تقييم/تمريض رابع

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لأجل النشر والتطوير

HEALTH ASSESSMENT

CODE: NUR 223-3

يعني حالتي لقوته وقدرته

HEATLH – A STATE IN WHICH A PERSON IS ABLE TO LIVE TO HIS OR HER POTENTIAL.

ILLNESS : THE UNIQUE RESPONSE OF A PERSON TO A DISEASE

WELLNESS : AN ACTIVE STATE, ORIENTED TOWARD MAXIMIZING THE POTENTIAL OF THE INDIVIDUAL

PURPOSE OF HEALTH ASSESSMNET:

- TO DETERMINE A PATIENT'S HEALTH STATUS, RISK FACTOR, AND NEED FOR EDUCATION AS A BASIS FOR DEVELOPING A NURSING CARE PLAN.
- PROVIDE SPECIFIC CUES FOR THE HEALTH PROBLEM

تحصيل أعلى إمكانات الفرد

ROLE OF NURSE: TO COLLECT COMPREHENSIVE DATA PERTINENT TO THE PATIENT'S HEALTH OR SITUATION.

ليش التقييم ؟!
1. عشان نخدر
- Health Status
- RF
2. need for education.
3. provide cues for health problem

HEALTH ASSESSMENT

- COMPREHENSIVE (ALL ASPECT)HEALTH HISTORY
- COMPLETE PHYSICAL EXAMINATION

لتطوير الـ NCP

STEPS IN IDENTIFICATION OF PATIENT'S PROBLEM

خطوات التعرف على مشكلة المريض

1. HOLISTIC (WHOLE PERSON) CARE
2. ASSESSMENT (HEALTH AND PHYSICAL)
3. OBSERVATION AND MEASUREMENT المراقبة والقياس
4. PROCEDURE AND INVESTIGATION

الفحوصات

HcAMI

1. Holistic care

It is important that nurses do not see patients in a reduced way as just a collection of body parts but try to understand the patient as a whole.

- a member of a community/ family
- an individual who has sexual needs, as well as physical, psychological, and social needs.

x

قراءة

7 FACETS / DIMENSION

7 أبعاد

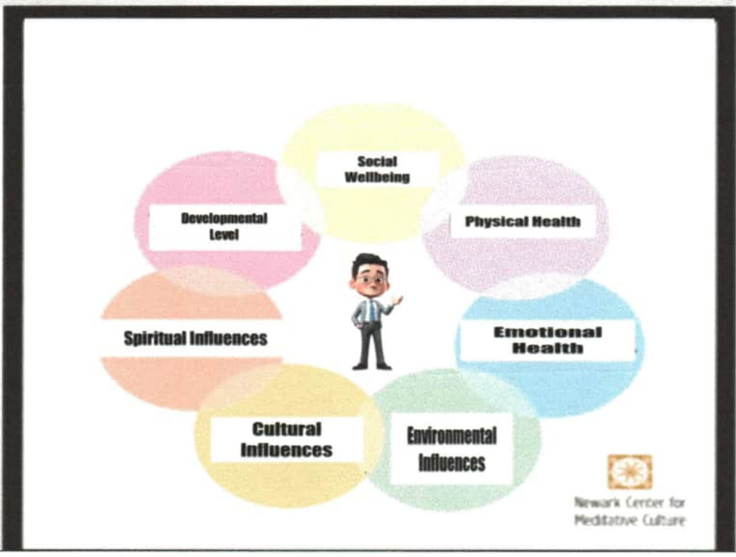
(Health is influenced by these dimensions)

- 1. PHYSICAL HEALTH
- 2. EMOTIONAL HEALTH
- 3. SOCIAL WELL BEING
- 4. CULTURAL INFLUENCES
- 5. SPIRITUAL INFLUENCES
- 6. ENVIRONMENTAL INFLUENCES
- 7. DEVELOPMENTAL LEVEL

- NOTE:
  1. A PERSON'S ABILITY TO ADAPT WHILE NOT COMPROMISING THE FACETS IS IMPORTANT FOR HEALTH MAINTENANCE.
  2. HEALTH IS NOT CONSTANT AND CANNOT BE TAKEN FOR GRANTED

التكيف دون المساس بالجوانب السابقة

الصحة ليست شيئ ثابتة أو مسلّم به !



نقصها

ROLE OF THE NURSE

- 1. THE NURSE AS CAREGIVER — يعني نعمل نحمل الي ما يقدر المريض يسويه / مُساعد
  - PERFORM HEALTH RELATED ACTIVITIES THAT A SICK PERSON CANNOT PERFORM INDEPENDENTLY.
- 2. THE NURSE AS EDUCATOR — مُعلّم
  - ONE WHO PROVIDES HEALTH TEACHING PERTINENT TO EACH CLIENT'S NEED AND KNOWLEDGE BASE. — تعليم المرضى
- 3. THE NURSE AS COLLABORATOR — متعاون
  - ONE WHO WORKS WITH OTHERS TO ACHIEVE A COMMON GOAL — يعمل مع الآخرين لتحقيق هدف مشترك
- 4. THE NURSE AS DELEGATOR — مفوّض
  - ONE WHO ASSIGNS TASK TO SOMEONE — تعيين مهمة لشخص معين

2. Assessment (subjective/objective data)

History → subjective; PE, investigations → objective

مجرد تجميع معلومات

a systematic way of gathering information about a patient's physiological, psychological, the sociological, and spiritual status

- a. Health Assessment — أعمّ
- b. Physical Assessment

2

COMPONENTS OF HEALTH HISTORY

HEALTH HISTORY

History

- FIRST STEP OF PATIENT ASSESSMENT.
- COLLECTION OF SUBJECTIVE AND OBJECTIVE (PHYSICAL EXAMINATION))DATA.
- IDENTIFY PATIENT STRENGTHS AND AREAS OF HEALTH CARE NEEDS. = لمعرفة احتياجات المريض

PURPOSE:

- PROVIDES THE FOUNDATION FOR IDENTIFYING NURSING PROBLEMS AND PROVIDE A FOCUS FOR THE PHYSICAL EXAMINATION
- A FRAMEWORK FOR ORGANIZING PATIENT INFORMATION IN WRITTEN OR VERBAL FORM.

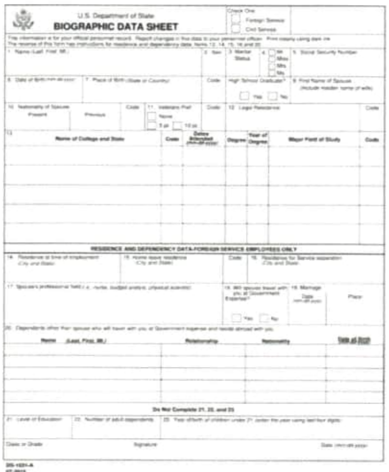
1. Foundation for ident. N.P.
2. Focus for PE
3. organize patient info.

7 COMPONENTS OF COMPREHENSIVE HEALTH HISTORY

1. IDENTIFYING DATA AND SOURCE OF THE HISTORY
2. CHIEF COMPLAINTS CC
3. HISTORY OF PRESENT ILLNESS (HPI)
4. PAST HISTORY
5. FAMILY HISTORY
6. REVIEW OF THE SYSTEM
7. HEALTH PATTERN → overview of lifestyle: nutrition, exercise, sleep, habits.

1. IDENTIFYING DATA

- ❑ AGE
- ❑ DATE OF BIRTH
- ❑ GENDER
- ❑ OCCUPATION
- ❑ MARITAL RELATIONSHIP
- ❑ EDUCATION LEVEL
- ❑ PRIMARY LANGUAGE SPOKEN AND READ


U.S. Department of State
BIOGRAPHIC DATA SHEET

SOURCE OF HISTORY

- PATIENT (PRIMARY)
- FAMILY MEMBER (SECONDARY)
- FRIEND (SECONDARY)
- LETTER OF REFERRAL(SECONDARY)
- MEDICAL RECORD (SECONDARY)

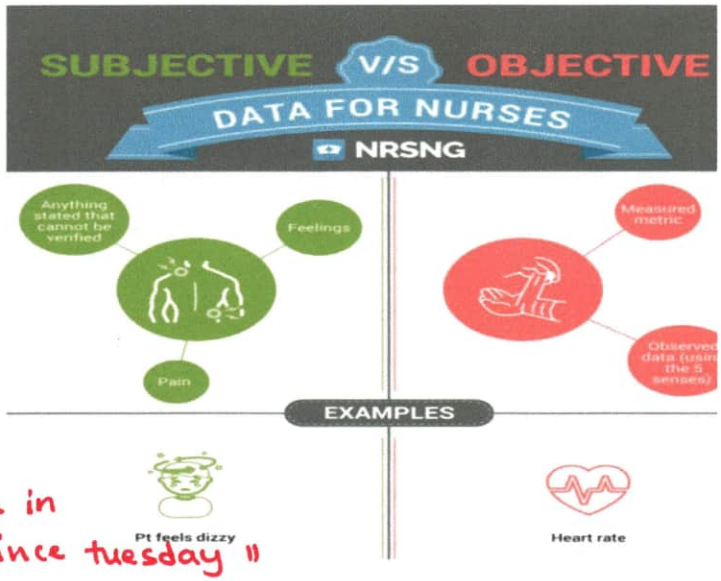
1° المريض هو
2° والباقي

REASON FOR SEEKING HEALTH CARE (CHIEF COMPLAINT). CC

سبب الزيارة

- the reason for the client to visit
  - * What is your major health problem or concern at this time? شو مشكلتك
    - focus on the most significant concern and answers the questions **"WHY ARE YOU HERE?"**
  - * How do you feel about having to seek health care? شو حاسس وانت جاي لهون؟
    - encourage the client to discuss fears or other feelings about having to see a health care provider.

CHIEF COMPLAINT (cc:)



" I have a sharp pain in my lower back since tuesday "

3. History of Present Illness.

- chronological account of the patient's chief complaint and the events surrounding it.

ex. cc :- (Persistent cough)

- ✓ Self-treatment (OTC drugs)
- ✓ Past occurrence of the symptoms
- ✓ Pertinent positive and or negative
- ✓ Risk factor or other pertinent information → asthma ? allergy ? smooking ? air pollution ?
- ✓ ❖ Information related to the symptoms
  - ↳ onset - duration
  - characteristic
  - severity
  - Provocating
  - Relieving

+ve :-
- ✓ dry cough
- ✓ wheezing
- ✓ sputum, 2 spoonful
- ✓ chest tightness

-ve :-
- ✓ no fever
- ✓ no chills
- ✓ no blood in sputum

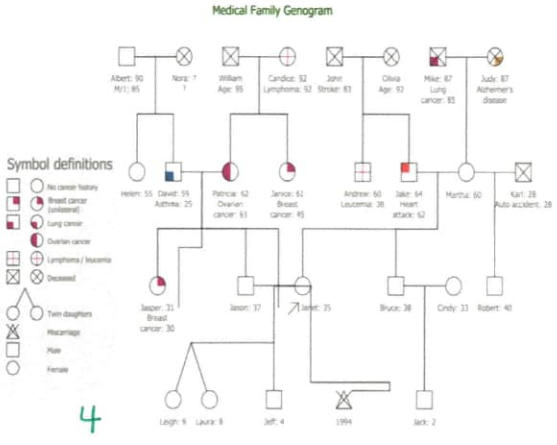
4. PAST HISTORY

- ✓ **ALLERGIES**
- ✓ **MEDICATIONS**
  - NAME
  - DOSE/ROUTE
  - FREQUENCY OF USE
  - HOME REMEDIES/ NONPRESCRIPTION DRUGS
- ✓ **CHILDHOOD ILLNESSES**
- ✓ **ADULT ILLNESSES**
  - MEDICAL
  - SURGICAL
  - ACCIDENTS
  - Psychiatric
- ✓ **HEALTH MAINTENANCE**
  - ✓ - IMMUNIZATION
  - ✓ - SCREENING TEST
  - ✓ - SAFETY MEASURES
  - ✓ - RISK FACTORS
    - TOBACCO
    - ENVIRONMENTAL HAZARD
    - SUBSTANCE ABUSE
    - ALCOHOL

5. FAMILY HISTORY

- SIBLINGS, PARENTS, GRANDPARENTS, AND CHILDREN
  - AGE AND HEALTH
  - CAUSE OF DEATH
- DOCUMENTS OF PRESENCE OR ABSENCE OF SPECIFIC ILLNESSES IN FAMILY (HYPERTENSION, CAD)

GENOGRAM



6. REVIEW OF THE SYSTEM

RS

- A SERIES OF QUESTIONS ABOUT ALL BODY SYSTEM THAT HELPS TO REVEAL CONCERNS OR PROBLEMS
- MAY UNCOVER PROBLEMS THAT THE PATIENT HAS OVERLOOKED, PARTICULARLY IN AREAS UNRELATED TO THE PRESENT ILLNESS.

NOTE:

- IT IS HELPFUL TO PREPARE THE PATIENT TO QUESTIONS.
- START FROM GENERAL QUESTIONS THEN SHIFT TO MORE SPECIFIC.
- ADDITIONAL QUESTIONS WILL VARY DEPENDING ON AGE, COMPLAINTS, GENERAL STATE OF HEALTH, AND YOUR CLINICAL JUDGEMENT


HEART

PATIENT NAME_______________ DOB _______________

14-POINT REVIEW OF SYSTEMS

PLEASE CIRCLE CURRENT SYMPTOMS/DEVICES

CONSTITUTIONAL: ☐FEVER ☐NIGHT SWEATS ☐CHILLS ☐FATIGUE ☐WEIGHT GAIN/LOSS ☐CHANGES IN APPETITE

EYES: ☐CHANGE IN VISION ☐LOSS OF VISION ☐BLURRED VISION ☐DOUBLE VISION ☐GLASSES

EARS: ☐DIFFICULTY HEARING ☐HEARING LOSS ☐HEARING AIDES

NOSE: ☐NASAL CONGESTION ☐NASAL DISCHARGE

MOUTH/THROAT/VOICE: ☐DENTURES ☐LIP SORES ☐MOUTH SORES ☐TONGUE SORES ☐SORE THROAT

HEAD/NECK: ☐NECK PAIN ☐NECK STIFFNESS

SKIN: ☐RASH ☐LESIONS ☐NAILS ☐BRUISING ☐ITCHING

RESPIRATORY: ☐COUGH ☐WHEEZING ☐SHORTNESS OF BREATH WHEN LYING DOWN ☐DIFFICULTY BREATHING ☐WAKING UP FROM SLEEP GASPING FOR AIR

CARDIOVASCULAR: ☐CHEST PAIN ☐PALPITATIONS ☐PASSING OUT ☐LOWER EXTREMITY EDEMA

GASTROINTESTINAL/GENITOURINARY: ☐ABDOMINAL PAIN ☐NAUSEA ☐CONSTIPATION ☐DIARRHEA ☐VOMITING ☐PAINFUL URINATION

MUSCULOSKELETAL: ☐MUSCLE PAIN ☐BACK PAIN ☐MUSCLE CRAMPS ☐JOINT PAIN

NEUROLOGICAL: ☐HEADACHES ☐LIGHT HEADACHES ☐DIZZINESS ☐WEAKNESS ON ONE SIDE

PSYCHIATRIC: ☐SLEEP DISTURBANCES ☐ANXIETY ☐DEPRESSION ☐THOUGHTS OF SUICIDE

REVIEW OF THE SYSTEM / SAMPLE QUESTIONS

Review of Systems:

- **General:** Usual weight, recent weight change, clothing that fits more tightly or loosely than before; weakness, fatigue, or fever.
- **Skin:** Rashes, lumps, sores, itching, dryness, changes in color; changes in hair or nails; changes in size or color of moles.

Conti…

Head, Eyes, Ears, Nose, Throat (HEENT)

- **Head:** Headache, head injury, dizziness, light headedness.
- **Eyes:** Vision, glasses or contact lenses, last examination, pain, redness, excessive tearing, double or blurred vision, spots, specks, flashing lights, glaucoma, cataracts.
- **Ears:** Hearing, tinnitus, vertigo, earaches, infection, discharge. If hearing is decreased, use or non-use of hearing aids.
- **Nose and sinuses:** Frequent colds, nasal stuffiness, discharge, or itching, hay fever, nosebleeds, sinus trouble.
- **Throat (or mouth and pharynx):** Condition of teeth and gums, bleeding gums, dentures, if any, and how they fit, last dental examination, sore tongue, dry mouth, frequent sore throats, hoarseness.

Conti….

- **Neck:** "Swollen glands," goiter, lumps, pain, or stiffness in the neck.
- **Breasts:** Lumps, pain, or discomfort, nipple discharge, self-examination practices.
- **Respiratory:** Cough, sputum (color, quantity), hemoptysis, dyspnea, wheezing, pleurisy, last chest x-ray.

❑ Peripheral vascular:

- Intermittent claudication; leg cramps; varicose veins; past clots in the veins; swelling in calves, legs, or feet; color change in fingertips or toes during cold weather; swelling with redness or tenderness.

❑ Urinary:

- Frequency of urination, polyuria, nocturia, urgency, burning or pain during urination, hematuria, urinary infections, kidney or flank pain, kidney stones, ureteral colic, supra-pubic pain, incontinence; in males, reduced caliber or force of the urinary stream, hesitancy, dribbling.

dysuria

❑ Cardiovascular:

- "Heart trouble," high blood pressure, rheumatic fever, heart murmurs, chest pain or discomfort, palpitations, dyspnea, orthopnea, paroxysmal nocturnal dyspnea, edema, results of past electrocardiograms or other cardiovascular tests.

PND

❑ Gastrointestinal:

- Trouble swallowing, heartburn, appetite, nausea. Bowel movements, stool color and size, change in bowel habits, pain with defecation, rectal bleeding or black or tarry stools, hemorrhoids, constipation, diarrhea. Abdominal pain, food intolerance, excessive belching or passing of gas. Jaundice, liver or gallbladder trouble, hepatitis.

Hematochezia

Melena

blood + vomiting = hematemesis

blood + vomiting = coffee ground emesis.

Conti….

❑ Musculoskeletal:

- Muscle or joint pain, stiffness, arthritis, gout, backache. If present, describe location of affected joints or muscles, any swelling, redness, pain, tenderness, stiffness, weakness, or limitation of motion or activity; include timing of symptoms (e.g., morning or evening), duration, and any history of trauma. Neck or low back pain.
- Joint pain with systemic features such as fever, chills, rash, anorexia, weight loss, or weakness.

❑ Psychiatric:

- Nervousness, tension, mood, including depression, memory change, suicide attempts, if relevant.

❑ **Neurologic:**

- Changes in mood, attention, or speech; changes in orientation, memory, insight, or judgment; headache, dizziness, vertigo, fainting, blackouts; weakness, paralysis, numbness or loss of sensation, tingling or "pins and needles," tremors or other involuntary movements, seizures.

❑ **Hematologic:**

- Anemia, easy bruising or bleeding, past transfusions, transfusion reactions.

❑ **Endocrine:**

- "Thyroid trouble," heat or cold intolerance, excessive sweating, excessive thirst or hunger, polyuria, change in glove or shoe size.

↳ DM

↳ GH (acromegaly)

7. HEALTH PATTERN

- GATHER PERSONAL/ SOCIAL HISTORY FROM THE PATIENT DAILY LIVING ROUTINES THAT MAY INFLUENCE HEALTH AND ILLNESS

Health Pattern	Sample Questions
Self-perception–self-concept: Describes self-concept and perceptions of self (e.g., body image, feeling state, self-esteem, personal identity, and social identity)	How would a friend describe you? How do you feel about your ability to handle ___? If you could change anything about yourself, what would you change?
Value-belief: Describes patterns of values, beliefs (including spiritual), or goals that guide choices or decisions	What is your source of strength and hope? Is religion or God significant to you? Describe how.
Activity-exercise: Describes pattern of exercise, activity, leisure, and recreation	Describe your exercise routine or activities Describe your leisure and recreation activities. Have you experienced any change in your activities due to your illness?
Sleep-rest: Describes patterns of sleep, rest, and relaxation	At what time do you usually retire and awaken? Do you feel rested?
Nutrition: Describes pattern of food and fluid consumption	Describe a typical day's diet. Are you on any special diet?
Role-relationship:	

PHYSICAL EXAMINATION

- A PROCESS TO OBTAIN OBJECTIVE DATA FROM THE PATIENT.

PURPOSE:

- TO DETERMINE CHANGES IN A PATIENT'S HEALTH STATUS AND HOW TO RESPOND TO A PROBLEM AS WELL AS PROMOTE HEALTHY LIFESTYLE AND WELLBEING

1. determine changes in H.S.
2. how to respond to a problem
3. promote healthy lifestyle

FOUR BASIC TYPES OF ASSESSMENT

1. COMPREHENSIVE HEALTH ASSESSMENT.

- INVOLVES A COMPLETE HEALTH HISTORY AND PHYSICAL EXAMINATION.
- PROVIDES THE NURSE WITH A FULL PICTURE OF THE PATIENT'S HEALTH STATUS, AS WELL AS HEALTH PROMOTION AND RISK REDUCTION NEEDS.

HS + HP needs + RR needs

2. FOCUSED OR PROBLEM ORIENTED ASSESSMENT

- CONDUCTED TO ADDRESS A SPECIFIC PROBLEM / CURRENT HEALTH PROBLEM

3. FOLLOW UP HISTORY 2 جزء من

- A FORM OF FOCUSED ASSESSMENT
- PATIENT PROBLEM IS EVALUATED AFTER TREATMENT, OR A SECOND SHIFT NURSE MAY FOLLOW UP A PROBLEM IDENTIFIED BY A NURSE ON EARLIER SHIFT.

Treatment → evaluation

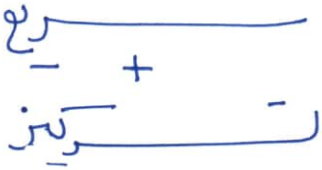
1st shift → 2nd shift

FOUR BASIC TYPES OF HEALTH ASSESSMENT

4. EMERGENCY ASSESSMENT

- *RAPID, FOCUSED* ASSESSMENT CONDUCTED WHEN ADDRESSING A LIFE-THREATENING OR UNSTABLE CONDITION
- SYSTEMIC PRIORITIZATION

EX: ASSESSMENT OF CIRCULATION, AIRWAY, AND BREATHING



TYPES OF PATIENT DATA

1. SUBJECTIVE INFORMATION / SUBJECTIVE DATA
2. OBJECTIVE INFORMATION / OBJECTIVE DATA

Differences Between Subjective and Objective Data

Subjective Data—Symptoms	Objective Data—Signs
What the patient tells you	What you detect during the examination
The history, from Chief Complaint through Review of Systems	All physical examination findings
Example: Mrs. G is a 54-year-old hairdresser who reports pressure over her left chest "like an elephant sitting there," which goes into her left neck and arm.	*Example:* Mrs. G is an older, overweight white female, who is pleasant and cooperative. Height 5′4″, weight 150 lbs, BMI 26, BP 160/80 right arm, sitting, HR 96 and regular, respiratory rate 24 and regular, temperature 97.5°F oral

NOTE: WHEN STUDENTS ARE COLLECTING THE INFORMATION AND SHARING IT WITH INSTRUCTORS, ADDRESSES AND PHONE NUMBERS SHOULD BE DELETED, AND INITIALS (NOT NAMES) SHOULD BE USED TO PROTECT THE CLIENT'S PRIVACY.

3. OBSERVATIONS AND MEASUREMENTS

nurses may not realize it, but they begin to 'assess' and 'make observations' about patients from the very moment they set eyes upon them.

- wheelchair/ walking?
- using a stick, limping, unsteady gait?
- facial color?
- breathing rapid or shallow?
- poor posture?
- vital signs
- bleeding?
- increased or decreased body wt ?

facial expression like ← Pain, fear, anxiety.

cool moist or dehydrated skin.

MEASUREMENT

- VITAL SIGNS
  1. TEMPERATURE
  2. CARDIAC RATE/ PULSE RATE
  3. RESPIRATORY RATE
  4. BLOOD PRESSURE
  5. PAIN (5TH VITAL SIGNS)

O – L – D – C – A – R – T – S

- **O – ONSET**
- **L – LOCATION**
- **D – DURATION**
- **C – CHARACTERISTIC SYMPTOMS**
- **A – ASSOCIATED MANIFESTATION**
- **R- RELIEVING FACTORS**
- **T- TREATMENT**

OLD CART

HR Temp.
RR Pain
BP

4. PROCEDURES AND INVESTIGATION

- **LABORATORY – PHYSIOLOGICAL FUNCTION OF AN ORGAN**
- **DIAGNOSTIC PROCEDURE – ANATOMICAL STRUCTURE OF AN ORGAN**
  - CT
  - USS
  - endoscopy