

Comprehensive Holistic Health Assessment

Introduction

Culture and values, family and social roles, self-care behaviors, job-related stress, developmental tasks, and the failures and frustrations of life are all parts of the comprehensive holistic exam.

It can be challenging to incorporate holistic elements into your current assessment routine; however, understanding a patient in a more holistic way adds value to the care we provide. There can be hurdles in adding the elements listed here; however, omitting this data can have negative impacts on patient care as well as outcomes.

Case Study: Marjorie

M.P. is a 45-year-old woman who presents to the family practice for a yearly check-up.

Subjective data:

- Married
- Exercises daily
- Nonsmoker, never smoked
- Registered nurse in hospital
- Has two children who live at home
- No complaints at this time
- No medications
- Multivitamin daily
- Allergy to PCN = Hives

Objective data:

- Vital Signs:
- T36.7 BP 108/62
- HR 62 Resp 14
- Height 5 ft. 7 in
- Weight: 160 lbs
- Up to date Imm.

Question 1:

How should the nurse sequence and proceed with the physical exam?

Answer:

Each nurse has a unique way of performing the head-to-toe assessment.

Starting with less invasive examination procedures will allow time to establish trust with the patient. However, establishing a routine helps the nurse become organized and develop a system for the physical examination.

Begin with the head.

Examine the facial characteristics - skin, hair, eyes, ears, mouth, throat, and range of motion of the neck

Incorporate the neurologic, integumentary, musculoskeletal, visual, and auditory systems that are within the head, neck, nose, and mouth regions.

Move on to the next region of the body and repeat the process.

After all body regions have been examined, document the findings by body system.

Question 2:

What pointers or tips can the experienced nurse give to a new nurse who wants to improve his or her technique?

Answer:

Tips for success include the following:

- Begin with a clear plan of what you will do and in what order.
- Develop a routine; this helps with consistency.
- Be organized; have all necessary equipment.
- Be systematic and comprehensive; this requires practice.
- Imagine yourself as the patient. Consider how you would want a nurse to prepare to assess you.

Question 3:

What are the components of the general survey that are collected during a health history?

Answer:

The components of the general survey are:

- Level of consciousness and mental status
- Mood or affect
- Personal hygiene
- Skin color
- Posture and position
- Mobility
- Ability to hear and speak

Question 4:

To avoid introducing tension to the abdominal region, an abdominal exam proceeds in the following order:

Answer:

To avoid introducing tension to the abdominal region, an abdominal exam proceeds in the following order:

- Observe skin characteristics from pubis to mid-chest region for scars, lesions, vascularity, bulges, and navel.
- Inspect abdominal contour.
- Observe for movement of abdomen, peristalsis, and pulsations.
- Auscultate abdomen (all quadrants) for bowel sounds, bruits, and venous hums.
- Lightly palpate all quadrants for tenderness, guarding, and masses.
- Deeply palpate all quadrants for tenderness, guarding, and masses.