Phases of the Interview

**Introductory Phase:**

Introduce self and develop an empathetic relationship. Insure confidentiality and quickly explain areas to be covered. Develop trusting relationship with patients.

**Working Phase:**

Conduct assessment:
- Biographic data
- Reasons for seeking care
- History of present health concern
- Past health history
- Family health history
- ROS
- Life style and health practices profile
- Developmental level (Analytical)

**Summary and Closure Phase**

Summarizes information obtained during the working phase and validates problems and goals with the client.
The purpose of the case study is to apply nursing process to a patient/family under the student's care. In order to complete a case study the student must complete a health history and physical, analysis data from assessment, diagnosis problems, plan actions to resolve problem, implement the plan and evaluate the progress of the plan.

A case study will be due every third week. Assignments and dates will be determined by the course instructors.

The format to follow will include:

1. **Complete health history**
   - Biographical data
   - Chief complaint (reasons for seeking health care provider)
   - Presenting symptoms (history of present health concern)
   - Past health history
   - Family health history
   - Review of systems (ROS)
   - Life style and health practices profile
   - Development level

   **Physical examination**
   - By body system
   - Focus is on complaining area
   - Review all test (lab, x-ray, EKG, PFT, etc..) results

2. **Analysis of data**
   - Analysis of subjective and objective data to make a nursing judgement in the form of nursing diagnosis, collaborative problem or referral
   - Identify abnormal data and strengths
   - Identify problems
   - Propose possible nursing diagnosis
   - Confirm or rule out
   - Document conclusions

3. **Plan**
   - Determine outcome criteria (Goal)
   - Develop actions that will accomplish the outcome criteria (interventions)
     - Plan interventions
       - Independent for ND (Action)
       - Interdependent of CP (Monitor and Action)
       - Dependent (requires a medical order)

4. **Implementation/Evaluation**
   - Carry out the plan and evaluate the outcome of the interventions.
   - Make changes in plan were appropriate to achieve outcomes
**Biographical Data (Identifying Data)**

Client is primary source
All others are secondary sources, chart, H& P, and family.
- Date
- Name Address
- Phone number
- Gender
- Culture
- Ethnicity and subculture (date and place of birth)
- Marital status
- Religious or spiritual practices
- Primary and secondary languages spoken and written
- Educational level
- Work status
- Identify significant others

**Chief Complaint (Reasons for seeking a health care provider):**

1. What is your major health problem, concern or complaint at this time?
2. How do you feel about having to seek health care?
   Identifies primary concern and previous experiences with HCP

**Present Symptoms (Present Illness)**

Provides full, dear, chronological account of how each symptom developed and what events were related to them.

Focus on:
- Onset
- Progression
- Duration
  - Describe the signs, symptoms and related problems
  - Discuss what they perceive caused the problem
  - Evaluate what makes it worse, and better
  - What treatments have been initiated and results
Use OLDCARTS:
O  Onset         When did it first start?
L  Location      Where is the problem or where does it hurts?
D  Duration      How long has the problem been ongoing?
C  Characteristics Describe the problem or pain. Does it radiate, non-radiating

A  Aggravating/Alleviating Factors
R  Relieving Factors—What is currently being done to treat and how is it working?
T  Timing
S  Severity

**Past Health History**
Describes the client’s past, from the earliest beginnings and progressing to the present.

Question includes:
- Birth
- Growth
- Development
- Childhood diseases
- Immunizations
- Allergies
- Previous health problems
- Hospitalizations
- Surgeries
- Pregnancies/deliveries
- Previous accidents
- Injuries
- Emotional or psychiatric problems

This area assists in identifying risk factors

**Family Health History**

Identifies genetic predisposition and environmental influences.
Should do a genogram.
Should also include at least 3 generations, usually past generations.
Review of Body Systems (ROS)
Each body system is addressed and the client is asked questions to draw out current or recent health problems. This section is only the client's subjective information and not the examiner's observations.

**General:**
Usual weight, recent weight change, any clothes that fit tighter or looser than before, weakness, fatigue, or fever.

**Skin, hair & nails:**
Skin color changes, temperature, condition, excessive sweating, rashes, lumps, itching, lesions baling, dandruff, condition of nails

**Head & Neck:**
Headache, head injury, swelling, pain or stiffness of neck, difficulty swallowing, sore throat, enlarged lymph nodes, goiter.

**Eyes and Ears:**
Vision, eye infections, redness, excessive tearing, halos around lights, blurring, loss of side vision, moving black spots/specks in visual fields, flashing lights, double vision, eye pain and last eye exam. Ear question should include hearing, hearing aids, ringing or bunting (tinnitus), vertigo, infection, ear-aches, drainage from ears, and dimness.

**Mouth, throat, nose and sinuses:**
Condition of teeth and gums, bleeding gums, dentures (fit), dry mouth, last dental exam, sore throats, mouth lesions, hoarseness, rhinorrhea, nasal obstruction, frequent colds, hay fever, sneezing or itching of eyes, ears nose or throat, nose bleeds snoring.

**Thorax and lungs:**
Difficulty breathing, pain, wheezing, bronchitis, emphysema, pneumonia, TB, pleurisy, shortness of breath during routine activity, orthopnea, cough or sputum, hemoptysis and last chest x-ray

**Breasts:**
Lumps, pain or discomfort, discharge from nipples, swollen or tender lymph nodes on axilla. Performs self breast exam

**Heart and neck vessels:**
Heart trouble, high blood pressure, rheumatic fever, heart murmurs, dyspnea, orthopnea, paroxysmal nocturnal dyspnea, chest pain or discomfort, pressure, palpitation, edema and last EKG
**Abdomen:**
Trouble swallowing, heart burn, appetite change, reguration, vomiting blood, food intolerance, excessive belching or passing gas, jaundice, liver or gallbladder problems, hepatitis, indigestion, difficulty swallowing, nausea, vomiting, abdominal pain.

**Male genitalia:**
Excessive or painful urination, polyuria, nocturia, urgency, frequency or difficulty starting and maintaining urinary stream, leaking of urine, blood noted in sexual problems, perineal lesions, penile drainage, pain, or swelling in scrotum, difficulty achieving an erection and or difficulty ejaculating, hernias.

**Female Genitalia:**
Age of menarche, regularity, frequency, duration of periods, amount of bleeding, bleeding between periods or after intercourse, LMP dysmenorrhea, PMS, voiding problems (dribbling, incontinence), pregnancies, and type/problem with delivery, abortions, pelvic, pain, vaginal discharge, itching sores lumps, age of menopause, post menopausal bleeding and use of hormone replacement therapy.

**Anus, Rectum:**
Bowel habits, pain with defecation presence of hemorrhoids, blood in stool, constipation, diarrhea.

**Peripheral Vascular:**
Intermittent claudication, varicose veins, past clots in veins, swelling edema of legs and feet, pain, cramping sores on legs.

**Musculoskeletal:**
Swelling, redness, pain stiffness of joints, arthritis, gout, backache, if present describe location and symptoms, ability to perform activities of daily living, muscle strength.

**Neurological:**
Fainting, black outs, seizures, weakness, paralysis, numbness, general mood, behavior, depression, anger, concussion, headaches, loss of strength or sensation, difficulty speaking, memory problems, strange thought/actions, difficulty learning.

**Hematologic:**
Anemia, easy bruising or bleeding, past transfusion and reaction to them.

**Endocrine:**
Thyroid trouble, heat or cold intolerance, excessive sweating, diabetes, excessive thirst or hunger, polyuria.
Psychosocial History:

Deals with the client's human responses:
- Nutritional habits
- Activity/exercise patterns
- Sleep/rest patterns
- Use of medications and substances
- Self concept & Self concept activities
- Relationships
- Value/belief system
- Education/Work
- Stress level & coping style
- Environment

Description of typical day:
If you are lucky most the above will be described with this question:
Tell me what an average or typical day is for you. Start with awakening in the morning and continue until bedtime.

Nutritional habits:
List average 24 hour intake, with emphasis on what foods are eaten and in what amounts. Include snacks, fluid intake and other substances consumed.

In this area also include bowel movements, laxative use and urination.

This maybe completed after the initial assessment by the patient

Activity Level/Exercise:
Record regular exercise, not routine work. Walking up and down a hall way is not regular exercise. Goal is to increase heart rate and maintain it for about 12 min. 3 times a week (minimum).

Work exercise can be stressful and fatiguing while exercise is designed to reduce stress and strengthen the individual.

Sleep/Rest:
Usual time of sleep and waking. How many hours, any interruptions. Does the client feel rested upon awakening. Average sleep is 5 to 8 hours a night
Medication and substance use:

This area is to assess risk for disease and self care. Includes:
- Prescription medications
- OTC medications
- Alcohol includes beer and wine

**The cage questionnaire**
- Have you ever felt the need to cut down on drinking?
- Have you ever felt annoyed by criticism of drinking?
- Have you ever had guilty feelings about drinking?
- Have you ever taken a drink first thing in the morning to steady your nerves or get rid of a hangover?

Caffeinated drinks
Cigarettes or other tobacco products, how much and how long

Illicit drugs

Self-Concept & Self Care Responsibilities

This area includes:
- Sexual responsibility
- Basic hygiene practices
- Regularity of health care check-ups (dental & vision)
- Breast/testicular self examination
- Health screening: Pap smear, stools for OB, cholesterol
- Accident prevention & hazard protection (Seat belts, smoke alarms)
- Physical violence
  Consider when:
  - Injuries are unexplained, seem inconsistent with story, concealed by client, or cause embarrassment
  - Client has delayed getting treatment for trauma Past history of repeated injuries or accidents
  - Client or family member has history of alcohol or drug abuse
  - Frequent health care visit with multiple complaints

Sample questions:
- What are your strengths and weaknesses?
- How do you feel about yourself, about your appearance?
- Can you tell me what activities you do to keep your self safe, healthy or to prevent disease?
- Do you practice safe sex?
- How do you keep your home safe?
- Do you drive safely?
- See trauma: Can you tell me what happened? Did someone hit you? Do your arguments ever lead to physical fighting?
**Social Activities:**

Identifies outlets for support and relaxation. Look to see if it reaches beyond the family and work.

Questions:
- *What do you do for fun and relaxation?*
- *With who do you socialize most frequently?*
- *Are you involved in any community activities?*
- *How do you feel about your community?*
- *Do you feel that you have enough time to socialize?*
- *What do you see as your contribution to society?*

Questions:
- *Who is the most important person in your life?*
- *What was it like growing up in your family?*
- *What is your relationship like with your spouse?*
- *What is your relationship like with your children?*
- *Describe any relationships you have with significant others?*
- *Do you get along with your in-laws?*
- *Are you close to your extended family?*
- *Do you have any pets?*
- *What is your role in your family?*
- *Is it an important role?*
- *Are you satisfied with your current sexual relationship?*
- *Have there been any recent changes?*

**Values/Belief system**

This includes the client's philosophical, religious, and spiritual beliefs.

Questions:
- *What is most important to you in life?*
- *What do you hope to accomplish in your life?*
- *Do you have a religious affiliation?*
- *Is it important to you? What gives you strength and hope?*

**Education and Work**

Kind and amount of education, enjoyment of education, satisfaction with education

Similar questions concerning work?
Stress levels & coping styles
How much stress is the client under and how they cope with it?
Questions:
  - What types of things make you angry?
  - How would you describe your stress level?
  - How do you manage anger or stress?
  - What do you see as the greatest stressors in your life?
  - Where do you usually turn for help in a time of crisis?

Environment
Assess health hazards:
  - What risks are you aware of in your environment, (home, work, neighborhood, or other activities).
  - What type of precautions do you take to protect yourself and family?
  - Do you believe you are in danger of becoming a victim of violence?

Developmental Level
Compares health history data with normal developmental parameters.
Height
weight
Erickson's psychosocial developmental stages
  Must look at behavior not chronological age

Young Adult: Intimacy vs. Isolation
Have achieved self efficacy and is ready for intimate relationships. Usually with long term relationship but also includes maintaining bisexual friendships. If the person is unable to express emotion and trust than isolation and loneliness may occur. Some people try to cope with this developmental stage by becoming very spiritual or social, playing an acceptable role, but never fully sharing who they are or becoming emotionally involved with others.

Questions to ask yourself:
  - Accept self: physically, cognitively and emotionally?
  - Have independence from parental home?
  - Express love responsibility, emotionally, and sexually?
  - Have a social friendship group?
  - Participate in the community?
  - Have a philosophy of living and life?
  - Have a profession of a life's work that provides a means of contribution?
  - Solve problem of life that accompany independence from parental home?
Middlescent: Generativity vs. stagnation

Can share self with others and establish nurturing relationships. During this stage the adult will be able to extend self and possessions to others. This in the way we raise children and guiding there lives, but can be accomplished without children. This is done through teaching other, children, adults, mentoring young workers or providing experience and wisdom to assist in growth. Stagnation occurs when the person has not accomplished one or more of the previous developmental tasks and is unable to give to future generations. Can not move on may stay in school or work in same position, never finish the project.

Ask yourself does the client:

- Have healthful life patterns?
- Find self as a life-mate for another person?
- Derive satisfaction from contributing to growth and developments of others?
- Have an abiding intimacy?
- Maintain a stable home?
- Find pleasure in an established work or profession?
- Take pride in self and family accomplishments and contributions?
- Adjust to physical changes of aging?

Older Adult: Ego Integrity vs. Despair

Person looks back and either finds that life was good or despairs that goals were not accomplished. Occurs over long times and waves. Completion is when person reminiscences a series a past event in a new and more positive light. Can be a very rich and rewarding time in a persons life, but may not come till the final weeks of the persons life. If the older person is not able to feel grateful for his or her life, is not able to accept those less desirable aspects as merely part of living, or is not able to integrate all of the experiences of life, than the person will spend his or her last days in bitterness and regret, and will die in despair?
- Adjust to changing physical self?
- Recognize changes present as a result of aging, in relationships and activities?
- Continue interests outside self and home?
- Complete transition from retirement at work to satisfying alternative activities?
- Establish relationships with others his or her own age?
- Adjust to deaths of relatives, spouse, and friends?
- Maintain maximum level of physical functioning through diet, exercise and personal care.
- Find meaning in past life and face inevitable mortality of self and significant others?
- Integrate philosophical or religious values into understanding of self to promote comfort?
- Review accomplishments and recognize meaningful contributions he or she has made to community and relatives?
Objective Data

Preparing for the assessment:
- Develop your own comfort and confidence, this requires practice.
  - Wash your hands
  - Wear gloves
  - New pin
  - Wear mask and protective eye wear

Prepare the physical setting:
- Comfortable warm environment
- Private area free of interruptions from others
- Quiet area free of distractions
- Adequate lighting
- Finn examination table
- A bedside table or location to hold equipment

Physical assessment techniques:
- Inspection
- Palpation
- Percussion
- Auscultation

Inspection:
Involves using the senses of vision, smell and hearing to observe and detect any normal or abnormal findings. Started with the being of history.

Guidelines:
- Comfortable environment
- Good lighting preferably sunlight
- Look and observe before touching.
- Completely expose the body part you are inspecting while draping the rest of the person.
- Note the following characteristic while inspecting the client: color patterns, size, location, consistency, symmetry, movement, behavior, odors or sounds
- Compare the appearance of symmetric body parts, or both sides of any individual body part.
Palpation
Using hand and fingers to feel:
- Texture: rough/smooth
- Temperature: warm/cold
- Moisture: dry/wet
- Mobility: fixed/movable/still/vibrating
- Consistency: soft/hard/ fluid filled
- Strength of pulses: strong/ weak/thready/bounding
- Size: small/medium/large
- Shape: well defined/ irregular
  Degree of tenderness:

Use three parts of the hand:
- Fingerpads: fine discriminations: pulses, textures, size consistency, shape, crepitus
- Ulnar or palmar surface of hand: Vibration, thrills, fremitus
- Dorsal surface of hand: Temperature

How to palpate:
Light Palpation: little to no depression. Feel the surface structure using a circular motion. Feel for pulses, tenderness, surface skin texture, temperature and moisture.

Moderate palpation: Depress skin 1 to 2 cm, use hand with circular movements to feel easily palpable body organs and masses. Note the size consistency, mobility of structures you palpate.

Deep palpation: Place your dominant hand on the skin surface and your other hand on top of your dominant hand to apply pressure. Depress between 2.5 to 5 cm. This allows for deep organ or structures that are covered by thick muscle to be felt.

Bimanual palpation: Use two hands, one on each side of the body part. Use one hand to apply pressure and the other hand to feel the structure. Note the size, shape, consistency, and mobility of the structure. Use for uterus, breasts, spleen kidney.

Percussion:
Involves tapping body parts to produce sound waves. Allows you to assess underlying structures. Percussion use:

- Eliciting Pain: Percussion helps to determine exactly what underlying structures are inflamed. Inflammation = tenderness or soreness

- Determining location, size and shape: Notes changes between borders of an organ this provides information about location, size and shape.

- Determine density: Is structure solid, fluid filled or air filled

- Detecting abnormal masses: Superficial abnormal structures/masses can be detected using percussion. Percussion vibrations penetrate approximately 5 cm deep. Deep masses cannot be percussed.

- Eliciting reflexes: DTR's with use of percussion hammer
**Types of percussion:**

- **Direct:** direct tapping on body with one or two fingers to elicit tenderness

- **Blunt:** place one hand flat on skin and strike hand with other hand, this will elicit tenderness.

- **Indirect:** Most common, produces sound or tone that varies with the density of underlying structures. As density increases the sound of the tone becomes quieter. Classified according to origin, quality, intensity, and pitch.

**How to Percuss**

- Place the middle finger of your nondominant hand on the body part you are going to percuss.

- Keep your other fingers off the body part being percussed because they will dampen the tone you elicit.

- Use the pad of your middle finger of the other hand to strike the middle finger of your nondominant hand that is placed on the body part.

- Withdraw your finger immediately to avoid dampening the tone. Deliver two quick taps and listen carefully to the tone.

- Use quick, sharp taps by quickly flexing your wrist, not your forearm.

**Auscultation**

- Use of stethoscope to listen to sounds

  - **The sounds:** Intensity: loud or soft
    - Pitch: high or low
    - Duration: length
    - Quality: Musical, crackling rasp
How to auscultate

Eliminate distracting noises from the environment

Expose the body part you are going to auscultate. Do not auscultate through clothes. This will obscure sound.

Use the diaphragm of the stethoscope to listen for normal heart sounds, breath sounds and bowel sounds (high pitched sounds). Press the diaphragm firmly.

Use the bell to listen for abnormal heart sounds and bruits (low pitched sounds). Hold the bell lightly on the body.
Nursing Assessment

Purpose of Assessment:
Identify patterns of functioning that make conclusions about the clients health.
Confirm to or deviate from norms.
- Determine: Nursing Diagnosis (ND)
- Collaborative Problem (CP)
- Referral

ND: "A clinical judgment about individuals, family or community responses to actual and potential health problems and life process"

CP: "Physiological complications that nurses monitor to detect their onset of changes in status". These are managed collaboratively.

Referrals: Identified problem that require the assistance of other HCP

Assessment data:
  Subjective data:
  - Sensations, symptoms, feelings, perceptions, desires, preferences, beliefs, ideas and values.

Objective data:
- Directly observed, physical characteristics, body functions, appearance, behavior, V.S., lab findings, assessment tools.

Validation of data:
- Confirming that the subjective and objective data you have collected are reliable and accurate.
- Failure to validate data may result in premature closure of the assessment or collection of inaccurate data.

Documentation of data
- Provide the health care team with a database that becomes the foundation for the entire nursing process.

Preparing of the assessment
- Review demographic data
- Review-Medical diagnosis and progress notes
- Caution: Premature judgments (Keep and open mind)
- Lab tests and abnormal findings, Understand purpose and meaning of findings
Analysis of Data

In this section the student needs an extra sheet of paper to initially write down her/his analysis to the data collected in the assessment. This includes the assessment, lab, x-ray, physical therapy, dietary, or other departments. The analysis should include:

- List out abnormal and pertinent normal data
- Identify and list the patient/family strengths
- Cluster the data together, this will allow you to infer and identify problems
- List all nursing diagnosis
- Check the nursing diagnosis for the defining characteristics
  - If the defining characteristic are present, then the diagnosis exists
  - If the defining characteristic are not present, then continue to assess
- List all Collaborative problems
  - Should be reflected in the medical diagnosis
- List all referrals

Plan

Utilizing the liars created in the analysis, develop goals to each nursing diagnosis, collaborative problem and referral. Remember that the goal needs to have measurable outcome criteria that will resolve the problem. Then actions/interventions need to be developed that will monitor/evaluate the problem, directly resolve the problem, or is directly involved in the resolution or maintenance of the problem.

Implementation/Evaluation

This area is were you try to actions that you stated would be used and to evaluate if the actions worked. This will include assessment skills to evaluate and basic nursing skills to safely and effectively implement.