to the particular anatomic, physiologic, and chemical processes involved in his illness or injury. In addition, the patient may recall events in his own life or in relatives' lives that may indicate an increased risk for certain pathologic processes.

A complete health history provides the following information about a patient:

- biographical data
- chief complaint (or concern)
- history of present illness (or current health status)
- past history
- family history
- psychosocial history
- activities of daily living
- review of systems.

Follow this orderly format in taking your patient's history, but allow for modifications based on your patient's chief complaint or concern. For example, the health history of a patient with a localized allergic reaction will be much shorter than that of a patient who complains vaguely of mental confusion and severe headaches.

If your patient has a chief complaint, use information from your health history to decide if his problems stem from physiologic causes or psychophysiological maladaptation and how your nursing interventions may help. The depth of such a history depends on the patient's cooperation and your skill in asking insightful questions.

A patient who requests a complete physical checkup may not even have a chief complaint. Such a patient's health history would be comprehensive, with detailed information about life-style, self-image, family and other interpersonal relationships, and degree of satisfaction with current health status.

Be sure to record health history data in an organized fashion so that the information will be meaningful to everyone involved in a patient's care. Some hospitals provide patient questionnaires or computerized checklists (see *Using an assessment checklist*). These forms make history taking easier, but they're not always available. Therefore, you must know how to take a comprehensive health history without them. This is easy to do if you develop an orderly and systematic method of interviewing. Ask the history questions in the same order every time. With experience, you'll know which types of questions to ask in specific patient situations.

Review of systems

When interviewing the patient, use this review of systems as a guide.

General: overall state of health, ability to carry out activities of daily living, weight changes, fatigue, exercise tolerance, fever, night sweats, repeated infections

Skin: changes in color, pigmentation, temperature, moisture, or hair distribution; eruptions; pruritus; scaling; bruising; bleeding; dryness; excessive oiliness; growths; moles; scars; rashes; scalp lesions; brittle, soft, or abnormally formed nails; cyanotic nail beds; pressure ulcers

Head: trauma, lumps, alopecia, headaches

Eyes: nearsightedness, farsightedness, glaucoma, cataracts, blurred vision, double vision, tearing, burning, itching, photophobia, pain, inflammation, swelling, color blindness, injuries (also ask about use of glasses or contact lenses and date of last eye examination)

Using an assessment checklist

To make sure you cover all key points during your health history interview, you may use an assessment checklist, such as the one shown below. Though the format of such guides may vary from one institution to another, all guides include the same key elements.

- ☐ *Reason for hospitalization or chief complaint:* As patient sees it.
 - ☐ *Duration of this problem:* As patient recalls it. Has it affected patient's life-style?
 - ☐ *Other illnesses and previous experience with hospitalization:* Reason? When? Results? Impressions of previous hospitalizations? Problems encountered? Effect of this hospitalization on education? Family? Child care? Employment? Finances?
 - ☐ *Observation of patient's condition:* Level of consciousness? Well-nourished? Healthy? Color? Skin turgor? Senses? Headaches? Cough? Syncope? Nausea? Seizures? Edema? Lumps? Bruises or bleeding? Inflammation? Integrity of skin? Pressure areas? Temperature? Range of motion? Unusual sensations? Paralysis? Odors? Discharges? Pain?
 - ☐ *Mental and emotional status:* Cooperative? Understanding? Anxious? Language? Expectations? Feelings about illness? State of consciousness? Mood? Self-image? Reaction to stress? Rapport with interviewer and staff? Compatibility with roommate?
 - ☐ *Review of systems:* Neurologic, EENT, Pulmonary, Cardiovascular, GI, GU, Skin, Reproductive, Musculoskeletal, and so forth.
 - ☐ *Allergies:* Food? Drugs? Type of reaction?
 - ☐ *Medication:* Dosage? Why taken? When taken? Last dose? Does he have it with him? Any others taken occasionally? Recently? Why? Ask about over-the-counter drugs, cough preparations, and use of alcohol or illegal drugs.
 - ☐ *Prostheses:* Pacemaker? Intermittent positive-pressure breathing unit? Tracheostomy tube? Drainage tubes? Feeding tube? Catheter? Ostomy appliance? Breast form? Hearing aid? Glasses or contacts? Dentures? Cane? Walker? Brace? False eye? Prosthetic leg? Does the patient have the device with him? Need anything?
 - ☐ *Hygiene patterns:* Dentures? Gums? Teeth? Bath or shower? When?
 - ☐ *Rest and sleep patterns:* Usual times? Aids? Difficulties?
 - ☐ *Activity status:* Self-care? Ambulatory? Aids? Daily exercise?
 - ☐ *Bladder and bowel patterns:* Continent? Frequency? Nocturia? Characteristics of stool and urine? Discharge? Pain? Ostomy? Appliances? Who cares for these? Laxatives? Medications?
 - ☐ *Meals and diet:* Feeds self? Diet restrictions (therapeutic and cultural or preferential)? Frequency? Snacks? Allergies? Dislikes? Fad diets? Usual dietary intake?
 - ☐ *Health practices:* Breast self-examination? Physical examination? Pap smear? Testicular self-examination? Digital rectal examination? Smoking? ECG? Annual chest X-ray? Practices related to other conditions, such as glaucoma testing, urine testing, weight control?
 - ☐ *Life-style:* Parent? Family? Number of children? Residence? Occupation? Recreation? Diversion? Interests? Financial status? Religion? Education? Ethnic background? Living environment?
 - ☐ *Typical day profile:* Have patient describe.
 - ☐ *Informant:* From whom did you obtain this information? Patient? Family? Old records? Ambulance driver?
-

Ears: deafness, tinnitus, vertigo, discharge, pain, tenderness behind the ears, mastoiditis, otitis or other ear infections, earaches, ear surgery

Nose: sinusitis, discharge, colds, or coryza more than four times a year; rhinitis; trauma; sneezing; loss of sense of smell; obstruction; breathing problems; epistaxis

Mouth and throat: changes in color or sores on tongue, dental caries, loss of teeth, toothaches, bleeding gums, lesions, loss of taste, hoarseness, sore throats (streptococcal), tonsillitis, voice changes, dysphagia, date of last dental checkup, use of dentures, bridges, or dental appliances

Neck: pain, stiffness, swelling, limited movement

Breasts: change in development or lactation pattern, trauma, lumps, pain, discharge from nipples, gynecomastia, changes in contour or in nipples, history of breast cancer (also ask if the patient knows how to perform breast self-examination)

Cardiovascular: palpitations, tachycardia, or other rhythm irregularities; pain in chest; dyspnea on exertion; orthopnea; cyanosis; edema; ascites; intermittent claudication; cold extremities; phlebitis; postural hypotension; hypertension; rheumatic fever (also ask if an electrocardiogram has been performed recently)

Respiratory: dyspnea, shortness of breath, pain, wheezing, paroxysmal nocturnal dyspnea, orthopnea (number of pillows used), cough, sputum, hemoptysis, night sweats, emphysema, pleurisy, bronchitis, tuberculosis (contacts), pneumonia, asthma, upper respiratory tract infections (also ask about results of chest X-ray and tuberculin skin test)

Gastrointestinal: changes in appetite or weight, dysphagia, nausea, vomiting, heartburn, eructation, flatulence, abdominal pain, colic, hematemesis, jaundice (pain, fever, intensity, duration, color of urine), stools (color, frequency, consistency, odor, use of laxatives), hemorrhoids, rectal bleeding, changes in bowel habits

Renal, genitourinary: color of urine, polyuria, oliguria, nocturia (number of times per night), dysuria, frequency, urgency, problem with stream, dribbling, pyuria, retention, passage of stones or gravel, venereal disease (discharge), infections, perineal rashes and irritations (also ask if protein or sugar has ever been found in urine)

Reproductive: male—lesions, impotence, prostate problems (also ask about use of contraceptives); **female**—irregular bleeding, discharge, pruritus, pain on intercourse, protrusions, dysmenorrhea, vaginal infections (also ask about number of pregnancies; delivery dates; complications; abortions; onset, regularity, and amount of flow during menarche; last normal period; use of contraceptives; date of menopause; last Pap test)

Neurologic: headaches, seizures, fainting spells, dizziness, tremors, twitches, aphasia, loss of sensation, weakness, paralysis, numbness, tingling, balance problems

Psychiatric: changes in mood, anxiety, depression, inability to concentrate, phobias, suicidal or homicidal thoughts, hallucinations, delusions

Musculoskeletal: muscle pain, swelling, redness, pain in joints, back problems, injuries (such as broken bones, pulled tendons), gait problems, weakness, paralysis, deformities, limited motion, contractures

Hematopoietic: anemia (type, degree, treatment, response), bleeding, fatigue, bruising (also ask if patient is receiving anticoagulant therapy)

Endocrine, metabolic: polyuria, polydipsia, polyphagia, thyroid problem, heat or cold intolerance, excessive sweating, changes in hair distribution and amount, nervousness, swollen neck (goiter), moon face, buffalo hump

When documenting the health history, be sure to record negative findings as well as positive ones. Note the absence of symptoms that other history data indicate could be present. For example, if a patient reports pain and burning in his abdomen, ask him if he has experienced nausea and vomiting or noticed blood in his stools. Record the presence *or* absence of these symptoms.

Also remember that the information will be used by others who'll also care for the patient. It could even be used as a legal document in a liability case, a malpractice suit, or an insurance disability claim. With these considerations in mind, record history data thoroughly and precisely. Continue your questioning until you're satisfied that you've recorded sufficient detail. Don't be satisfied with inadequate answers, such as "a lot" or "a little." These words mean different things to different people and must be explained to be meaningful. If taking notes seems to make the patient anxious, explain the importance of keeping a written record. To facilitate accurate recording of your patient's answers, familiarize yourself with standard history data abbreviations.

Once you complete your patient's health history, it becomes part of the permanent written record. It will serve as a subjective data base with which you and other health care professionals can monitor the patient's progress. Remember that history data must be specific and precise. Avoid generalities. Instead, provide pertinent, concise, detailed information that will help determine the direction and sequence of the physical examination—the next phase in your patient assessment.

Physical examination

After taking your patient's health history, the next step in the assessment process is the *physical examination*. During this assessment phase, you obtain objective data that usually confirm or rule out suspicions raised during the health history interview.

You use four basic techniques to perform a physical examination: *inspection*, *palpation*, *percussion*, and *auscultation* (IPPA). These skills require you to use your senses of sight, hearing, touch, and smell—all necessary for an accurate appraisal of the structures and functions of body systems. If, after much careful study and practice, you learn to use IPPA skills effectively, you'll be less likely to overlook something important during the physical examination. In addition, each examination technique collects data that validate and amplify data collected through other IPPA techniques.

Accurate and complete physical assessments depend on two interrelated elements. One is the critical act of sensory perception, by which you receive and perceive external stimuli. The other element is the conceptual, or cognitive, process by which you relate these stimuli to your knowledge base. This two-step process gives meaning to your assessment data.

You need to develop a system for assessing patients that identifies their problem areas in priority order. By performing physical assessments systematically and efficiently instead of in a random or indiscriminate manner, you'll save time and identify priority problems quickly.

Choosing an examination method. The most commonly used methods for completing a total systematic physical assessment are *head to toe* and *major body systems*.

Using the head-to-toe method, you systematically assess your patient—as the name suggests—beginning at the head and working toward the toes. Examine all parts of one body region before progressing to the next region to save time and energy for yourself and your patient. Proceed from left to right within each region so that you can make symmetrical comparisons. Don't examine the patient's left side from head to toe, then his right side.

The major-body-systems method involves systematically assessing your patient by examining each body system in priority order or in a predesignated sequence.

Both the head-to-toe and the major-body-systems methods are systematic and provide a logical, organized framework for collecting physical assessment data. They also provide the same information; therefore, neither is more correct than the other. So choose the method (or a variation of it) that works well for you and is appropriate for your patient population. Follow this routine whenever you assess a patient and try not to deviate from it.

To decide which method to use, first determine whether the patient's condition is life-threatening. Identifying the *priority* problems of a patient suffering from a life-threatening illness or injury—for example, severe trauma, a heart attack, or GI hemorrhage—is essential to preserve his life and function and to prevent compounded damage.

Next, identify the *patient population* to which the patient belongs, and take the common characteristics of that population into account in choosing an examination method. For example, elderly or debilitated patients tire easily; for a patient in either category, you'd select a method that necessitates minimal position changes. Also, you'd probably defer parts of the examination to avoid tiring your patient.

Try to view your patient as an integrated whole rather than as a collection of parts, regardless of the examination method you use. Remember, the integrity of a body *region* may reflect adequate functioning of many body *systems*, both inside and outside this particular region. For example, the integrity of the chest region may provide important clues about the functioning of the cardiovascular and respiratory systems. Similarly, the integrity of a body *system* may reflect adequate functioning of many body *regions* and of the various systems within these regions.

The chief complaint. You may want to plan your physical examination around your patient's chief complaint or concern. To do this, begin by examining the body system or region that corresponds to the chief complaint. This allows you to identify priority problems promptly and reassures your patient that you are paying attention to his primary reason for seeking health care.

Consider the following example. Your patient, Sarah Clemson, is a 65-year-old, active, well-nourished woman who appears younger than her chronologic age. She complains of having difficulty breathing on exertion; she also has a dry, frequent, painful cough. Intermittent chills have persisted for 3 days. First, you'd record her vital signs: temperature, 103° F (39.4° C); pulse rate, 106 beats/minute; respiratory rate, 29 to 30 breaths/minute; blood pressure, 128/82 mm Hg.

Because Mrs. Clemson's chief complaints are difficulty breathing, a cough, and chills, your physical examination would initially focus on her *respiratory system*. You'd examine the patency of her airways, observe the color of her lips and extremities, and systematically palpate her lung fields for symmetry of expansion, crepitus, increased or decreased fremitus, and areas of tenderness. Then, after auscultating her lung fields for abnormal or adventitious sounds (such as crackles, rhonchi, or wheezing), you'd percuss her lung fields for increased or decreased resonance.

Next, you'd examine Mrs. Clemson's *cardiovascular system*, looking for further clues to the cause of her signs and symptoms. You'd inspect her neck veins for distention and her extremities for edema, venous engorgement, and pigmented areas. Then, you'd palpate her chest to see if you could feel the heart's apical impulse at the fifth intercostal space, in the midclavicular line. You'd also palpate for a precordial heave and for valvular thrills. After determining her apical pulse rate, you'd auscultate for any abnormal heart sounds.

At this point in the examination, you would probably be aware of Mrs. Clemson's level of consciousness, motor ability, and ability to use her muscles and joints. You probably wouldn't need to perform a more thorough musculoskeletal or neurologic examination. You would, however, proceed with an examination of her GI, genitourinary, and integumentary systems, modifying the examination sequence depending on your findings and Mrs. Clemson's tolerance. If her signs and symptoms worsened during the examination, you'd interrupt the procedure to report her condition to her doctor. Then you'd plan to come back and finish the examination after her condition had stabilized.

Documenting physical examination findings. Physical examination findings are crucial to arriving at a nursing diagnosis and, ultimately, to developing a sound nursing plan of care. Record your examination results thoroughly, accurately, and clearly.

Although some examiners don't like to use a printed form to record physical assessment findings, preferring to work with a blank paper, others believe that standardized data collection forms can make recording physical examination results easier. These forms simplify comprehensive data collection and documentation by providing a concise format for outlining and recording pertinent information. They also remind you to include all essential assessment data.

When documenting, describe exactly what you've inspected, palpated, percussed, or auscultated. Don't use general terms, such as *normal*, *abnormal*, *good*, or *poor*. Instead, be specific. Include positive and negative findings. Try to document as soon as possible after completing your assessment. Remember that abbreviations aid conciseness (see *Documentation tips*, page 10).