**NURSING CARE DELIVERY MODELS**

Before World War I, nurses usually visited the sick in their homes to care for them. As hospital care improved and nursing education evolved, more sick people were treated in hospitals. Providing care to groups of patients rather than to individuals required nurses to be efficient and use their time effectively. Over the years, various types of care delivery models were designed to meet the goals of efficient and effective nursing care. Organizing patient care today often requires the professional nurse to work through other care providers, such as UAPs and LPN/LVNs, to achieve excellent patient outcomes. Delivery of high quality patient care does not happen by chance. Each nurse manager must select a care delivery model appropriate for the unit, the acuity of the patients, and the type and number of nursing staff members available. There are a number of principles for selecting a care delivery model. Four Classic Nursing/ patient care delivery models are

* Team nursing
* Total patient care
* Functional nursing
* Primary nursing
* Variations have been adopted to improve care

**PRINCIPLES FOR SELECTING A CARE DELIVERY MODEL**

The care delivery model should:

•Facilitate meeting the organization’s goals

•Be cost effective

•Contribute to meeting patients’ outcomes

•Provide role satisfaction for nurses

•Allow implementation of the nursing process

•Provide adequate communication among all healthcare providers

•Support RNs’responsibility for the overall direction of nursing care

•Be designed to give RNs the responsibility, authority, and accountability for planning, organizing and evaluating nursing care

•Ensure that the skills and knowledge of each care provider are used for the best patient outcomes •Ensure that communication can occur

•Ensure that the model advances professional nursing practice

•Provide for care that is perceived by the patient as a coherent whole (unity of action by a team of RNs,LPN/LVNs,or others)

•Provide the workgroups of RNs,LPN/LVNs,and other workers the appropriate knowledge required to meet the nursing care needs of the patient

Team Nursing In response to the frustration some nurses felt when using a functional approach to patient care, Lambertson (1953) designed team nursing. She envisioned nursing teams as democratic work groups with different skill levels represented by different team members. They were assigned as a team to a defined group of patients.

**Team Nursing**

Team nursing has been widely used in hospitals and long-term care facilities. The team usually consists of an RN, who serves as team leader; an LPN/LVN; and one or more UAP. The team leader, although ultimately responsible for all the care provided, delegates (assigns responsibility for) certain patients to each team member. Each member of the team provides the level of care for which he or she is best prepared. The least skilled and most inexperienced members care for the patients who require the least complex care, and the most skilled and experienced members care for the most seriously ill patients who require the most complex care.

In team nursing, the RN team leader supervises and coordinates all care for a particular shift, makes assessments, and documents responses to care. The LPN/ LVN team member provides direct care by performing treatments and procedures and reporting patient responses to the team leader. The UAP provides routine, direct personal care. Today, team nursing is still used, but the model is often modified. Many of the patient focused care models use RNs as team leaders coordinating care for a group of patients and supervising multi skilled workers who have been trained to perform a variety of comfort measures such as positioning and technical procedures such as taking vital signs or drawing blood. Team nursing has both advantages and disadvantages; these are

**Advantages**

•Potential for building team spirit

•Provides comprehensive care

•Each worker’s abilities are used to the fullest

•Promotes job satisfaction

•Decreases non-professional duties of RNs

**Disadvantages**

•Ongoing need for communication among team members requires commitment of time

•All team members must promote team work,or else team nursing is unsuccessful

•Team composition varies from day to day, which can be confusing and disruptive and decreases continuity of care

•May result in blurred role boundaries, resulting in confusion and resentment

**Primary Nursing**

Primary nursing was designed to promote the concept of an identified nurse for every patient during the patient’s stay on a particular unit. The goal of primary nursing is to deliver consistent, comprehensive care by identifying one nurse who is responsible, has authority, and is accountable for the patient’s nursing care outcomes for the period during which the patient is in a unit. In primary nursing, each newly admitted patient is assigned to a primary nurse. Primary nurses assess their patients, plan their care, and write the plan of care. While on duty, they care for their patients and delegate responsibility to associate nurses when they are off duty. Associate nurses may be other RNs or LPN/LVNs. Patients are divided among primary nurses in such a manner that each nurse is responsible for the care of a group of patients 24 hours a day. Unless there is a compelling reason to transfer a patient, the primary nurse cares for the patient in the unit from the time of admission to the time of discharge. The primary nurse may be assisted by other care providers (such as other nurses, aides, and technicians) but retains accountability, or responsibility, for care outcomes 24 hours a day while the patient is in the unit. The primary nurse communicates effectively with associate nurses caring for the patient on other shifts and with primary nurses in other units if the patient is transferred (e.g., to the operating room or intensive care unit). Primary nursing is used in a variety of settings and is often modified from its original form.

**Advantages**

•High patient and family satisfaction

•Promotes RN responsibility, authority, autonomy, and accountability

•Nurse can care for entire patient—physically, emotionally, socially, and spiritually

•Patient knows nurse well, and nurse knows patient well

•Promotes patient-centered decision making

•Increases coordination and continuity of care

•Promotes professionalism

•Promotes job satisfaction and sense of accomplishment for nurses

**Disadvantages**

•Difficult to hire all RN staff

•Expensive to pay all RN staff

•Nurses are not familiar with other patients, making it difficult to “cover” for each other

•May create conflicts between primary and associate nurses

•Stress of round-the-clock responsibility

•Heavy responsibility, especially for new nurses

**Patient-Centered Care**

Patient-centered care is a contemporary care delivery model implemented by a multidisciplinary team of health professionals. This model of care is based on the patient’s right to individualized care that takes his or her values and beliefs into consideration when planning and providing care. Nurses and other providers must be flexible, respect the patient’s beliefs and wishes, and negotiate with the patient to meet patient expectations. Patient-centered care is more an attitude than a particular model of care, and traditional models, alone or in combination, may be used. The attitude of caregivers is that patients’ needs have priority over the institution’s needs. The model was pioneered by the Planetree Institute in 1978 after its founder experienced several “dehumanizing” hospitalizations. Patient-centered care brings together traditional and nontraditional components of care that work toward optimizing the healing environment. Such components as the architectural design of the facilities; educational programs for patients and families; emphasis on beauty, gardens, art, food, and nutrition; availability of complementary therapies such as massage and aromatherapy; emphasis on spirituality; and community interaction are the hallmarks of patient-centered care. These components are integrated with best medical practices to form a coherent continuum of care characterized by teamwork, communication, and collaboration among professionals and with patients and families.

**Advantages**

•Expedites care

•Promotes patient convenience

•Capitalizes on professional competence of team members

•Emphasizes continuum of care and reduces fragmentation of care

•Uses resources efficiently

•Fosters teamwork, collaboration and communication

**Disadvantages**

•Requires “right staff at right time” to meet patient needs

•Difficult to explain; uses several models of care delivery

•Requires a lot of RNs; must have both clinical and management skills

**Functional Nursing**

It is a task-oriented method wherein a particular nursing function is assigned to each staff member. The medication nurse, treatment nurse and bedside nurse are all products of this system. For efficiency, nursing was essentially divided into tasks, a model that proved very beneficial when staffing was poor. The key idea was for nurses to be assigned to tasks, not to patients.

Advantages:

* A very efficient way to delivery care.
* Could accomplish a lot of tasks in a small amount of time
* Staff members do only what they are capable of doing
* Least costly as fewer RNs are required

Disadvantages:

* Care of patients become fragmented and depersonalized
* Patients do not have one identifiable nurse
* Very narrow scope of practice for RNs
* Leads to patient and nurse dissatisfaction

**Team Nursing**

This is the most commonly used model and is still in use today. It was developed in the 1950’s in order to somewhat ameliorate the fragmentation that was inherent in the functional model. The goal of team nursing is for a team to work democratically. In the ideal team, an RN is assigned as a Team Leader for a group of patients. The Team Leader has a core of staff reporting to her, and together they work to disseminate the care activities. The team member possessing the skill needed by the individual patient is assigned to that patient, but the Team Leader still has accountability for all of the care. Team conferences occur in which the expertise of every staff member is used to plan the care.

Advantages:

* Each member’s capabilities are maximized so job satisfaction should be high
* Patients have one nurse (the Team Leader) with  immediate access to other health providers

Disadvantages:

* Requires a team spirit and commitment to succeed
* RN may be the Team Leader one day and a team member the next, thus continuity of patient care may suffer
* Care is still fragmented with only 8 or 12 hour accountability

**Primary Nursing**

The hallmark of this modality is that one nurse cares for one group of patients with a 24-hour accountability for planning their care. In other words, a Primary Nurse (PN) cares for her primary patients every time she works and for as long as the patient remains on her unit. An Associate Nurse cares for the patient in the PN’s absence and follows the PN’s individualized plan of care. This is a decentralized delivery model: more responsibility and authority is placed with each staff nurse.

Advantages:

* Increased satisfaction for patients and nurses
* More professional system: RN plans and communicates with all healthcare members. RNs are seen as more knowledgeable and responsible.
* RNs more satisfied because they continue to learn as as part of the in-depth care they are required to deliver to their patient

Disadvantage:

* Only confines a nurse’s talents to a limited number of patients, so other patients cannot benefit if the RN is competitive
* Can be intimidating for RNs who are less skilled and knowledgeable

**Modular Nursing (District Nursing)**

This is a modification of team and primary nursing. It is a geographical assignment of patient that encourages continuity of care by organizing a group of staff to work with a group of patients in the same locale.

Advantages:

* Useful when there are a few Rns
* RNs plan their care

Disadvantage:

* Paraprofessionals do technical aspects of nursing care

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**Modalities of Nursing Care**

This refers to the manner in which nursing care is organized and provided. It depends on the philosophy of the organization, nurse staffing and client population.

* **Case Method/Total Patient Care**

In case method, the nurse cares for one patient whom the nurse cares for exclusively. The Case Method evolved into what we now call private duty nursing. It was the first type of nursing care delivery system.

In Total Patient Care, the nurse is responsible for the total care of the patient during the nurse’s working shift. The RN is responsible for several patients.

Advantages:

Consistency in carrying out the nursing care plan

Patient needs are quickly met as high number of RN hours are spent on the patient

Relationship based on trust is developed between the RN and the patient’s family

Disadvantage:

It can be very costly

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Disadvantage:

Paraprofessionals do technical aspects of nursing care

**PRIMARY CARE NURSING (PSN)**

PSN refers to comprehensive individualized care provided by the same nurse throughout the period of time. This type of care allows the nurse to give direct patient care rather than manage and supervise the functions of others who provide direct care for the patients. This care method was rejected by many institutions as too costly. The pt/nurse ratio is small and a specialized professional staff is needed because the primary nurse is usually a registered professional staff.

**ROLE OF A PRIMARY NURSE**

1. The primary nurse accepts total 24 hrs. responsibility for a patient‘s nsg care.
2. The PC nurse is responsible and accountable for involving the patient & family directly in all facet of care and has autonomy in making decision in this regard.
3. The PC nurse communicates with other members of health care team regarding the pt’s health care. This process promotes continuity of care and collaborative effort directed towards quality patient’s care.
4. The PC nurse assumes responsibility for making appropriate referral and for ensuring that all relevant information is provided to those who will be involved in the patient’s continued care including the family. During times when the primary nurse is not scheduled to work, an associate nurse implements the plan of care and provides feedback to the primary nurse for evaluation of the plan of care.

The long time survival of PCN as it is currently designed is uncertain as cost containment measures continue and pt’s acuity increases, staffing ratio of patient to nurses also increases. Many nursing services depts. and agencies are meeting the increased workload demand by making modifications in their approach to primary nursing or by reverting to team or functional system for the delivery of care. Others are changing their staff mix and re- designing the model of practice to accommodate nurse’s extended role, still others are changing to more innovative system such as case management.

**Health History, Review Of Systems,  and Universal Precautions**

**Introduction**

Health assessment consists of 3 major parts. The **clinical history** (which includes the review of functional health patterns), **review of systems (ROS),** and the **physical exam.** The physical exam is usually done by a system’s approach (e.g. head to toe).

The **clinical history** is done at the beginning of the interview while the client is fully dressed. The clinical history consists of the chief complaint, history of the present problem or illness, past medical history, family history, social history, and the ROS. These are discussed in more detail later in the outline.

The **ROS** is a summary of the client’s past and current health and is sometimes done in a self- administered format (or checklist) by the client. There is a sample of a ROS in your text and in your syllabus. Take a moment to look at it and review the questions. You will note that this is a **subjective** history (e.g. what the "subject" or "client" says). It is the responsibility of the practitioner to review each positive or yes statement on the ROS using one of the **symptom analysis** techniques (OLD CART, PQRST, or other). The practitioner uses this information during the physical exam. For example, if your client has a clinical history that includes multiple cardiac risk factors, more attention is paid to the cardiovascular system during the exam.

Information regarding the health history can also be obtained throughout the physical exam.

**The Health History**

**HISTORY FIRST - THEN Physical Exam**

It is essential for the primary nurse to collect data from the client at 1st contact in order to give adequate & comprehensive nursing care.

**I. PURPOSE**

1. Collection of data about an individual's health state.
2. The health history is the primary method for the nurse to establish rapport and trust with the client and to gather information that is needed to develop the care plan.
3. The history taking helps the nurse to assess the client's health needs and problems and gather knowledge within the context of the person's lifestyle, culture, and living conditions.
4. Data gathering through interviews and questionnaires is done using a standardized, systematic method.
5. Helps to determine nursing care needs and nursing diagnosis.

**II. TYPES OF HEALTH HISTORIES**

1. There are many formats available for taking a health history. Four of the more commonly used types of health history formats are the complete history, the interval history, the problem focused history and the emergency health history.
2. The **complete health history** is taken on the initial visit to a clinic or acute care setting. It provides a comprehensive and complete database of the needs of the client. It is usually taken only once and is updated as needed.
3. The **interval health history** (Follow-up history) format collects information during visits subsequent to the initial database collected in the complete health history. The purpose is to collect pertinent information that has occurred since the last visit.
4. The **problem focused or chief complaint focused history** is used to collect data about the most important or chief problem facing the client at the present time.
5. **Emergency Health History** - rapid collection usually in life threatening situations.

**III. ETHICAL CONSIDERATIONS**

1. During the history (and the physical exam) the client and the nurse enter into a partnership which promotes trust and satisfaction.
2. The partnership is directed towards the collection of biological, psychosocial, cultural, and spiritual information about the client and the environment in which the individual is living.  
   Data includes sensitive information about physical problems, past illness, and injury, socioeconomic factors such as income, occupation, and insurance, health status of family members, lifestyle and living conditions, and culture.
3. Confidentiality and patient autonomy are part Nursing's professional code of ethics. Student nurses should be familiar with the principles for maintaining an ethical client/patient relationship and confidentiality of the data collection. Things to know include the concepts of confidentiality and autonomy and understanding the definitions and meanings of the concepts of beneficence, non-maleficence, utilitarianism, fairness, and justice.

**N.B.** To learn more about these concepts read about them in your text.

1. Confidentiality
2. Autonomy
3. Beneficence
4. Non-maleficence
5. Utilitarianism
6. Fairness
7. Justice

**IV. COMMUNICATION WITH PATIENTS**

1. Communicating with patients is very important and sets the stage for development of a therapeutic relationship. A therapeutic relationship is built on trust. Patients need to feel they can trust the caregiver in order to provide them with the information the caregiver needs to develop a plan of care.
2. To enhance communication and the development of trust and therapeutic relationship, there are several important points to keep in mind. These include use of a professional approach and manner, confidentiality and ethics, and communication style and technique.
3. The client starts to make an assessment of the nursing student as soon as he/she walks in the door. The nurse should use a friendly but professional approach and dress appropriately for the clinical setting. Generally you will wear nice clothes or a uniform, your lab coat and student’s name tag.
4. Avoid extremes in dress, hairstyle, and mannerism which may be distracting or frightening to older clients.
5. You should be friendly in manner but not patronizing or social. Remember, the client is not coming for tea and conversation; they are present because they have a chief complaint of some urgency.
6. Try to show sensitivity and demonstrate a caring attitude. Do not show judgment or make judgmental statements about clients. Examine your own feelings or past prejudices. They have no place in the therapeutic relationship. Each client is treated equally and with dignity regardless of background and lifestyle.
7. Another thing you can do is to think of some of the ways of handling tensions that may occur during the interview and history taking. For example, how would you interact with clients who are anxious or angry? What would you do if a client was threatening or who was acting inappropriately during an interview? Discuss these different situations and think beforehand how you would handle them. Also, ask some of your classmates how they might handle different situations or ask if they have had any challenging experiences.
8. You will be given a communication technique handout and an opportunity to practice therapeutic communication in the laboratory with a partner before you do the clinical rotation..
9. The nurse should ask questions about alcohol, drugs, sexuality, and sexual preferences during the interview. These are sensitive questions and need a tactful approach.

**MAXIMIZING COMMUNICATION**

1. Internal Assets - are those traits which the interviewer brings to the setting

-genuine liking of people

-empathy - recognizing and accepting the other persons feelings without criticism, judgment. **Not** feeling sorry for the client (this is **sympathy**!).

-active listening

2. External Assets - factors within the environment that you can control.

-privacy

-comfortable physical setting

-maintain eye contact

-refuse interruptions

-appropriate dress

**COMMUNICATION TECHNIQUES TO AVOID**

\* **Collect data - DON'T PASS JUDGMENT!**

**DON'T:**

-reassure

-give advice

-use professional jargon (USE LAYMAN'S TERMS)

-interrupt

-talk too much

**PRINCIPLES OF DATA COLLECTION**

1. Word questions so client can understand.
2. Keep questions brief and simple.
3. Ask one question at a time.
4. Use open-ended questions whenever possible.
5. Clarify the client’s responses if necessary.
6. Summarize when the history is lengthy.

**SETTING FOR THE INTERVIEW**

1. There are some things to think about in terms of the setting. You should use a comfortable setting for data collection. The room should be warm, quiet, and have chairs and a writing area. Greet the patient; offer a handshake and introduce yourself.
2. Always take time to sit down and face the patient.
3. Have good eye contact.
4. The patient should be in street clothes (it is preferable not to have the client undress during the interview).
5. The room should have a door which can be closed to insure privacy.
6. Maintain a conversational voice tone.
7. Explain all procedures.
8. Avoid distractions in the setting such as TV, radio, and other people.
9. A beeper or telephone which goes off during the interview demonstrates to the client that you are either too busy to attend to their needs, or don't care. Any type of interruption is unfair to the client and affects the development of trust, caring, and the therapeutic relationship.

**VI. OUTLINE FOR CLINICAL HISTORY**

You will use an organized format for asking the history and review of systems (ROS) questions. a commonly used format used by staff nurses, advanced practice registered nurses, clinical specialists, and medical staff is shown below. .

1. ***Chief complaint:*** Brief description of client's problem in the client's words. One to two words only (i.e. sore throat, leg pain, etc.)!
2. ***History of present illness:*** Chronological course of events and state of present health. Use a symptom analysis method such as OLDCART (onset, location, duration, character, attenuates, relieves, treatment used) for each symptom mentioned. This is where you "explain" the chief complaint.
3. ***Past medical history:*** Data of childhood and adult illnesses, immunizations, surgeries, serious injuries, medications, allergies, and blood transfusion. Be sure to include allergies to medications, foods, and environmental factors. Don't forget to ask about latex and food allergy.
4. ***Personal and social history:*** Socioeconomic and cultural data. You may use a cultural assessment form if you want to be very thorough. Otherwise you will want to know about marital status, living arrangements, significant others, environmental factors, ethnic group and religion ( cultural practices that may affect health recovery are noted) primary language and educational level, lifestyles or personal habits e.g amount, frequency and duration of substance used (tobacco, alcohol etc) Knowing if the patient has insurance and adequate income for living and health related expenses is very important. If the client has barely enough to live on for food and rent, giving them prescriptions and expecting them to follow the medication regimen may not be possible.
5. ***Family History:*** Diagram of disease and family illnesses and death. Since many diseases have a hereditary component, this information is important. A genogram may be helpful for displaying the family history. Client’s support system is essential in times of stress. Ethnic affiliation –.
6. ***Functional Health Patterns:*** This is a part of the screening history. Information is gathered as it relates to Activity/Exercise, Sleep/Rest, Nutrition Elimination, Cognitive/Perceptual, Role/Relationships, Coping/Stress, Self-perception/Concept, Value/Belief and Sexuality & Reproduction. These categories are known as "Gordon’s Functional Health Patterns" .
7. ***Review of Systems:*** An organ system checklist with detailed information depending on what the client’s problems are and in which systems. Physiologic and psychological data is organized according to body systems. This data can be gathered by interview or letting the patient fill in a checklist. Each symptom checked as a "yes" is further analyzed using the OLDCART method mentioned.
8. ***Concluding Questions:*** At the end of the interview ask the client if there is anything else that needs to be discussed. Do not forget this question as many times clients will bring up something on their minds that they did not tell you earlier.
9. Lastly, review principles of confidentiality mentioned earlier. Everything the patient has told you is confidential and is not to be discussed with anyone other than the healthcare team. No one who is not caring for the patient has the right to know about what is discussed with the team or has the right to see the patient's medical record. Confidentiality of information is especially critical with the use of computerized data bases and medical records. Part of the nursing code of ethics is that the patient record is confidential.

**DEFINITIONS**

When conducting the health history, make sure you only use "layman's" terms so as not to confuse the patient. **The Review of Systems** checklist contains many terms you may not be familiar with. Below are some explanations.

**Malaise** -uneasy feeling of weakness or discomfort

**Lesions** - areas of pathologically altered tissue

**Diplopia** - double vision

**Photophobia** - sensitivity to light

**Glaucoma** - disease of the eye with increased intraocular pressure

**Tinnitus** - ringing in the ears

**Vertigo** - dizziness

**Epistaxis** - nose bleeds

**Dysphagia** - difficulty swallowing

**Pruritus** - itching

**Gynecomastia** - enlargement of breast tissue in males

**Dyspnea** - shortness of breath

**Orthopnea** - shortness of breath while lying down

**Hemoptysis** - coughing up blood

**Cyanosis** - bluish color of skin (due to decreased oxygenation)

**Paroxysmal nocturnal dyspnea** - sudden shortness of breath at night

**Palpitations** - rapid pounding of heart

**Syncope** - fainting

**Varicose Veins** - enlarged, twisted superficial veins

**Hematemesis** - vomiting blood

**Jaundice** - yellow skin or sclera

**Melena** - black, tarry stools (indicates blood)

**Urgency** - have to urinate NOW (can't hold it)

**Dysuria** - painful urination

**Nocturia** - frequent urination at night

**Hematuria** - blood in urine

**Hesitancy** - difficulty starting urine stream

**Post-coital bleeding** - bleeding after intercourse

**Muscle Atrophy** - muscle shrinking

**Paresthesia** - numbness and tingling

**Paralysis** - lacking/loss of movement

**Tics** - spasms of muscle contractions, twitching

**Tremors** - quivering

**Spasms** - involuntary sudden movement or convulsive muscle contraction

**Insomnia** - inability to sleep

**Delusions** - false beliefs

**Hallucinations** - false perceptions (can be visual, auditory or olfactory)

**VII.  AGE AND CONDITION RELATED VARIATIONS IN OBTAINING HISTORY AND ROS**

* The format is somewhat different for infants, children, and adolescents. For example for newborns, data is collected about pregnancy, labor and delivery course and birth condition. Dietary and developmental issues are also important. You may use other tools such as the Denver Developmental Screening Test (DDST) for infants and children. Age specific social history includes things such as thumb sucking and temperament (such as temper tantrums) or other behaviors.
* System review is also a little different depending on age and condition related variations. For example, you cannot collect history from infants, as they have not developed language skills. Young children can be asked some questions, but most of the data is collected from parents. Older individuals may or may not be reliable historians, depending on cognitive functioning and memory. The format needs to be modified for these age and condition specific factors. You will be provided the appropriate forms for the clinical setting where you are practicing and for the age and condition related variations discussed.
* For adolescents, ask about relationships, self-esteem, sexual relations, school, and recreational drugs. Use an exploring method of interview when working with adolescents. Also, adolescents may not want to talk with parents around or answer personal questions about sexuality issues, drugs, smoking and alcohol, so provide an opportunity for discussion away from parents.
* With older adults, explore age specific concerns. These might include sexual intimacy issues which are common in this age group. Other questions that are appropriate might relate to pain in the joints, fatigue, and shortness of breath. It is important to differentiate the normal symptoms of aging from those that are more serious and may be indicators of impending heart failure or other chronic illness. It is also important to evaluate the reliability of the data as a few older folks may have dementia and memory problems.
* You can revise existing forms to accommodate for age and developmental conditions. Most clinical sites will have their own forms and format. You can also supplement the format with age specific tools such as the DDST mentioned earlier, or a mental status exam such as the Mini Mental Status Exam (MMSE) tool for older confused patients. For patients with head injury or neurological deficits, an appropriate assessment tool for gathering data may be the Glasgow Coma Scale, which is used as part of the neurological exam. This tool may be used to assess cognitive function and level of consciousness before starting a history and ROS to assess if the patient is a reliable source.
* Concentrate on building good communications skills and techniques with your clients. Use every opportunity to practice and evaluate your newly developing skills. Most of the tools presented are applicable across ages. It is also important to ask about concerns related to abuse, violence, or drug use in the home.

PHYSICAL / HEALTH EXAMINATION

A complete physical assessment may be conducted starting from the head proceeding in a systematic manner towards the toes. However the procedure can vary according to the age of the individual, the preference of the nurse, the location of the examination and the agency’s priorities and procedures.

Purposes of physical health assessment

* To obtain baseline data about the client’s functional ability.
* To supplement, confirm or refute data obtained in the nursing history.
* To obtain data that will help the nurse establish nursing diagnosis and plan the client’s care.
* To evaluate the physiologic outcomes of health care and thus the progress of a client’s health care
* To make clinical judgement on the client’s health status.

**Methods of examination**

Physical examination involves 4 processes viz

**Inspection:-**This is the visual examination i.e assessing the client using the senses – sight, auditory, olfactory etc. It is deliberate, purposeful and systematic. The nurse inspect with the naked eyes or with a lighted instrument such as otoscope. In addition to visual observation, olfactory and auditory cues are noted.

**Palpation** is the exam of the body using the sense of touch. The pads of the fingers are used. The concentration of nerve endings makes them highly sensitive to tactile discrimination. Palpation is used to determine

* Texture e.g hair
* Temp. e.g skin
* Vibration e.g joints
* Position, size, consistency and mobility of organs or masses.
* Distension e.g bladder
* Pulsation
* Presence of pain upon pressure
* Palpation could be deep or light

**Light Palpation** This should always precede deep palpation, the nurse extends the dominant

hand’s fingers parallel to the skin surface & presses gently while moving the hand in a circle

**Deep palpation:** - This is done with two hands (bimanually) or one hand for deep bimanual palpation. The nurse extends the dominant hand as for light palpation, then places the finger pads of the non- dominant hand on the dorsal surface of the distal interphallangeal joint of the middle 3 fingers of the dominant hand. For using one hand, the finger pads of the dominant hand pressed over the area to be palpated. Often, the non- dominant hand is used to support a mass or organ to be palpated.

**Guideline for palpation**

1. The nurse’s hands should be clean and warm with short fingernails.
2. Areas of tenderness should be palpated last
3. Deep palpation should be done after light palpation.

**Percussion:** - This is the act of striking the body surface to elicit sound that can be heard or vibrations that can be felt.

**Indirect or immediate percussion** here the nurse strikes the area to be percussed directly with the pads of 2, 3 or 4th fingers or with the pad of the middle finger(3rd finger) , this technique is used in percussing an adult sinuses (cavity)

**Direct or mediate percussion**. It is the striking of an object e.g a finger held against the body area to be examined. In this technique the middle finger of the non- dominant hand ( pleximeter) is placed firmly on the client’s skin , using the tip of the flexed middle finger of the other hand (plexor). The nurse strikes the pleximeter usually at the distal interphallangeal joints.

Percussion is used to determine the size and shape of internal organs by establishing their borders; it indicates whether tissue is fluid-filled, air-filled or solid. Percussion elicits five types of sounds .viz

Flatness

Dullness

Resonance

Hyper-resonance

Tympany

**Auscultation** This is the process of listening to sound produced within the body. There are 2 main types viz

a) **Direct auscultation**. This is the use of unaided ear to listen to a respiratory wheeze or the grating of a moving joint.

b) **Indirect auscultation** It is the use of a stethoscope or any other instrument which amplifies the sound and conveys them to the nurse’s ears.

**Infection Control Guidelines to Prevent the Spread of Disease**

* During the physical exam, you will have direct contact with clients. For yours and your client’s protection, you need to have a basic understanding of infection control principles to prevent the spread of microorganisms.
* In order for an infection to occur three things must be present. There must be microorganisms in sufficient numbers to produce disease, there must be a route of transmission for the microorganism and third, the person must be susceptible to the invading organism. Infection cannot occur if all three of these elements are not present. (Remember agent, host and environment?)
* Think of these 3 elements (microorganisms, transmission route, and susceptibility) as interconnected. You can prevent the spread of diseases by understanding the interconnectivity of these 3 elements. Hand washing is one way to prevent the transmission. Having your immunizations up to date is a way to decrease your susceptibility.
* Hospital infection control specialist’s work very hard to prevent the spread of microorganisms. There are two tiers of precautions: standard precautions (for all patients, all patients are treated as if infected) and transmission based.
* Transmission based precautions include contact, droplet, and airborne precautions. These may include special isolation rooms and procedures and the use of gowns, gloves, disposable linen, and special filters. Each hospital has a special policy and procedure outlining these precautions.
* Standard precautions are followed by all health care practitioners for all clients. Each client is considered infected. You should wear gowns and gloves when handling any body fluids.
* Handwashing is one of the easiest ways to prevent the spread of disease but is also the one most neglected by healthcare practitioners. Some pointers are:
* Use soap, running water, and a 15 second scrub. Be sure to wash in between the fingers.
* Wash your hands even if wearing gloves.
* Bacteria can go through gloves into the skin.
* Wash your hands each time you enter and leave the patient’s room.
* If you are allergic to or sensitive to latex, be sure to use latex free gloves.

**UNIVERSAL PRECAUTIONS**

\*\* Health care workers should consider all patients as potentially infectious. Treat all blood and body fluids as if they were contaminated.

\*\* Handwashing is the BEST way to prevent infection

GENERAL GUIDELINES

1. Blood and body fluid precautions used for ALL patients.
2. Gloves should be worn when touching blood, body fluids, non-intact skin and during venipuncture or other vascular access procedures.
3. Masks or protective eyewear, gowns and aprons worn as needed to protect yourself.
4. Hands and other skin surfaces washed immediately if contaminated with blood or body fluids.
5. Prevent injuries from needles, scalpels or other sharps.
6. Mouthpieces and resuscitation bags should be used for mouth to mouth resuscitation.
7. Health care workers with exudative lesions or weeping dermatitis should check with their supervisors before giving care.
8. Pregnant health care workers should strictly adhere to precautions since the infant could be at risk.

IX. Latex Allergies

1. Latex is a protein present in more than 40,000 products. Products that contain latex include car tires, toys, and clothes. In hospitals products containing latex include catheters, Band-Aids, and tape to name a few.
2. Latex gloves are very common in hospitals and are the source of many allergies in healthcare personnel.
3. An allergic response to latex is an IgE cell mediated (histamine) response. Symptoms include redness, swelling, and itching.
4. Nurses with latex allergies or sensitivity should use latex free gloves or powder free low protein gloves.