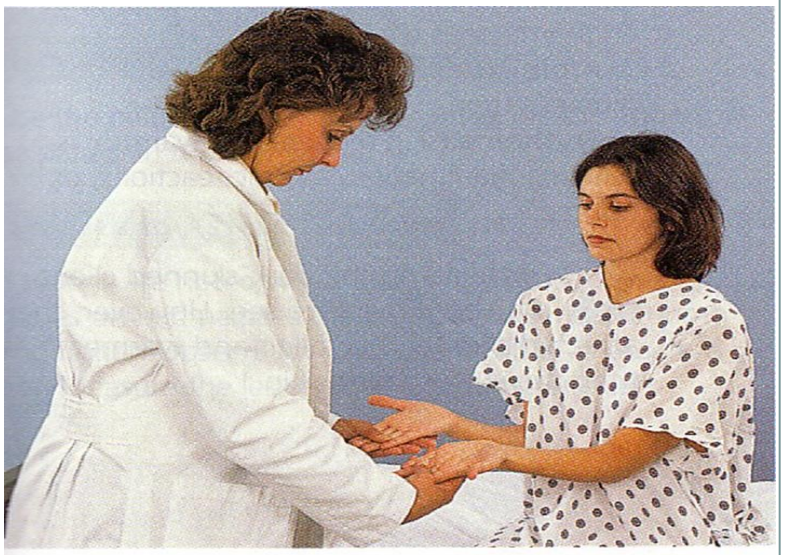
Health Assessment

Assessment: systematic collection of data to determine patient's health status and any actual or potential health problems.

Assessment data are gathered through the health history and the physical examination.



Inspecting the palms is an opportunity to assess overall coloration. (© B. Proud.)

Types of assessment

- Initial assessment:

Initial assessment is performed within a specified time after admission to a health care agency for the purpose of establishing a complete database for problem identifications, and future comparison.

Problem-Focused

- Problem-focused assessment is an ongoing process integrated with nursing care to determine the status of a specific problem identified in an earlier assessment.

Emergency assessment

- Emergency assessment occurs during any physiologic or psychological crisis of the client to identify the life-threatening problems.

Time-lapsed

- Time-lapsed reassessment occurs several months after the initial assessment to compare the client's current status to baseline data previously obtained.

Phases of Assessment Process

1. Collecting data.
2. Validating (verifying) data.
3. Organizing data.
4. Analyze the data.
5. Documenting data

Types of data

Subjective Data

- Symptoms or covert data
- Can be described only by person affected
- Includes pain, anxiety, sensations, feelings, values, beliefs, and attitudes.

Objective Data

- Signs or overt data.
- Detectable by an observer.
- Can be seen, heard, felt, or smelled.
- Obtained through observation or physical examination.

Methods of Data Collection

Interviewing

Planned communication or a conversation with a purpose.

It's used to:

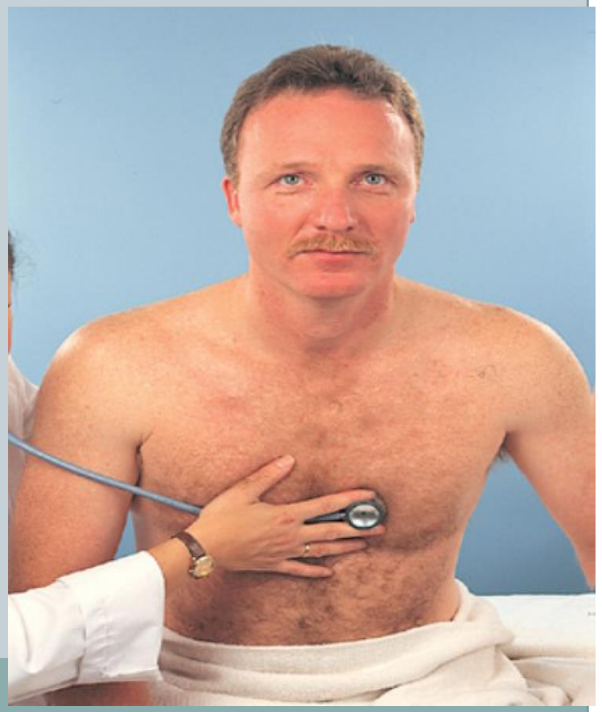
- Take a history.
- Identify problems.
- Teach patient.
- Provide support or counseling

Observing

- Gathering data using the senses.
- Used to obtain following types of data:
  - Skin color (vision).
  - Body or breath odors (smell).
  - Lung or heart sounds (hearing).
  - Skin temperature (touch).

Examining (physical examination)

- Systematic data-collection method. It uses inspection, auscultation, palpation, and percussion
- Blood pressure , Pulses
- Heart and lungs sounds
- Skin temperature and moisture
- Muscle strength



Basic components of health assessment

- (A)Complete health history
- (B)Physical examination

Health History

Health history is "a review of the client's functional health patterns prior to the current contact with a health care agency."

Components of health history:

- Demographic information(Name - Gender - Address - Type of health insurance - Date of birth)
- Reason for seeking health care
- History of the present illness **(COLDSPA)** (Character- Onset – Location- Duration- Severity/Intensity- Pattern- Associated factors/How it affects the client)

- Past health history (Major illnesses- Allergies- Previous injuries/Fractures- Childhood diseases/Immunizations)
- Family medical history
- Lifestyle practices/Nutrition
- Current medication
- Psychological history
- Sociocultural history


Thank You!