Specific health assessment pain assessment

Specific health assessment refers to an assessment of a specific problem and it may be the initial assessment or an ongoing assessment (Bayoumi., 2009). A risk assessment is a type of assessment that uses an individual ' s personal data, genetic and environmental information to determine the risk of developing a specific disease such as cervical cancer, breast cancer, pancreatic cancer etc. (Duke, 2010). The objective of this essay is to discuss about a type of specific assessment which is pain assessment. In order to answer this question, first of all, the essay will touch on the differences between comprehensive health assessment and specific assessment. Later, the essay will discuss on the purpose and intent of pain assessment, how this pain assessment contributes to a person's comprehensive health assessment and three abnormal findings when performing the pain assessment. Lastly, it will discuss the actions that I can take for each of the three abnormal findings.

Body

A comprehensive health assessment is a thorough head-to-toe physical examination which includes a review of the medical history , a complete physical examination , a complete laboratory tests, body fat assessment, exercise tolerance test, nutrition assessment, fitness assessment and stress management. (Glymph, 2010). It is usually the initial assessment. On the other hand, a specific assessment is problem oriented . It focuses on a specific problem and not a general health (Bayoumi., 2009). If a patient's condition does not permit a comprehensive health assessment, a specific assessment of the patient's current health problem is done. It is done frequently to monitor and evaluate the patient's progress (Bayoumi., 2009).

A specific assessment is a part of a comprehensive health assessment. When the patient's condition is favorable again, a comprehensive health assessment is carried out. For example, one day, a 65-year-old man came to the emergency department with acute chest pain. Instead of performing a comprehensive health assessment, I have to perform a specific pain assessment for this patient since his condition is not favorable. I should focus on chest pain assessment, perform an electrocardiography test and laboratory tests like complete blood count, biochemistry test, creatinine kinase test and test for troponin (Fogoros, 2009). Comprehensive health assessment is not suitable in this situation as it will provide less accurate information. It should be done when the patient's condition has gotten better . Among the tests for a comprehensive health assessment are urine analysis, chest x-ray, abdominal ultrasound, fitness test, ankle brachial index, visual acuity test etc (Billinkoff, 2012).

According to the Australian and New Zealand College of Anaesthetists, pain assessment has been identified as the 5th vital signs when assessing a patient (Wood, 2008). Pain assessment is important in providing an effective management. Pain assessment involves factors that may influence patient's experience and expression of pain, the process of describing pain, and factors that may affect nurses in pain assessment such as inadequate knowledge or skills about pain, patient's poor attitude, patient's age, type and stage of disease and misconceptions about pain like the fear that patients will be addicted to pain medication (Wood, 2008). Pain assessment can be carried out using an assessment tool that identifies the quantity and

quality of the patient's experience of pain (Wood, 2008). A pain scale from 0-10 where 10 represents worst possible pain can be used.

The first abnormal finding when I perform a pain assessment in a 55-year-old man is an acute chest pain. Generally, acute chest pain is an emergency situation as it can be life-threatening. Acute chest pain is a warning symptom for heart attack, angina pectoris, aortic dissection, pulmonary embolism, spontaneous pneumothorax , perforated viscus, pericarditis, pneumonia and other esophagus related causes (Cunha & Stoppler, 2012). As a professional nurse, first of all, I should assess the patient's airway, breathing and circulation (Lynda, 2009). This is the primary assessment. Secondary assessment includes location of pain, the nature of pain, characteristics of pain, chronology of pain, the situation at the time of pain, provoking and relieving factors and other symptoms in association with chest pain (Lynda, 2009). In this patient, his airway and circulation are clear but he has shortness of breath. The pain started substernally after exercising and radiates to the jaw, left arm , back and neck. The pain is dull in character. The pain is continuous and constant. It lasts for more than 30 minutes and is not relieved by rest. According to the patient, he rates the pain as 8/10 according to the pain scale. For interventions, I should have the patient rests on the bed in Fowler or Semi-Fowler position (Nanda, 2009). Later, I will perform 12 leads electrocardiography to rule out the causes of the patient's chest pain (Nanda, 2009). Also, I will observe his 5 vital signs such as body temperature, blood pressure, pulse, respiratory rate and pain (Nanda, 2009). If necessary, I will give patient oxygen or pain killer to relieve pain. At the same time, I will observe the side effects of the medications. Besides, I will

set up an intravenous drip to rehydrate patient and take blood samples for further laboratory investigations. It is necessary for me to try and reduce environmental stimuli such as noises and be calm when dealing with this patient. I should continuously monitor the patient's vital signs and look out for any complication if there is any (Nanda, 2009).

Secondly, the patient has headache. As a professional nurse, I should start my assessment from collecting subjective data from the patient. Subjective data that I should collect are like trying to understand the causes of the headache, aware of trigger factors, measures to reduce headache, location, frequency and pattern of pain, beginning of the attack, accompanying symptoms and family history (Nanda, Nursing Assessment and Nursing Diagnosis of Headaches , 2012). The objective data include the patient's behavior like anxious, changes in ability to perform daily activities and body temperature (Nanda, Nursing Assessment and Nursing Diagnosis of Headaches , 2012) . It is found that the patient is constantly stressed out. He always takes one or two tablets of paracetamol when he has a headache. Often, the headache is located frontally but sometimes it involves the whole head. The pain is throbbing, moderate intensity, lasts about 4 hours each time and has 2-4 attacks each month. He had the first attack 10 years ago. Migraine headache runs in his family. Objective examination shows that the patient is anxious and is not able to perform his daily activities when he has an attack. The patient also experiences fatigue and has loss of appetite too in association with migraine headache. The interventions that can be taken for this patient include ensure that the patient takes medication when he has migraine attack, advise the patient to make a record of the attack, discuss

the physiological dynamics of stress and anxiety with the patient, instruct the patient to acknowledge me when the pain is severe, place patient in a dark and quiet room, put a cold compress on his head, massage his head if necessary, employ techniques of therapeutic touch and stress reduction, observe for any complications and give icy drinks containing carbonate to the patient (Nanda, Headache Nursing Care Plan Interventions, 2012).

Also, during the pain assessment, it is found that the patient experiences pain during urination. To assess the patient, subjective data that need to be collected are asking the patient whether he experiences pain during urination, frequency of urination, color of urine, the amount of urine each time, the presence or absence of odor, presence or absence of pain in the abdomen and other associated symptoms (Johny, 2011). Objective data include the vital signs of the patient such as the temperature, pulse, respiratory rate, blood pressure and urine output and presence or absence of abdominal muscle guarding (Johny, 2011). A urine analysis should be carried out. If necessary, an abdominal x-ray should be scheduled. It is found that the patient has moderate pain during urination, urinate 3 times per hour, yellow colour urine, small amount of urine each time, presence of foul smell and pain is felt at the back. Patient experiences fever and malaise as well. His vital signs are normal and there is no abdominal muscle guarding. Urine analysis shows that the patient has pyelonephritis. As a professional nurse, I should constantly monitor his urine output, monitor the results of repeated urine analysis, record the location, duration and intensity of pain, provide comfort measures such as massage, encourage the used of focused

relaxation breathing, provide perianal care as well as give antibiotics and analgesics according to the doctor's order (Wiwik, 2009).

Conclusion

In conclusion, a comprehensive health assessment involves an assessment from head-to-toe while a specific assessment is problem oriented. The specific assessment is carried out when the patient's condition is not favourable for a comprehensive health assessment. During the pain assessment in a 55-year-old patient, I found that he has an acute chest pain, migraine headache and pain during urination. As a professional nurse, I should carry out subjective assessment, objective assessment and laboratory tests for each abnormal findings. There is a specific care plan for each abnormal finding with the main objective which is to provide comfort to the patient and to reduce the pain.