

Health History and Physical Examination for the Nursing Assessment and Healthcare Management Plan

LISA BRACE, MS, RN

Dr. Elfleta L. Lawton– Nixon, DNP, RN
DDA Health Initiative



Objectives

- ▶ The Registered Nurse will be able to:
 - Identify the various sources for a health history and conduct a complete current nursing assessment of systems utilizing the nursing process.
 - Demonstrate (implementation) interventions by assigned staff for completing steps to achieve the registered nurse's (RN) identified health outcomes for their individuals in the Health Care Management Plan (HCMP).
 - Describe how to incorporate the findings of other health professionals within the nursing assessment and HCMP documentation.
 - Identify the major areas of health risk associated with people with intellectual disability.
 - Apply the principles of Nursing Process to a case study.



Health History

- ▶ Biographic Data
- ▶ Chief Complaint
- ▶ History of Present Illness
- ▶ Past History
- ▶ Current Health Data
- ▶ Lifestyle
- ▶ Social Data
- ▶ Mental Status Assessment
- ▶ Patterns of Healthcare



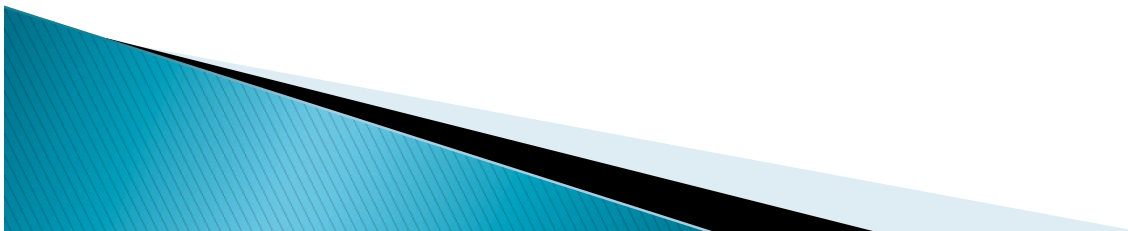
Chief Complaint

- ▶ Should be in individual's own words.
 - In the event the individual cannot speak, communicate with the Direct Support Professionals (DSPs) about their findings.



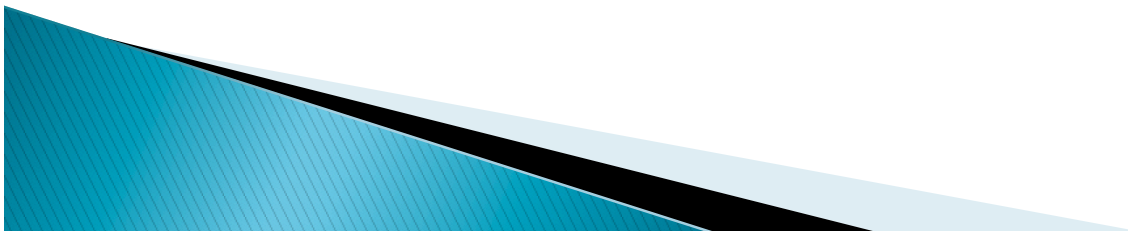
Past History

- ▶ Review the medical records (specialist evaluations, annual physicals, primary care provider notes, emergency room/hospitalization documents).
- ▶ Communicate with the primary care provider about diagnoses and medical history.
- ▶ Communicate with family (when applicable) .
- ▶ Communicate with previous provider(s) (assure medical documentation received).



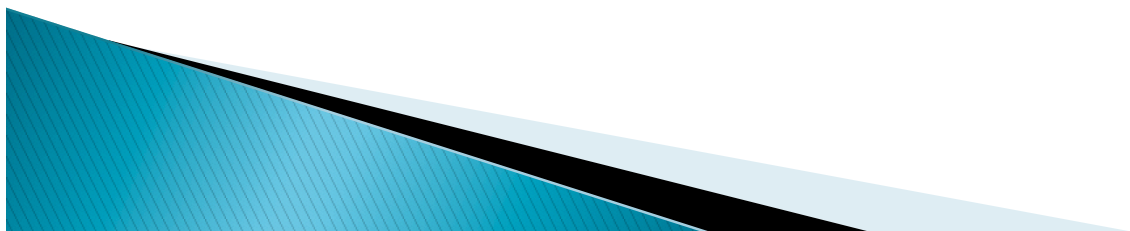
Components of the Mental Status Assessment

- ▶ General Appearance
- ▶ Behavior / activity
- ▶ Speech and language
- ▶ Mood and affect
- ▶ Thought process and content
- ▶ Perceptual disturbances
- ▶ Memory / cognitive
- ▶ Judgment and insight



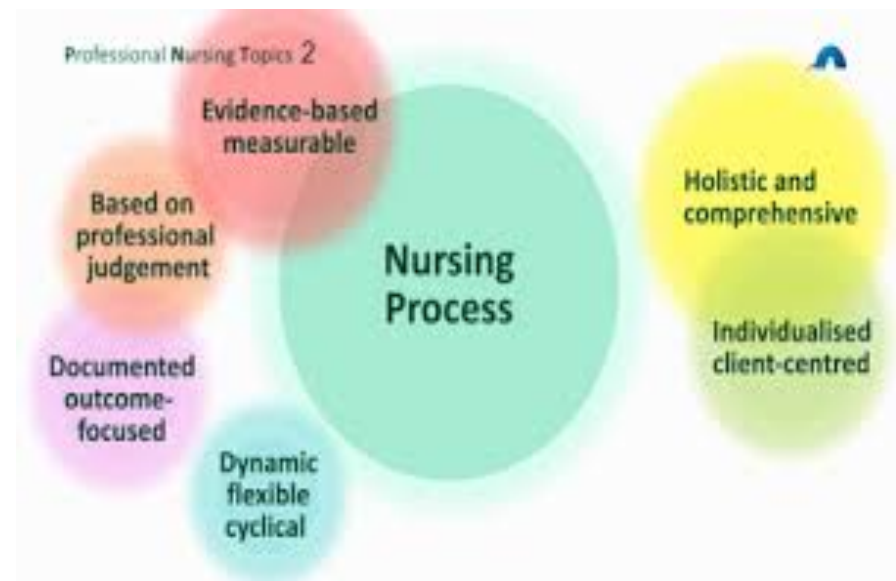
Characteristics of:

Feature	Dementia	Delirium	Depression
Onset	Gradual (months to years)	Abrupt (hours to a few weeks)	Either
Prognosis Course Attention Memory	Irreversible Progressive Normal Impaired recent and remote	Reversible Worse in P.M. Impaired recent and immediate	Variable Possibly worse in A.M. Variable Impairment
Cause	Caused by many diseases, including alcoholism, acquired immunodeficiency syndrome (AIDS), cerebral anoxia, and brain infarcts	Caused by acute illness, fever, infection, dehydration, electrolyte imbalance, medications, and alcoholism	May coincide with life event, such as death in the family, loss of a friend or a pet, or a move



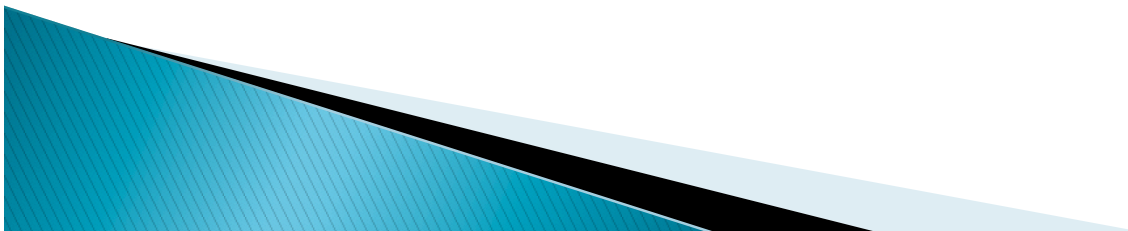
The Nursing Process

- ▶ Systematic problem solving method that has five steps
 - Assessment
 - Nursing Diagnoses
 - Planning
 - Implementation
 - Evaluation



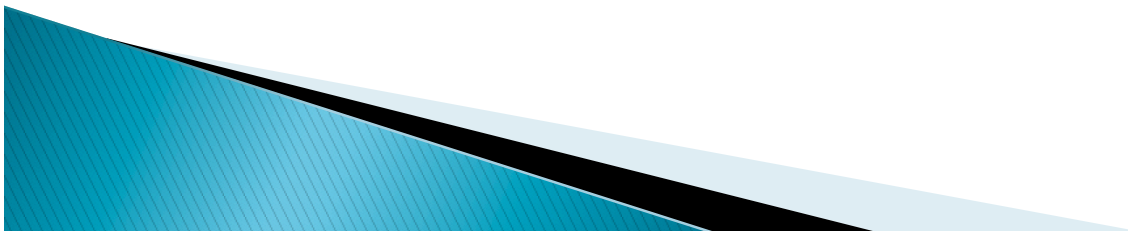
Nursing Assessment

- ▶ Must be completed by a registered nurse (RN).
 - This should not be delegated to a licensed practical nurse (LPN).
- ▶ Process of collecting, validating, and clustering data.
 - First and most important step in the nursing process.



Nursing Assessment

- ▶ A nursing assessment should be completed as part of the initial Individual Support Plan and revised annually. Any time within that 12 month period if there is a significant change in health condition, the nursing assessment will need to be revised. Notwithstanding, focused assessments may be needed at any time to detect changes in health.



Nursing Assessment

- ▶ Complete Health Forms 1, 2, and 3
 - Health Form 1 should be completed by nursing staff and filed in the medical record.
 - Health Form 2 should be completed by the Direct Support Professionals (DSP), and does not need to be filed in the medical record.
 - Health Form 3 should be completed by nursing staff, and does not need to be filed in the medical record.

- ▶ Complete Nursing Health and Safety Assessment



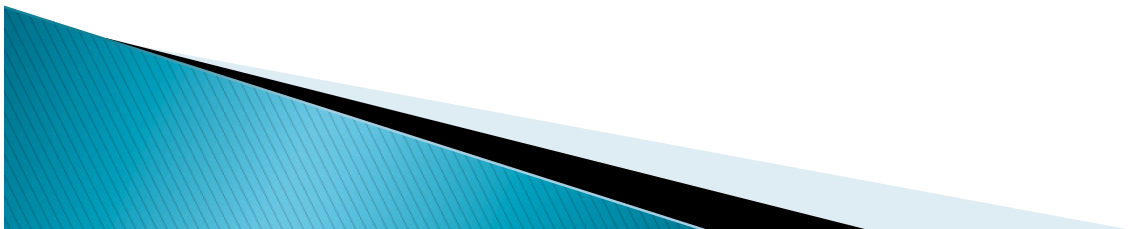
Nursing Health and Safety Assessment Forms

▶ Form A

- Designed for individuals needing an ICF level of care or 24 hour staff supports. In addition, the Director of Nursing in any setting may decide to use this form in order to best assess an individual's health care status.

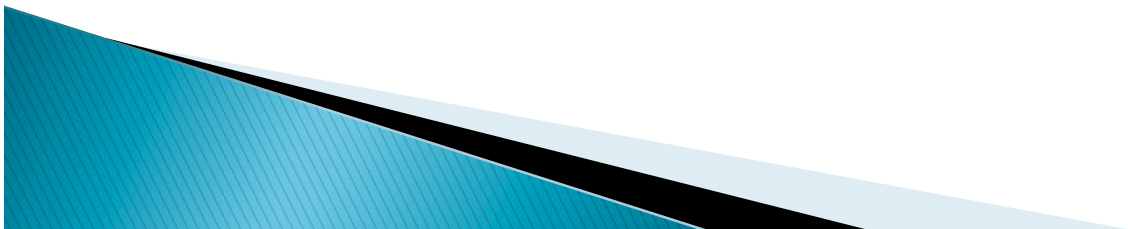
▶ Form B

- Designed for individuals receiving 20 hours or less of staff support each week. However, whether to use Nursing Assessment Form A or Form B for an individual, is always at the discretion of the Director of Nursing in that setting.



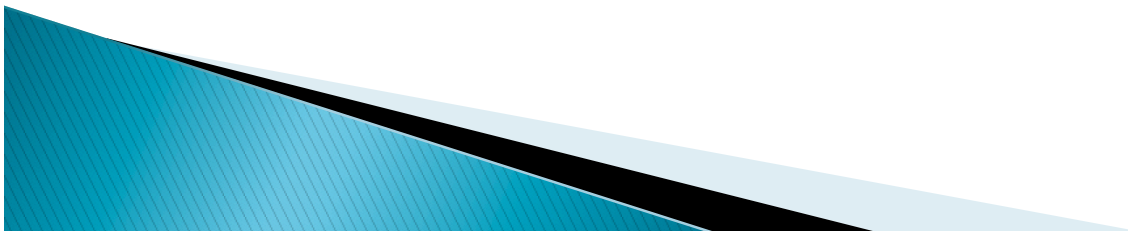
Nursing Health and Safety Assessment

- ▶ **Section I: Identifying Information**
 - Information similar to that found on the health passport.
- ▶ **Section II: Brief Health History**
 - Please be sure to include information that has happened within the past year.
 - Incorporate the information obtained from your health history.



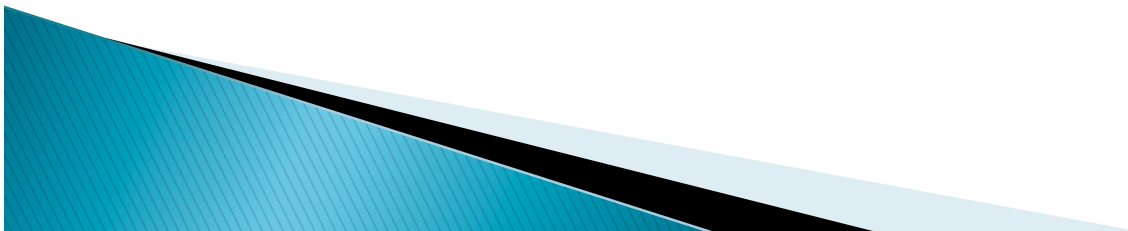
Nursing Health and Safety Assessment

- ▶ Section III: Health Data
 - Should be current medical information.
 - Includes information similar to that found on the health passport (medical problems, consent procedures, current medications, allergies, etc.)



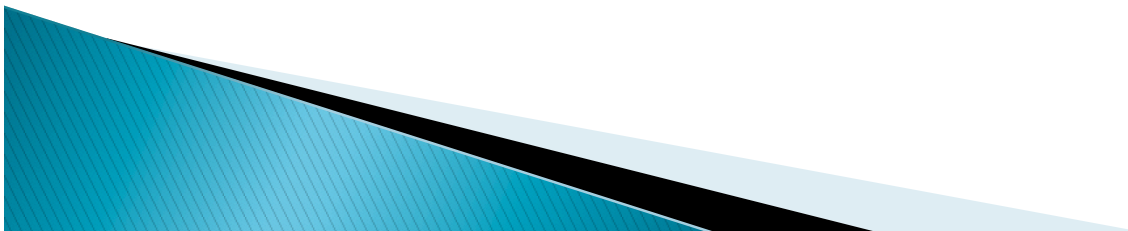
Nursing Health and Safety Assessment

- ▶ Section IV
 - Form A: Review of systems
 - Form B: Health Skills Assessment

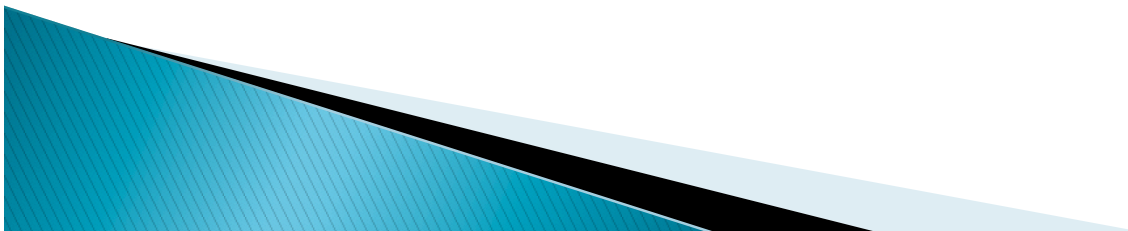
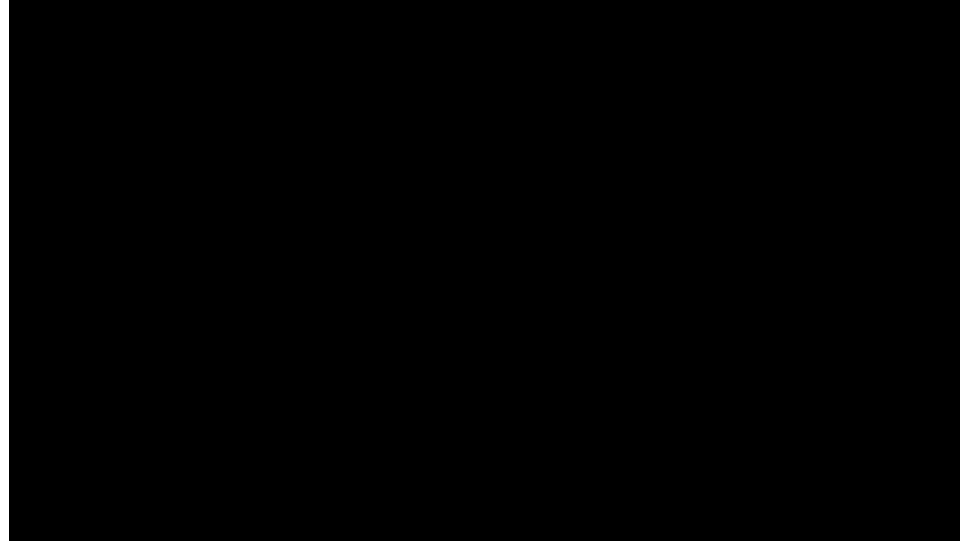


Physical Assessment

- ▶ Helps assess patient's health status and identify actual or potential problems
- ▶ Use techniques of inspection, palpation, percussion, and auscultation.

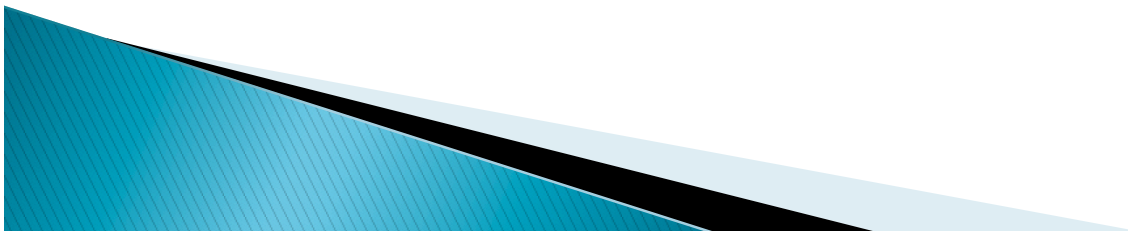


Physical Assessment Video



Types of Physical Assessments

- ▶ Complete physical assessment
 - Assess all structures, organs, body systems, etc.
- ▶ Focused physical assessment
 - Zero in on an acute problem

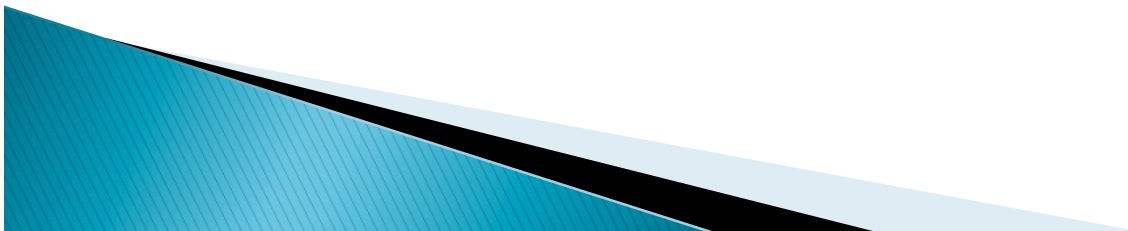
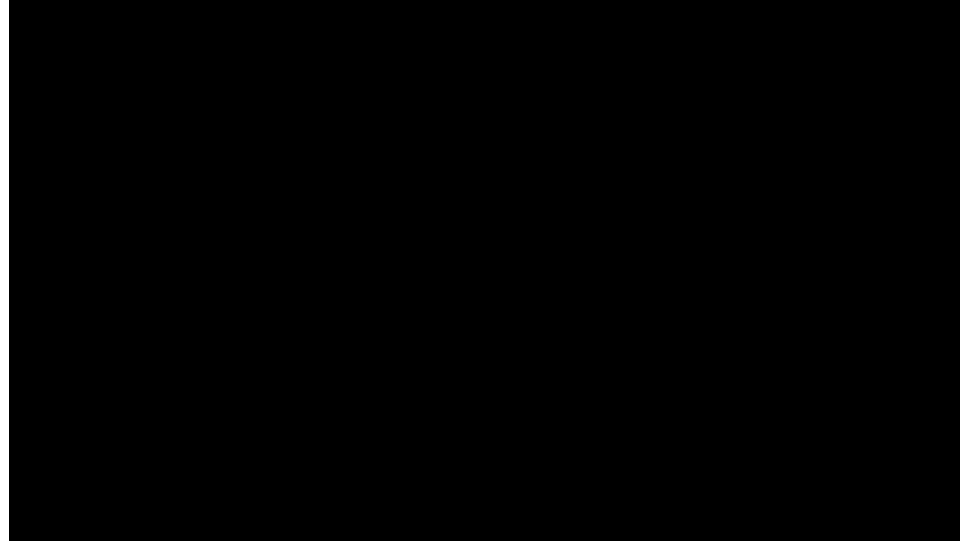


Complete Physical Assessment

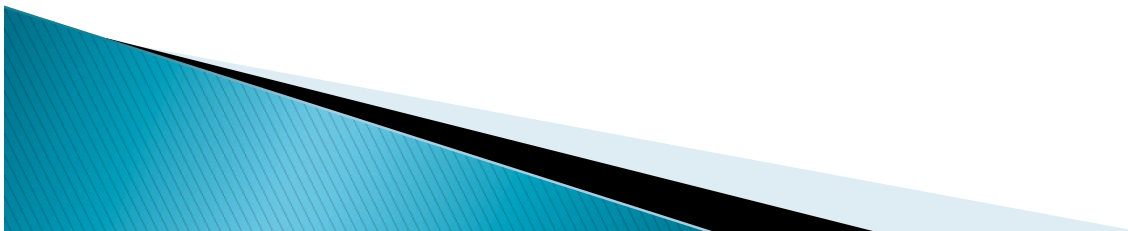
- ▶ Begins with general survey
 - Note appearance, behaviors, vital signs, and height/weight
- ▶ Head to toe systematic physical assessment
 - Proceed from one area to another, and remember that all systems are related.



Breath Sounds

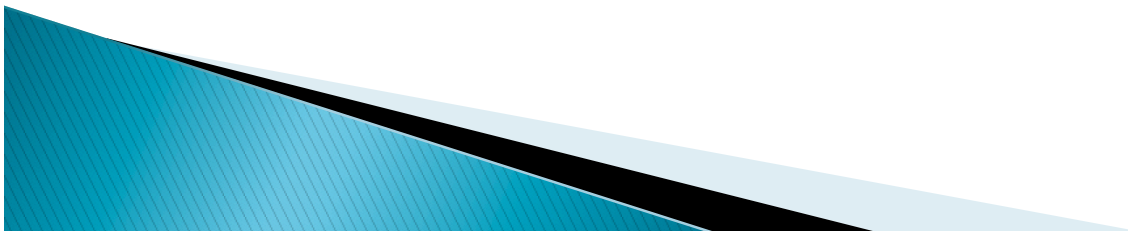


Heart Sounds



Physical Assessments

- ▶ *Techniques are similar to medical physical assessments, but underlying rationale is different*
 - Physicians diagnose and treat illness; Nurses diagnose and treat the individual's response to a health problem to promote health and well-being.



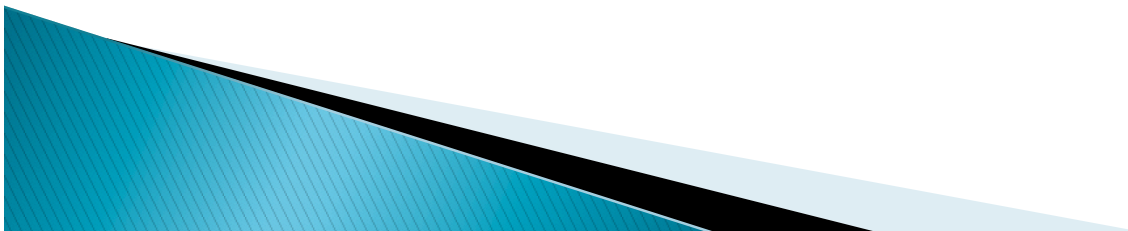
Findings from Health Professionals

- ▶ PT provides recommendation regarding ambulation, transfers, and safety.
- ▶ OT provides recommendations regarding adaptive equipment as it relates to ADLs.
- ▶ Speech and Language Pathologist provides information regarding speech and swallowing, and provides recommendations.
- ▶ Dietician provides recommendations for diet and meal protocols.
- ▶ Physician specialists provides information pertaining to medications and monitoring for a specific system concern.



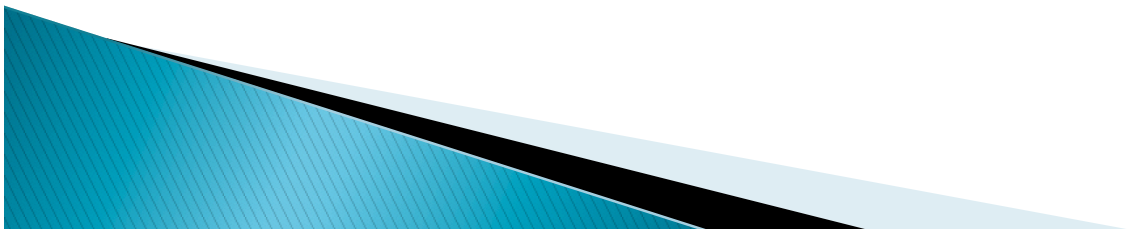
Findings from Health Professionals

- ▶ Read all specialists' reports.
- ▶ Obtain physician orders for specialists' recommendations.
- ▶ Observe the individual's response to the implemented recommendations.
- ▶ Incorporate information in nursing assessment and HCMP documentation.



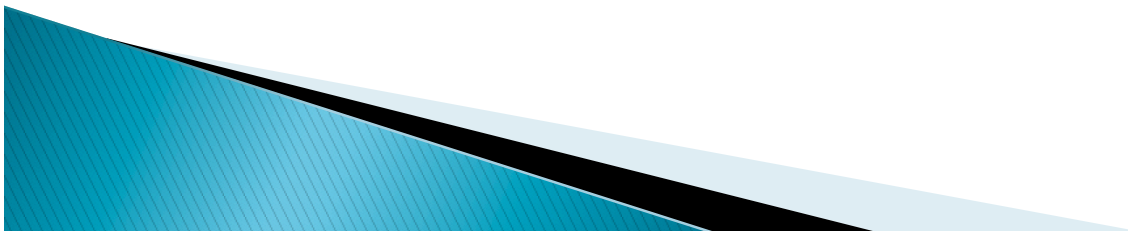
Areas of Health Risk for Individuals with IDD

- ▶ Cardiovascular
 - Cardiovascular disease
 - Hypertension
- ▶ Gastrointestinal
 - GERD
 - Constipation
- ▶ Musculoskeletal
 - Osteoporosis
- ▶ Oral Health
 - Gingivitis
 - Periodontal disease
- ▶ Lifestyle health risks
 - Tobacco use/ exposure
 - Overweight/Obesity



Areas of Health Risk for Individuals with IDD

- ▶ Urinary
 - Urinary Tract Infections
- ▶ Respiratory
 - Influenza
 - Pneumonia



Case Study



References

- ▶ Dillon, P.M. (2007). Nursing Health Assessment: A Critical Thinking, Case Studies Approach. Philadelphia: F.A. Davis Company.
- ▶ Haveman, M., Heller, T., Lee, L., Maaskant, M., Shooshtari, S., & Strydom, A. (2010). Major health risks in aging persons with intellectual disabilities: An overview of recent studies. *Journal of Policy and Practice in Intellectual Disabilities*, 7, 59-69
- ▶ Redoblado, R. (2010, Jan 29). *Components of Nursing Health History*. Retrieved from <http://www.scribd.com/doc/26052923/Components-of-Nursing-Health-History>

