Nursing health assessment persuasive essay

Health & Medicine, Nursing

Introduction

Nursinghealthassessment is an important role for a patient being diagnosis and give appropriate treatment (Bellack, 1992, p. 12). In my past clinical practice, only some simple assessments were conducted as it is able to reduce the affect of the problem but not solve it. After studied nursing health assessment, some more extensive and specific assessments should be done to identify patient’s health status. The actual problem, strengths deviations and the risk of the health problem are explored at a detail and in-depth way. This article is going to discuss about the specific nursing health assessment for a patient suffered from abdominal pain, who was met in my past practicum placement.

Case scenario

Ms. Ma, Age 54, housewife, admitted via A&E and complained she was having abdominal pain for 5 days. Sharp pain starts at mid-abdomen and then at right lower quadrant. Level of pain increased when coughing. She had had Panadol 500mg an hour ago but pain can not relief. Nausea and vomited small amount of undigestedfoodtwice in the past few days. No diarrhea. She feels tired but can not sleep because of the sharp pain. Her vital signs are: pulse 98, blood pressure 148/85 mmHg, temperature 39. 2oC. Her skin is warm and dry. Rebound pain occurred at the right lower quadrant of abdomen. She has hypertension and need to take medicine 2 times per day.

Ms. Ma was diagnosed with acute appendicitis. Keep NPO and IV 500ml normal saline is established. Blood test, abdominal X-ray and ultrasound abdomen are planned.

Assessment of abdomen

In the past clinical practice, I only give analgesics bydoctor’s order and the patient may sometimes relief pain after medication. However, abdominal assessment skills are necessary to identify Ms. Ma‘ s condition for getting at the root and having a better outcome.

There are five important steps for evaluating abdomen: take health history, inspection, auscultation, percussion and palpation. These assessment skills will be discussed one by one in the following paragraphs.

Health history and lifestyle health practices

First, find out the patient’s chief complaint, record the details and observe Ms. Ma‘ s general appearance.

Then, assess the abdomen pain by COLDSPA— character, onset, location, duration, severity, pattern and associated factors. It is the most accurate measurement to identify whether it is parietal peritoneal pain, visceral pain or referred pain (Judy, 2008).

After that, collect individual andfamilypast and current health status. Ask if there was any injuries or trauma may cause the pain, any eating disorder, any abdominal surgery was done before, any food allergy, history of suffering inflammatory bowel disease, family history of cancer and chronic

disease, etc. Also, collect Ms. Ma‘ s lifestyle and health practices. Ask her if smoke, drink or not, her eating habit, bowel pattern and movement, the amount, colour and texture of stool, any change in appetite, weight and abdominal girth recently and herstresslevel (MedicalEducation, 1998).

Past history and current lifestyle health practices are the useful information to identify the risk factors of the problem.

After collecting all background information, the physical examination should be proceed. Physical examination is using senses to collect objective data. It is used to identify the actual and potential health problems, discover patient’s abnormalities and diagnosis the problem (Nursing 2010 Magazine, 2010).

For physical examination of abdomen, Ms. Ma needs to empty her bladder first in order to avoid the bladder irritation then, place Ms. Ma in a supine position. The hands should be at aside and knees slightly bent. Tell her keep relax of the abdominal muscles. The assessment should be started in the right lower quadrant of abdomen and then proceeding in a clockwise direction. Also, the examination should go forward in the order of inspection, auscultation, palpation and finally percussion for avoid affecting the quality of bowel sound and increase peristalsis (Bellack, 1992).

Physical examination of abdomen

Inspection

Inspection is systemic visual examination. For abdominal examination, it should be started at the mouth, which is the beginning of gastrointestinal tract, and finally the rectum and anus (Bellack, 1992).

First, ask Ms. Ma opens her mouth and says “ Ar” or use tongue depressor to inspect the structure of mouth cavity to see whether any inflection, ulcer or not. Then, give a swelling test to Ms. Ma for examine the swelling ability. Place a spoon with some water on the middle part of her tongue and ask her to swell the water slowly to observe any choking or water leaks out. After that, inspect the texture of abdomen, the condition and colour of skin, any bruises or scars presence on abdomen. Normally, abdomen is homogenous in colour. If redness or yellow orange appear, it may indicate inflammation or liver disease respectively. Normal abdomen should also be symmetry from side to toe, flat and have normal movement when smooth respiration. If the abdomen is asymmetric, obesity, abnormal enlargement of organs, fluid distention or even intestinal obstruction may be suffered. Also, aortic pulsation should be present as Ms. Ma is having hypertension. Finally, ask Ms. Ma to take a deep breathe and hold it, it is used to inspect the presence of hernias or not (Bellack, 1992).

Auscultation

Auscultation of abdomen is used to define the bowel sound, which are caused by the movement of air or fluid at small intestine, by stethoscope.

The examination is started at the right lower quadrant, where the clearest bowel sound can be heard. Normal bowel sounds are at high-pitched,

bubbling sound and occur five to thirty times per minute. If hyperactive bowel sounds occur, it indicates diarrhea or early stage of gastroenteritis. If hypoactive or even absent of bowel sounds for five minutes, it indicates intestinal obstruction, peritonitis or pneumonia.

Besides bowel sounds, vascular sounds of aortic, renal, iliac, and femoral arteries can also be auscultated. It is an important examination to assess hypertension patient such like Ms. Ma whether she suffers from portal hypertensive and liver cirrhosis or not. If the vessels constricted or dilated, a bruit can be heard when blood flows (National Institute for Health and Clinical Excellence, 2008).

Palpation

Palpation is using sense of touch to collect data. For abdominal examination, finding out the location of pain is a great help of diagnosis abdominal pain. Light palpation and deep palpation are used to assess the abdominal organs, to define the tenderness and presence of mass. It is essential to assess the liver and spleen in abdominal examination.

Light palpation which is not more than 1 am deep on each quadrant. Normal abdomen should be smooth and consistent. If broad-like hardness appears, it states peritoneal irritation is suffered.

Deep palpation, which is press deeply from5cmto8cm, is used to indicate the abdominal organs and detect some obscure masses. Palpate the liver to test Murphy’s sign of cholecystitis. Palpate on the right upper quadrant at midclavicular line and parallel to the midline. If Ms. Ma feels pain and has inspiratory arrest, it states positive Murphy’s sign and indicate cholecystitis.

Then, palpate the spleen at costal margin on left upper quadrant to feel if the spleen is enlarged and Ms. Ma will feel pain when the peritoneum is inflamed.

Finally, as the rebound tenderness was being tested to Ms. Ma, that is pushing 90o angle at the right lower quadrant deeply and then release quickly. It is the reliable test of peritoneal inflammation if the patient feels sharp pain when the force released (Watkins, 2010).

Besides, obturator test and iliopsoas test can also be done for diagnosing appendicitis. For obturator test, Ms. MA need to hold her right leg above the knee at 90o angle, grasp the ankle and rotate her leg laterally and medically. If she feels pain, it states obturator muscle is irritated. For iliopsoas test, straight up Ms. Ma’s right leg and press deeply on her upper thigh and ask her to oppose the pressing force. If she feels pain, it states that she is suffering from appendicitis (Beltran, 2009).

Percussion

Percussion collects data by vibrations and sounds. For abdominal examination, percussion is used to assess the amount of fluid or gas, the location of mass, the size of liver and spleen. Normally, tympanic sound is found at hollow organs such as stomach and intestine; dullness sound is found at liver, spleen or masses.

To estimate the liver is enlarged or not, the normal distance of liver is 6 to12cm, which depends on the body size and gender, at the midclaricular line.

To estimate the spleen by percussing behind the left midaxillary line. If the distance is greater than7cm, it states that the spleen is enlarged due to infection, mononucleosis or trauma.

Moreover, test of shifting dullness and fluid wave to assess ascites. If the ascites of abdomen is more than 500ml, shifting dullness will be found. Normally, tympany is produced at abdominal midline (Bellack, 1992). However, for the abnormal case, dull sound is produced because of the cumulated fluid. Ask Ms. Ma rolls to right side and percuss from top to bottom. If the fluid is present, sound will change from tympanis to dullness and fluid wave will be generate when percuss on a side of the abdomen. It also has great variate in the abdominal girth.

Documentation

After the physical examination, documentation is necessary for the findings and development of care plan.

Current of illness

Ms. Ma states that her abdominal pain started five days ago. On the pain scale from 0 to 10, as 10 being the worst, she rates her pain is 7. Sharp pain occurs at mid-abdomen and then at right lower quadrant continuously. Level of pain increases when coughing. She has no known drug allergy and food allergy. She had Panadol 500mg an hour ago but pain can not relief. Nausea and vomited small amount of undigested food twice in the past few days. She has loss of appetite and lost about 3 pounds of body weight. No change in her abdominal girth. She has no diarrhea. She feels tired but can not sleep

because of the sharp pain. She is having fever as her vital signs are: pulse 98, blood pressure 148/85 mmHg, temperature 39. 2oC.

Past health history and lifestyle practice

Ms. Ma is a non-smoker and non-drinker. She has hypertension and need to take medicine 2 times per day. No abdominal surgery was dome before. She denies any injury or trauma occurs recently on her abdomen. She does not have history of suffering inflammatory bowel disease or family history of cancer and chronic disease.

She states that her eating habit is health and the amount, colour, texture of stool are normal, but constipation sometimes. She does not feel stress ordepression.

Physical examination

Ms. Ma has normal structure of mouth cavity and good swelling ability. There is no bruise or scar presence on abdomen. Her abdomen is symmetric and homogenous in colour. Her skin is warm but dry. By using the stethoscope, her bowel sounds are normal and no bruits are heard. Ms. Ma has rebound tenderness at the right lower quadrant of abdomen, pain occurs at obturator test and iliopsoas test when palpation. Normal tympanic sound is produced at abdominal midline when percussion.

Action and responses

Ms. Ma is hospitalized. IMI 50mg Tramadol is given and her pain is temporary relief. Blood test was done and the result shows the level of white blood cell is high. The abdominal X-ray and ultrasound abdomen show her appendix is enlarged

Ms. Ma is booked for an urgent operation for appendectomy.

Conclusion

In conclusion, some early symptoms of disease are not obvious, which will be easily misdiagnosed. Therefore, collecting health history and physical examination are very important as the data collected are in-depth and specific. It helps to have fast and accurate diagnosis in order to provide appropriate treatments to solve the patient’s problem and the symptoms at the same time.

Reference

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