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PROFESSOR

ICON

HEALTH ASSESSMENT

Defintion:-

It is a collecting of data about client health status. It is the detailed study of the entire body in order to determine general or mental condition of the body.

Purpose:-

- To identify the problem in the early stage
- To collect the data about physical, mental and social well being of the client
- To identify the causes and extent of the disease
- To evaluate or monitor the changes in the cleint health status
- To certitfy whether the client is medically fit to resume duty
- To contribute in the medical research
- To identify the patients weakness, strength, knowledge and coping abilities
- To collect the data systematically

Process:-

I) History collection
II) Physical examination

I) History collection :

Definition:

It is the collection of subjective data regarding clients health in a chronological order.

Purpose:

- To gather subjective data from the client
- To develop nurisng diagnosis(to identify the nature of the illness)
- To plan the action for promoting health, preventing illness, alleviating acute problems, to minimize the chronic health problems
- To meet the clients expectation for health
- To compare the client health status with optimum level of health.

Components of health history:

1) Biographical data
2) Chief complaints
3) Present health history
4) Past health history
5) Family history
6) Socio economic status
7) Personal history

8) Psychosocial history
9) Obstetrical history

1) Biographical data:
   It includes: name, address, phone number, age, palce of birth, gender, nationality, religion, marital status, educational level, health insurance, occupation, source of history
2) Chief complaints :
   It includes symptom analysis and chief complaints are document in clients own words.
3) Present heath history:

- Medical history
  - Onset of illness
  - Duration
  - Management done before admission
  - Treatment given in the hospital and present status
- Surgical history
  - Name of the surgery
  - Management
  - Post operative day

4) Past health history:
   It includes chiidlhood illness, surgeries, hospitalization, serious injuries, medical problem, medication, allergies, immunization, blood transfusion.
5) Family history:
   It includes patient spouse, children, sibling, parents & grandparents health status or if deceased, collect age and cause of death. Family hsitory of hereditory disease or illness such as diabetes mellitus, cancer, heart diseases etc.
   Family tree:

6) Socio economic status:
   it includes monthly family income, bread winner of the family, source of income, financial status, types of house (own/rented), facilities like electricity, ventilation, drainage, lighting, water, waste disposal & latrine facility, availability of hospital, clinics, health centres, market, temple, school and transport.
7) Personal history :
   It includes sleep pattern(hours of sleep during day & night), exercise pattern, dietary pattern(veg, non-veg, mixed, solid, liquid diet), bowel elimination (passing of stool/defecates), bladder elimination (passing of urine/voiding pattern)
8) Psychosocial history :
   It includes mood stability, communicating with others
9) Obstetrical history :
   It includes menstrual history/menstrual cycle(regular or irregular, no.of days in cycle, problem), history of pregnancy, abortion, labour, delivery
   G-Gravida , P-Para , L-Live children , A-Abortion, D-Dead

II) PHYSICAL EXAMINATION

Introduction:

Physical examination is a complete assessment of a patients physical and mental status.

Definition:

It is thr systematic collection of objective information that is directly observed or elicited through examination techniques.

Techniques of physical examination:

1) Inspection
2) Palpation
3) Percussion
4) Auscultation
5) Olfaction

1)Inspection:

- It is the systematic visual examination of the client
- It involves observation of the patients colour, size, shape, symmetry, position & movements

General inspection of a client focuses on:

- Overall appearance of health or illness
- Signs of distress
- Facial expression & mood
- Body size
- Grooming & personal hygiene

2)Palpation:

- It is the use of hands & fingers to gather the information through touch
- It is the assessment technique by the use of sense of touch
- It is the feeling of the body or parts to determine the size and position of the organ.
- The hands & fingers are the sensitive tools to assess such as
  - Temperature
  - Skin Turgor (check elasticity of the skin)
  - Texture (rough/smooth/soft/thick skin)
  - Moisture (eg. Oil/dry skin)
  - Size
  - Position
  - Consistency
  - Masses (swollen area)
  - Fluids

Surfaces of the hands and fingers:

- Dorsum surface is used to measure the temperature

- Palmer surface of fingers & fingers pads are used to assess skin turgor, texture, moisture, size , vibrations, position
- Fingertips are used to palpate the breast, lymph nodes & pulses
- Thumb and index finger are used to palpate the tissue firmness

Types of palpation:

i) Light palpation
ii) Deep palpation

i)Light palpation:

- It is used to detect the characteristics of the skin & the superficial tissues
- It is attained by pressing 1cm in depth to assess the skin pulses & tenderness(touch to pain)

ii)Deep palpation:

- It is attained by pressing of 2 to 4 cm in depth to determine the organ size & contour(boundary of organ)

Special consideration/principles of palpation:

- You should have short the finger nails
- Warm the hands & fingers prior to placing them on the patient skin surface.
- Encourage the patient to continue to breathe normally throughout the palpation.
- If pain is experienced during the palpation, discontinue the palpation immediately.
- Inform the patient where, when and how the touch will occur, especially when the patient cannot see what you are doing.
- Before palpation explanation is very important for the client because touch has the great significant in the culture.
- Always proceeds from light palpation to deep palpation because palpation may cause tenderness.

3) Percussion:-

- It is used by physician & advanced nursing practitioners
- It is used to determine the consistency of the underlying tissues.
- It is a examination by tapping the fingers on the patient's body surface to assess the condition of the internal organs by the sound that may produce.
- It is the striking the body surface on the skin with the sharp strokes in order to determine or produce palpable vibration & characteristics of the sound.
- It is used to detect the presence of air or fluid in the body surface.

Characteristics of the sound:

- Tympany – it is a drum like sound heard over the air such as gas in the stomach/abdomen.
- Resonance – it is a hallow sound heard over the air filled lung tissues
- Hyper resonance – it is the over inflated lungs.
- Dull sounds – it is heard over fluid filled area such as liver or urinary bladder
- Flat sounds – it is heard over the muscles.

Types of percussion:

i) Direct percussion
ii) Indirect percussion
iii) Direct fist percussion
iv) Indirect fist percussion

i)Direct percussion:

- it is accompanied by tapping the areas directly with the fingertips of the middle finger.

ii)Indirect percussion:

- Place the non dominant hand on the patients surface of the skin & make gentle pressure of the fingertips & give a stroke on the inter phalangeal joint of the middle finger by the dominant hand on the finger tips of the middle finger .

iii)Direct fist percussion:

- It is used to detect the presence of tenderness or pain in the internal organs such as liver or kidney with the ulnar aspect of the closed fist that directly hit the area where the organ is located.

iv)Indirect fist percussion:

- Place the non dominant hand on the patient's surface of the skin where the organ is examined.
- With the ulnar aspect of the closed fist used moderate intensity to hit the outstretched non-dominant hand on the dorsal aspect.

4) Auscultation:

- It is the process of listening the sounds that are generated within the body
- It is performed by placing the stethoscope(diaphragm or bell) against the body part being assessed.
- When auscultating , expose the part listened to, use the proper part of the stethoscope (diaphragm or bell) for specific sounds & listen in a quiet environment.
- Heart and blood vessel are auscultated for the circulation of blood.
- Lungs are auscultated for moving of air/breath sound.
- Abdomen is auscultated for the movements of gastro intestinal content sound/bowel souns

Characteristics of sound:

i) Pitch – ranging from higher to lower
ii) Loudness – ranging from soft to loud
iii) Quality – bubbling sounds or gurgling sounds
iv) Duration – short/medium/long sounds

5)Olfaction:

Olfaction can be assessed by sense of smell

Eg. Halitosis – foul smelling/bad odour