CHAPTER: 2nd

NURSING ASSESSMENT

24/07/21

NSG assessment is the ability to assess patients in a holistic manner is a skill integral to nsg regardless of the practice setting

HEALTH ASSESSMENT.

Health asses. is very important in any health care settings. The two components of a health asses. are health history & physical examination.

TYPES of health asses.

1. Comprehensive H.A: includes health history & complete physical examination, it is usually done when a client enters a health care setting. It encompasses the physical, psychological, social & spiritual dimensions of living.

2. Ongoing partial assessment: is one that is conducted at regular intervals during the care of the client. This type of assessment focuses on identified health problems to monitor positive or -ve changes & evaluate the effectiveness of interventions

3. Focused assessment: is conducted to assess a specific health problem.

4. Emergency asses: is a type of rapid focused assessment conducted to determine potentially fatal situations.

Purpose of the health assessment

1. To establish a database of the clients normal abilities, risk factors that can contribute to dysfunction and any current alteration in function.

2. To get a clear picture of the clients health status of health related problems.

3. To plan strategies to, encourage continuation of healthy patterns, prevent potential health problems and alleviate existing health problems.

4. To get a holistic view of the client.

26/07/21 ## Conducting a health assessment

1. Reviewing general information: it is good to collect some general information about the client using secondary data sources which includes chart or other health care providers. Clients name, age, current medical history, treatment etc, can be collected from secondary sources.

2. Consideration of the culture: cultural

Sensitivity is imp. when conducting a health assessment.

3. Preparation of the client: The client's physiological & psychological needs should be considered before & during the health assessment. The nurse should explain to the client about the process & what to expect during assessment. This will help to reduce the anxiety & will make the client comfortable.

4. Preparation of the environment: The env. must be comfortable for both nurse & the client. A clean, quiet & well-lit room is ideal. All the needed equipment in full functional capacity must be available.
- Provide privacy & confidentiality must be ensured.

5. Organizing and documenting: document pertinent information obtained during the interview.

6. Introduction to the client: The nurse must introduce herself/himself before starting the interview.

HEALTH HISTORY

It is a collection of subjective data that provides a detailed profile of the client's health status. While collecting health history, the nurse must be professional, concerned and attentive throughout the interview.

When the client responds to a question convey interest by maintaining eye contact, occasionally nodding or verbally responding to his/her remarks.

Health his includes the following.

1. Bio graphic data: name, address, gender, age, marital status, occupation, religious preferences, family income/month, year, etc. qualification.

2. Chief complaints: Documents in clients own words.

3. History of present illness: Onset, signs & symptoms, duration, treatment taken if any for the same, other complaints such as loss of appetite insomnia, disorders of stomach etc, also should be found.

4. Past medical history: Childhood illness - mumps, measles, etc so on.
Allergies mental diseases, accidents, injuries, surgeries, blood transfusions, use of over the counter products.

5. Family history: information about all family members (father, mother, grandparents, brothers & sisters) living or dead, cause of death (if any) condition of their health, family history of any illness e.g., diabetes mellitus, cancer, heart disease etc.

6. Lifestyle / high risk behaviour: Smoking alcoholism, substance abuse, food habits, likes & dislikes, pattern of sleep, exercise pattern, health care facility available.

7. Obstetrical history: Menstrual history, history of pregnancy, labour, puerperium & their complications, if any, history of children, alive or dead etc.