
UNIT 1
ASSESSMENT OF THE WHOLE PERSON

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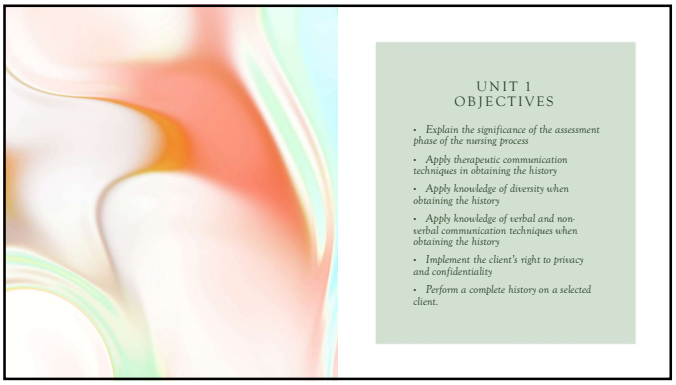
UNIT 1
OBJECTIVES
• Explain the significance of the assessment phase of the nursing process
• Apply therapeutic communication techniques in obtaining the history
• Apply knowledge of diversity when obtaining the history
• Apply knowledge of verbal and non-verbal communication techniques when obtaining the history
• Implement the client's right to privacy and confidentiality
• Perform a complete history on a selected client.

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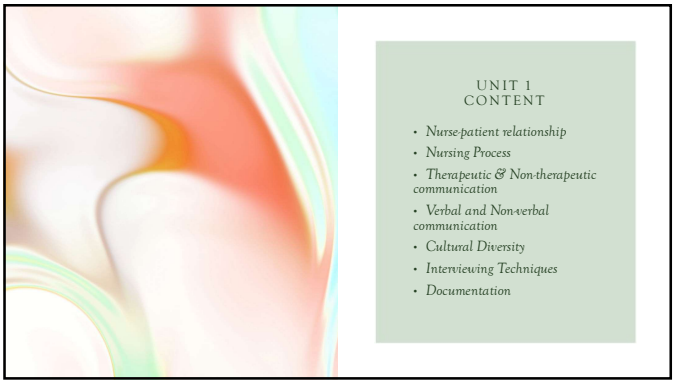
UNIT 1
CONTENT
• Nurse-patient relationship
• Nursing Process
• Therapeutic & Non-therapeutic communication
• Verbal and Non-verbal communication
• Cultural Diversity
• Interviewing Techniques
• Documentation

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CHAPTER 1
EVIDENCE-BASED ASSESSMENT

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CHAPTER 1 OBJECTIVES

Objectives For Chapters 1

Define vocabulary and terminology associated with the assigned chapter.

Describe components of the nursing process as related to health assessment.

Explain the process and purpose of assessing.

Differentiate objective and subjective data, primary and secondary data.

Identify methods of data collection and give examples of how each is useful.

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- *Tell me something about CD's case*
- *What did the examiner analyze & interpret?*
- *What data did the examiner gather?*

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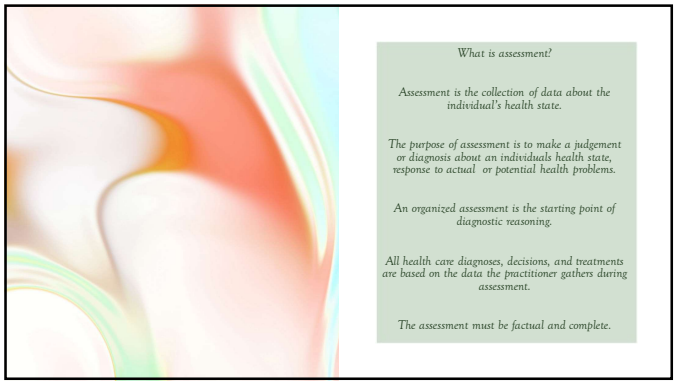
What is assessment?
Assessment is the collection of data about the individual's health state.
The purpose of assessment is to make a judgement or diagnosis about an individuals health state, response to actual or potential health problems.
An organized assessment is the starting point of diagnostic reasoning.
All health care diagnoses, decisions, and treatments are based on the data the practitioner gathers during assessment.
The assessment must be factual and complete.

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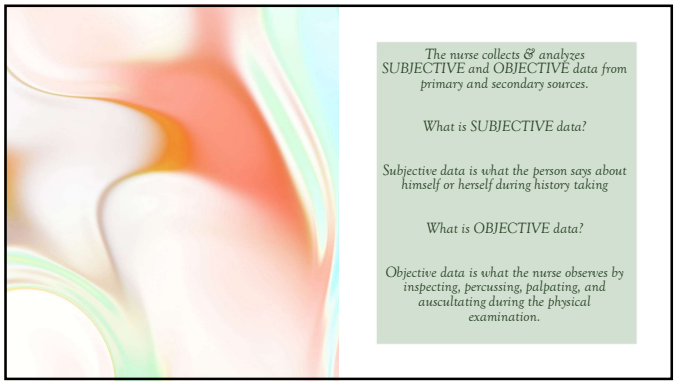
The nurse collects & analyzes SUBJECTIVE and OBJECTIVE data from primary and secondary sources.
What is SUBJECTIVE data?
Subjective data is what the person says about himself or herself during history taking
What is OBJECTIVE data?
Objective data is what the nurse observes by inspecting, percussing, palpating, and auscultating during the physical examination.

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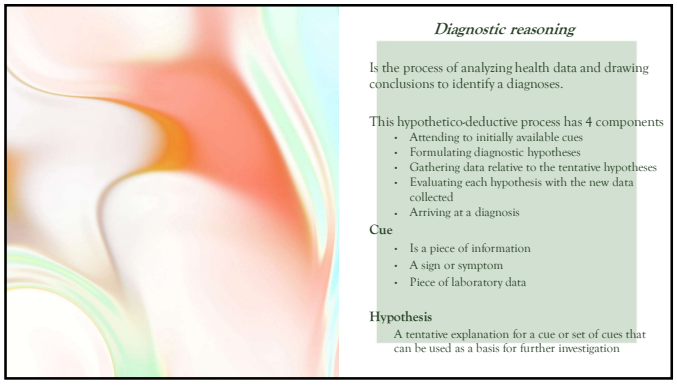
Diagnostic reasoning
Is the process of analyzing health data and drawing conclusions to identify a diagnoses.
This hypothetico-deductive process has 4 components
Attending to initially available cues
Formulating diagnostic hypotheses
Gathering data relative to the tentative hypotheses
Evaluating each hypothesis with the new data collected
Arriving at a diagnosis
Cue
Is a piece of information
A sign or symptom
Piece of laboratory data
Hypothesis
A tentative explanation for a cue or set of cues that can be used as a basis for further investigation

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The Nursing Process is the standard of practice in nursing.

It includes six phases:

- Assessment
- Diagnosis
- Outcome identification
- Planning
- Implementation
- Evaluation

The nursing process is a dynamic, interactive process

The nurses moves back and forth within the phases.

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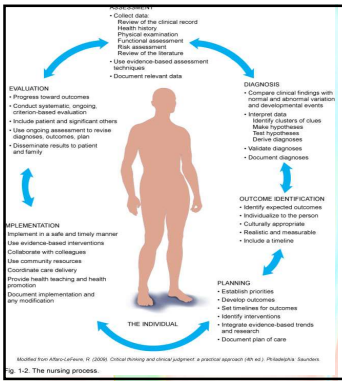

Modified from Alfaro-LeFevre, R. (2009). Critical thinking and clinical judgment: a practical approach (4th ed.). Philadelphia: Saunders.

Fig. 1-2. The nursing process.

- Nursing Process

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- Novice to Expert
- Novice
- Competent
- Proficient
- Expert

- Moving from Novice to Expert is through the use of critical thinking

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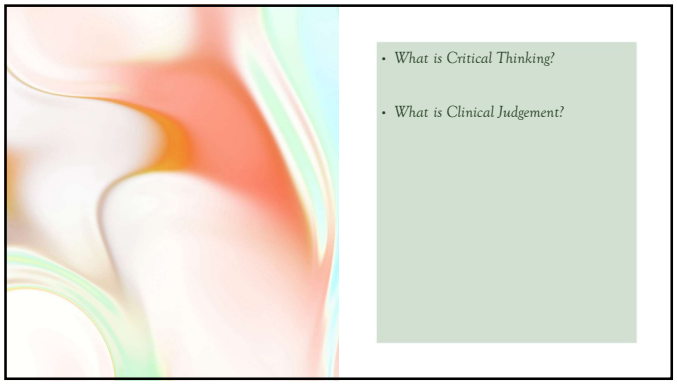
• What is Critical Thinking?
• What is Clinical Judgement?

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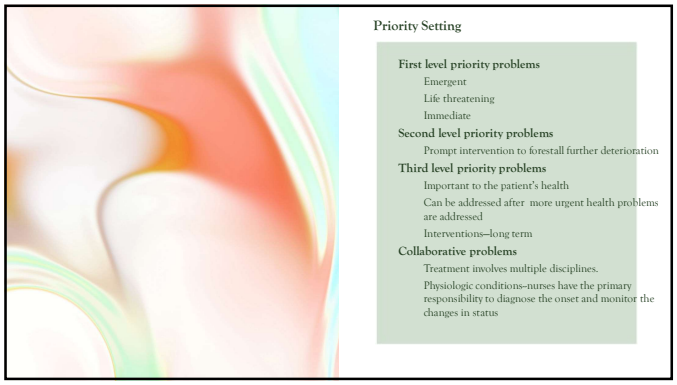
Priority Setting
First level priority problems
Emergent
Life threatening
Immediate
Second level priority problems
Prompt intervention to forestall further deterioration
Third level priority problems
Important to the patient's health
Can be addressed after more urgent health problems are addressed
Interventions–long term
Collaborative problems
Treatment involves multiple disciplines.
Physiologic conditions–nurses have the primary responsibility to diagnose the onset and monitor the changes in status

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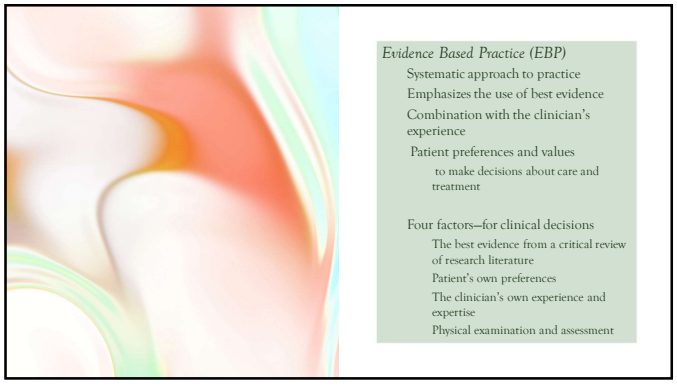
Evidence Based Practice (EBP)
Systematic approach to practice
Emphasizes the use of best evidence
Combination with the clinician's experience
Patient preferences and values
to make decisions about care and treatment
Four factors–for clinical decisions
The best evidence from a critical review of research literature
Patient's own preferences
The clinician's own experience and expertise
Physical examination and assessment

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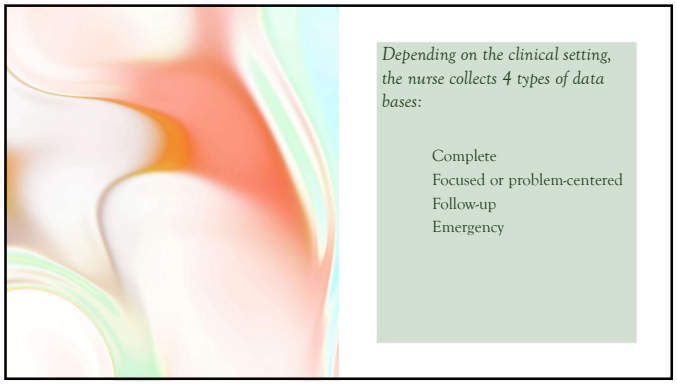

Depending on the clinical setting, the nurse collects 4 types of data bases:

- Complete
- Focused or problem-centered
- Follow-up
- Emergency

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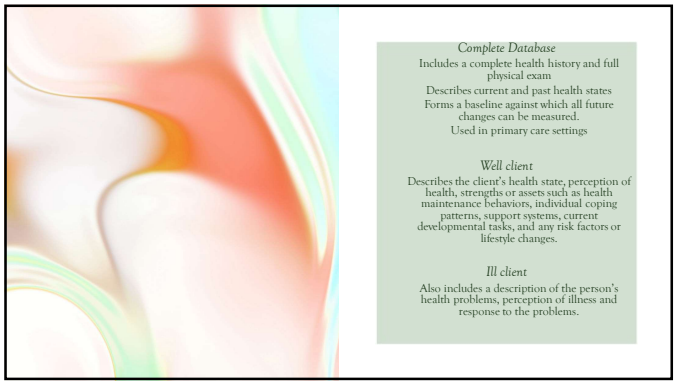

Complete Database

Includes a complete health history and full physical exam

Describes current and past health states

Forms a baseline against which all future changes can be measured.

Used in primary care settings

Well client

Describes the client's health state, perception of health, strengths or assets such as health maintenance behaviors, individual coping patterns, support systems, current developmental tasks, and any risk factors or lifestyle changes.

Ill client

Also includes a description of the person's health problems, perception of illness and response to the problems.

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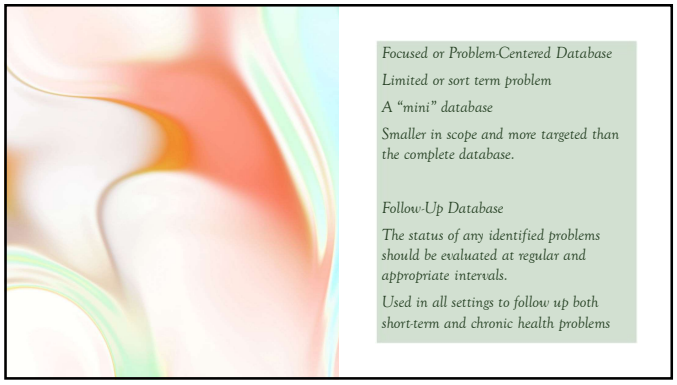

Focused or Problem-Centered Database

Limited or sort term problem

A "mini" database

Smaller in scope and more targeted than the complete database.

Follow-Up Database

The status of any identified problems should be evaluated at regular and appropriate intervals.

Used in all settings to follow up both short-term and chronic health problems

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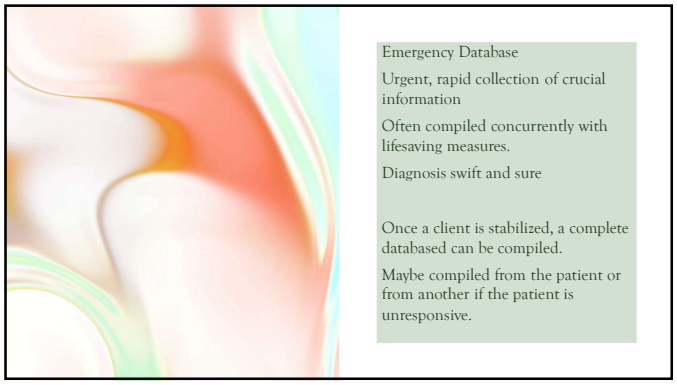
Emergency Database
Urgent, rapid collection of crucial information
Often compiled concurrently with lifesaving measures.
Diagnosis swift and sure
Once a client is stabilized, a complete databased can be compiled.
Maybe compiled from the patient or from another if the patient is unresponsive.

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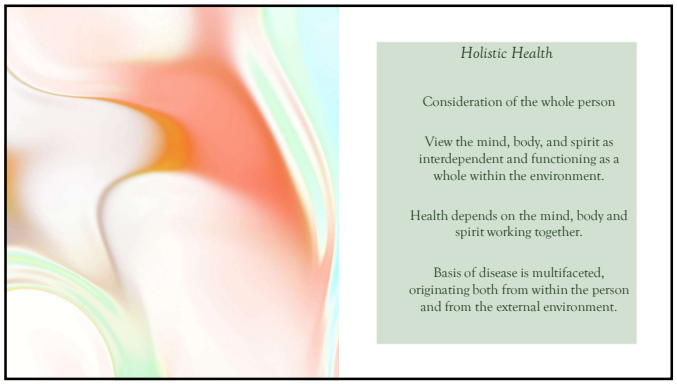
Holistic Health
Consideration of the whole person
View the mind, body, and spirit as interdependent and functioning as a whole within the environment.
Health depends on the mind, body and spirit working together.
Basis of disease is multifaceted, originating both from within the person and from the external environment.

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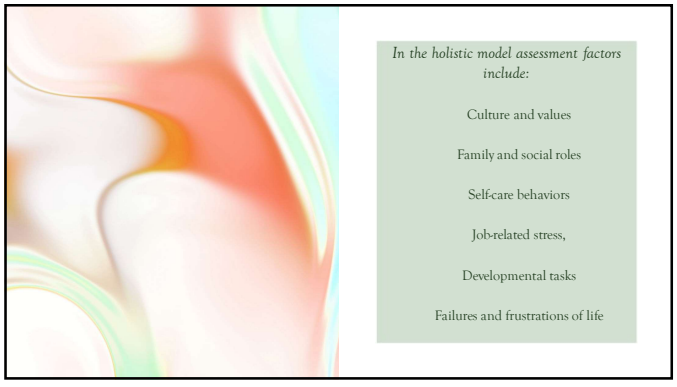
In the holistic model assessment factors include:
Culture and values
Family and social roles
Self-care behaviors
Job-related stress,
Developmental tasks
Failures and frustrations of life

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Health promotion and disease prevention now are part of our concept of health.

Guidelines to prevention emphasize the link between health and personal behavior.

Health promotion is a set of positive acts we can take .

Frequency interval of assessment varies

- Ill people seek care because of pain or some abnormal signs and symptoms
- Well people opinions are inconsistent about assessment intervals.
- Routine health checkups are an excellent opportunity to deliver preventive services update the complete database.

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The Guide to Clinical Preventive Services

- Evidence-based, gold standard recommendations
  - Screening,
  - Counseling
  - Preventive topics

Assessment factors must include culture

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THE END

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