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HEALTH ASSESSMENT AND PROMOTION IN NURSING PRACTICE

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Although health assessments are performed regularly and routinely, they must be conducted and documented with great thoroughness and attention to detail. Nursing assessments inform each step of the patient's care plan. Therefore, nurses have a tremendous responsibility to ensure they have the necessary skill sets to perform accurate evaluations for all patients. The article outlines main types of health assessment, that are included into the course of studies Health Assessment, which is aimed at development of systemic knowledge and understanding of conceptual foundations by students utilizing systematic history taking and the knowledge of therapeutic communication to elicit subjective data; collecting objective data; validating, analyzing and documentation of those data. Holistic health assessment is viewed from a health promotion, cultural, nutritional, mental health and developmental perspective. During this course students identify appropriate methods of data collection to conduct a multidimensional systemic screening health assessment on clients across the lifespan. Health Assessment is one of the main courses for students studying at I. Horbachevsky Ternopil National Medical University, Training program "Nursing", the first (bachelor) degree of higher education, branch of knowledge 00 "22 Health Care", specialty 223 "Nursing".

ОБСТЕЖЕННЯ ТА ОЦІНКА СТАНУ ЗДОРОВ'Я В ПРАКТИЦІ МЕДИЧНОЇ СЕСТРИ

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Незважаючи на те, що оцінку стану здоров'я пацієнтів зазвичай проводять на регулярній основі, вона вимагає великої ретельності та уваги до найменших деталей. Правильність обстеження пацієнтів визначає кожен подальший крок на шляху до встановлення діагнозу, призначення лікування та затвердження плану догляду за хворими. Саме тому медичні сестри повинні володіти необхідними навичками для проведення оцінки стану здоров'я пацієнтів. У статті окреслено основні види оцінки стану здоров'я пацієнтів, які вивчають на заняттях з предмета «Обстеження та оцінка стану здоров'я людини», спрямованого на розвиток у студентів системних знань і розуміння концептуальних основ шляхом виконання систематичного збору анамнезу та комунікації з хворими для виявлення даних суб'єктивного й об'єктивного обстежень, аналізу і документування цих даних. Цілісну оцінку стану здоров'я пацієнтів розглядають з точки зору їх зміцнення, культури харчування, психічного здоров'я та розвитку. В ході вивчення цього предмета студенти оволодівають методами збору даних для проведення багатовимірної системної скринінгової оцінки стану здоров'я пацієнтів протягом усього життя. Дисципліна «Обстеження та оцінка стану здоров'я людини» є однією з основних для студентів, які навчаються в Тернопільському національному медичному університеті імені І. Я. Горбачевського МОЗ України за програмою «Сестринська справа» першого (бакалаврського) рівня вищої освіти галузі знань 22 «Охорона здоров'я», спеціальності 223 «Медсестринство».

Introduction. As nursing becomes a first-level discipline, the central focus of the development process of nursing science is the independent exploration of the future path of nursing care. Health Assessment provides the core skills for basic nursing practice [1, 2]. This course focuses on the development of a body systems approach to health assessment of individuals emphasizing normal growth and developmental responses across the lifespan. Content includes an introduction to the knowledge and skills of health assessment through a variety of methodologies in the

classroom, opportunities to practice skills in the nursing laboratory and experiences in the clinical settings. Students apply communication techniques in eliciting comprehensive health histories and perform physical examinations in evaluating health status [3].

The main part. Health Assessment is one of the main courses, which provide the nurse with the knowledge needed to provide a complete health assessment for an adult patient. Health assessment of patients falls under the purview of both physicians and nurses. While some nurses practice in extended roles (Advanced Nurse Practitioners), others maintain a more traditional role in the acute care setting. Assessment of patients varies based on both role and setting. A cardiac care nurse will be more familiar with and attuned to cardiac issues. A nurse on a neurologic unit will be more familiar with a more complex neurologic exam [4].

General Health Assessment

The nursing health assessment is an incredibly valuable tool nurses have in their arsenal of skills. A thorough and skilled assessment allows you, the nurse, to obtain descriptions about your patient's symptoms, how the symptoms developed, and a process to discover any associated physical findings that will aid in the development of differential diagnoses. Assessment uses both subjective and objective data. Subjective assessment factors are those that are reported by the patient. Objective assessment data includes that which is observable and measurable [5, 6]. During the assessment period, nurses are given an opportunity to develop a rapport with their patients and their families. It is very important to remember the adage "first impressions are lasting impressions?" That adage is also very true in healthcare. The nurse is often the first person the patient sees when admitted to hospital unit, returns from testing, or at the beginning of a new shift. Nurse`s interactions with the patient give the patient and family lasting impressions about the nurse, other nurses, the facility they are working in, and how care will be managed [7].

In general, there are four fundamental types of assessments that nurses perform:

1. A comprehensive or complete health assessment.
2. An interval or abbreviated assessment.
3. A problem-focused assessment
4. An assessment for special populations

A comprehensive or complete health assessment usually begins with obtaining a thorough health history and physical exam. This type of assessment is usually performed in acute care settings upon admission, once your patient is stable, or when a new patient presents to an outpatient clinic. Nurses collect a patient's full health history and complete a physical exam. To provide patient-centered care across the lifespan, comprehensive holistic health assessments are an increasingly preferred method. It incorporates general assessment techniques with a detailed review of the patient's overall, lifelong risk profile and the influence of cultural, sociological and familial attributes.

If the patient has been under your care for some time, a complete health history is usually not indicated. Nurses perform *an interval or abbreviated assessment* at this time. These assessments are usually performed at subsequent visits in an outpatient setting, at change of shift, when returning from tests, or upon transfer to your unit from another in-house unit. This type of assessment is not as detailed as the complete assessment that occurs at admission. The advantage of an abbreviated assessment is that it allows you to thoroughly assess your patient in a shorter period of time [1, 6].

The third type of assessment that you may perform is a *problem-focused assessment.* The problem-focused assessment is usually indicated after a comprehensive assessment has identified a potential health problem. The problem-focused assessment is also indicated when an interval or abbreviated assessment shows a change in status from the most current previous assessment or report you received, when a new symptom emerges, or the patient develops any distress. An advantage of the focused assessment is that it directs you to ask about symptoms and move quickly to conducting a focused physical exam [4, 7].

The fourth type of assessment is the *assessment for special populations*, including: Pregnant patients, Children, Infants, The elderly. If there is any indication to perform a problem-focused or special population assessment during the comprehensive assessment, the assessment should occur after obtaining a baseline comprehensive assessment. Based upon the results of the problem-focused or special population assessment, you can decide how often to perform interval assessments to monitor your patient's identified problem. The special assessment should not replace the comprehensive or interval assessments, but should augment both the complete and interval assessments. These will not be specifically addressed in this course. A systematic physical assessment remains one of the

most vital components of patient care. A thorough physical assessment can be completed within a time frame that is practical and should never be dismissed due to time constraints [5].

The physical examination can be performed in a "head-to-toe" fashion, starting with the head and ending with the toes. Although some healthcare professionals have varied tactics to performing this skill, the key to assessment is to ensure a consistent, methodical approach to avoid missing any vital assessment areas. A physical examination should include:

– Complete set of vital signs (blood pressure, heart rate, respiratory rate and temperature)

– Pain Assessment. It is recommended to use the acronym "PQRST" for quick pain assessment:

• P=provoking factors (what brought on the pain?)

• Q=quality (describe the pain- i.e. stabbing, throbbing, burning)

• R=radiation (does the pain radiate anywhere?)

• S=severity/symptoms (how bad is the pain-rate it; are there other symptoms with the pain?)

• T=timing (is it constant? What makes it better/ worse?)

A review of systems can be incorporated during the physical exam. While examining each body system, it is appropriate to ask certain history questions that pertain to that system.

Conducting health assessments will be a more fruitful endeavor if nurses establish a sense of trust and rapport with their patients. They should explain what they are doing and why, including how the assessment can improve the patient's health. Individuals are more likely to share their symptoms and health concerns if they feel valued and seen as unique individuals.

Nurses must also have well-developed physical examination skills, such as percussion and auscultation, and know which findings are within normal limits and those that demand further investigation. This requires a solid knowledge of anatomy and physiology, extensive clinical expertise and an understanding of body language and nonverbal cues. A commitment to patient-centered care is key, too.

Conclusions. 1. Once nurses are familiar with the health assessment of the adult, it is necessary to adapt the assessment for specific patients such as infants, children, and the elderly. Knowledge of age-specific considerations will allow the nurse to evaluate the significance of the health history and exam results and apply specifics to an individualized plan of care.

2. Obtaining a concise and effective health history and physical exam takes practice. It is not enough to simply ask questions and perform a physical exam. As the patient's nurse, you must critically analyze all of the data you have obtained, synthesize the data into relevant problem focuses, and identify a plan of care for your patient based upon this synthesis.

3. As the plan of care is being carried out, reassessments must occur on a periodic basis. The frequency of reassessments is unique to each patient based upon their diagnosis. The ability of the nurse to efficiently and effectively obtain the health history and physical exam will ensure that appropriate plan of care will be enacted for all patients.

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