

Unit- 3

HEALTH ASSESSMENT

NAME- MITHUN D.

SUB - COMMUNITY HEALTH NURSING

DEPT.- COMMUNITY HEALTH NURSING

Health Assessment

❑ **Introduction–**

Health assessment is essential for planning, implementation, evaluation and taking related decision of health and community services. Health assessment is a regular and continuous process. This is an important tool to determine the health status of an individual, community or nation. Main facts related to health assessment are given below:

❑ **Components of health assessment:-**

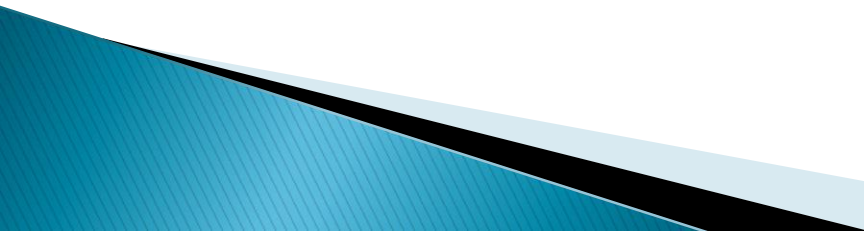
1. Taking History
 2. Physical Examination
- 

❑ **Places of Health Assessment:-**

1. Individual's Health
2. Health Center/Clinic
3. Hospital

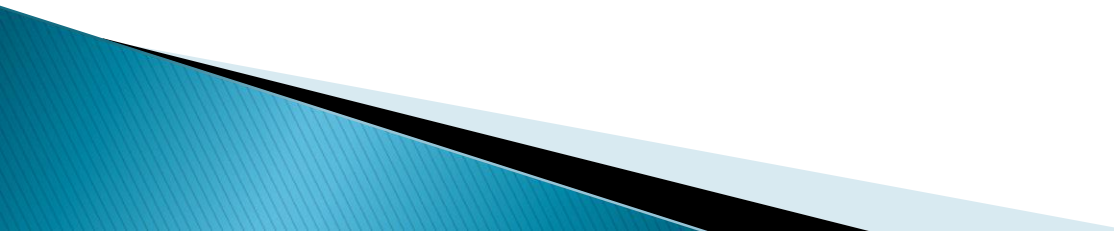
❑ **Characteristics of a healthy individual –**

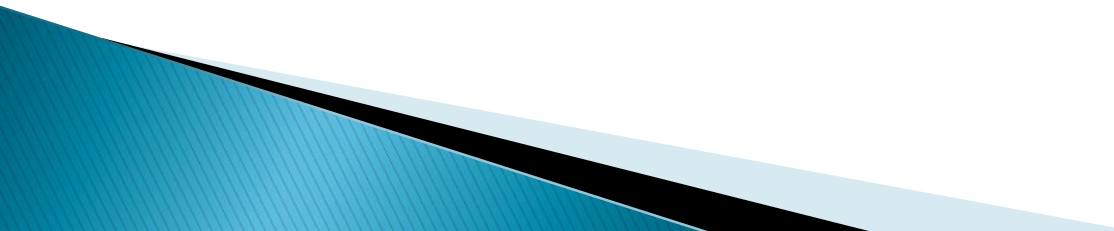
Characteristics of a healthy person can be discussed under the following headings:

1. Physical characteristics
 2. Social characteristics
 3. Spiritual and cultural characteristics
 4. Mental characteristics
- 

1. Physical characteristics—

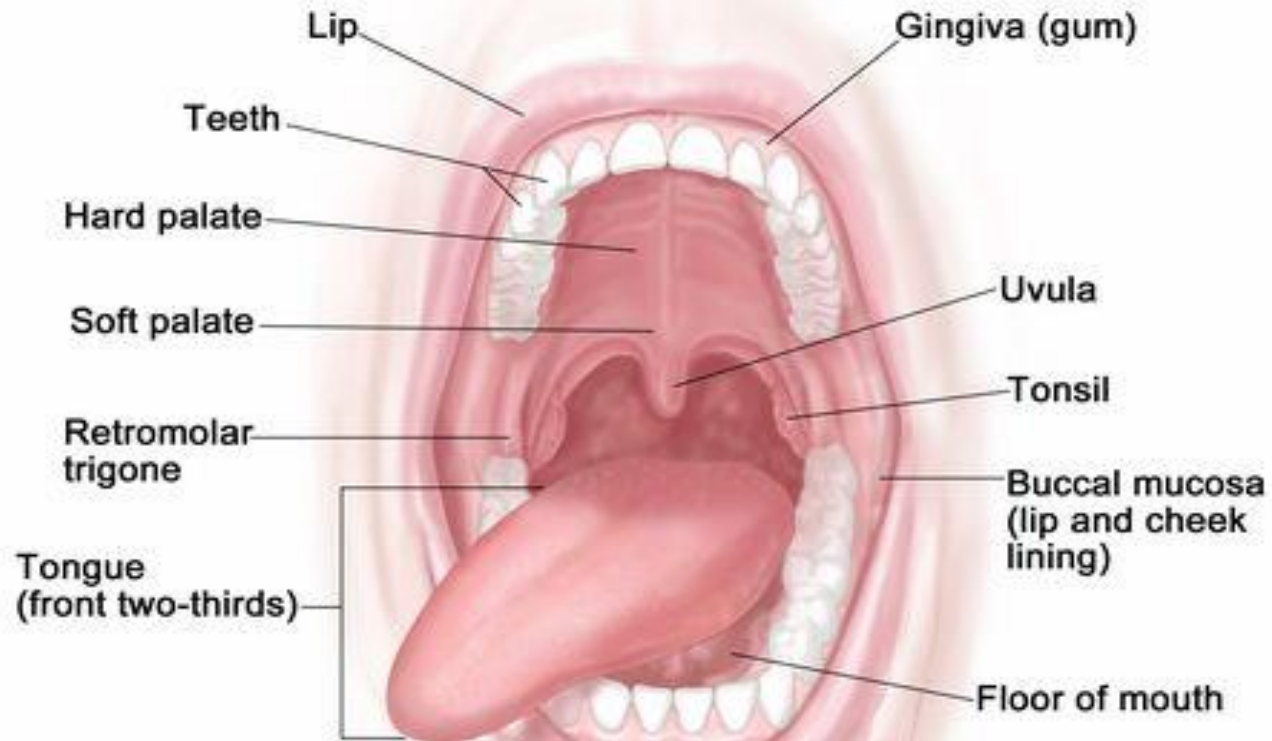
These account for a major part of an individual health, and most of them can be measured by head-to-toe assessment.

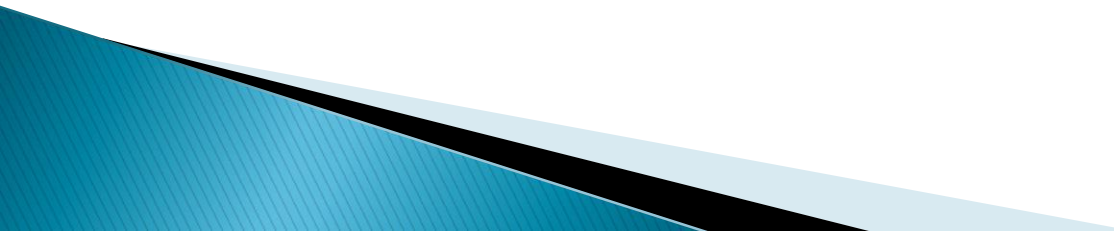
- **General physical appearance:-** Healthy appearance, weight and height according to normal standard, intelligent, pleasant, smiling face, friendly in nature, properly dressed and good posture.
 - **Mental status:-** Well-oriented to person, place and time, prompt responses in answering, maintain good eye contact, fully conscious.
- 

- **Speech:-** Clear and appropriate, correct selection of words during speech, command on sentences and wordings.
 - **Head and Neck:-**
 - **Hair:** Clean, shining, oiled and combed without dandruff.
 - **Scalp and Skull:** smooth, lesions or tenderness.
 - **Face:** Shining.
 - **Neck:** Symmetrical with smooth controlled movement.
- 

- **Eyes:** Symmetrical and in alignment with top of ears, eyebrows with equal distribution, lashes evenly spaced.
- **Ears:** Normal in size and symmetrical, hearing normal, discharge.
- **Nose:** Same colour as face, bleeding.
- **Mouth : -**
 - **Lips:** smooth, moist.
 - **Buccal mucosa:** pink and moist without discoloration, no ulcer.
 - **Gums:** bleeding and inflammation.
 - **Teeth:** 28 to 32 shiny white in good condition, without dental carries.
 - **Tongue and palate:** Middle, moist, pink and with smooth movement without nodule etc.
 - **Taste:** Successful identification of taste by tongue.

Anatomy of the Oral Cavity



- **Chest-** symmetrical.
 - **Heart**– Apical pulse 72-76 b/min and regular, no extra heart sounds or pulsation.
 - **Abdomen**– round, soft, bowel sounds audible and normal.
 - **Upper extremities**- arms symmetrical, muscles reflex normal.
 - **Lower extremities**– legs symmetrical, oedema or inflammation.
 - **Systems review**– Respiratory, cardiovascular.
- 

2. Social Characteristics— A healthy individual should:

- Have good relations, community.
- Follow the social change and social control.
- Be active socially for overall well-being of the society.

3. Spiritual and cultural characteristics—

A healthy individual should have holistic approach. He believes in his religion but should also respect other's religions and beliefs.

Spiritual and cultural characteristics play important role in health.

4. Mental Characteristics—

Characteristics of mentally healthy person are describe in personal hygiene And Environmental hygiene.

- Social hygiene.
- Industrial hygiene.
- School hygiene.

Health assessment of infant:-

Children below 1 year of age are called infants.

Given below are the important constituents of health assessment of infant:

1) Past medical history—

- General health and strength of the child.
- Health of mother during pregnancy.
- Birth history.
- History of neonatal stage.
- Feeding- Bottle feeding or breast feeding, food preference, eats himself or not, finding the age of weaning is also essential.
- Immunization.
- Communicable diseases, accidents or any other disease. The child admitted in hospital? If yes, then the duration and the details of the treatment given.

2) Assessment of Development:-

- Weight, height and the circumference of head and arm.

Here attention should be paid to the following:

- Mouth (age) in which head control acquired.
- Sitting without support.
- Standing with support or without any support.
- Walking with support or without support.
- Speaking words.
- Toilet training.

3) Family History:-

Information about the financial, social, domestic, educational and nutritional condition of the family can be obtained from the mother these have direct or indirect effect on the health of the infant.

4) Present illness and Chief complaint:-

Here, the attempt is made to find out the present illness and main complaint of the child.

5) Review of system:-

Here, a detailed check-up is done of all the systems of infant. Special attention should be paid to the following in the health check up if infant:

- Presence of pediculosis or any other skin diseases.
- Ear diseases.
- Excessive running of nose.
- Breathing from mouth or other allergic conditions.

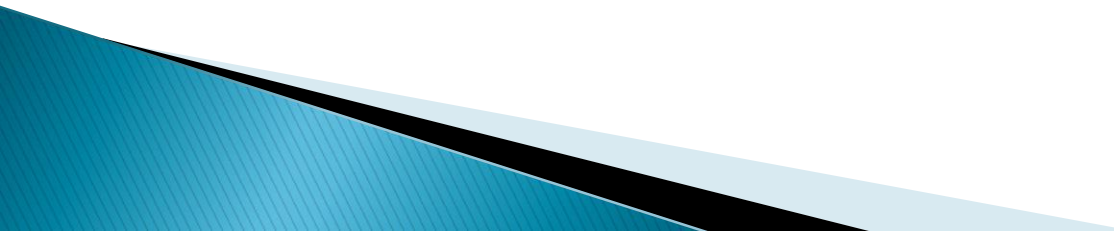
Thus, health assessment of infant is a multi-facet process, for which community health nurse should have special skills and capabilities.

Pre-school going child

Pre-school going age (1-4 years) is that period in a child's life, when intense growth and development takes place. His vaccination is also complete during this period.

During this age, children can suffer from dehydration, diarrhoea, malnutrition and infectious diseases.

Following component can be included in the health assessment of children belonging to this age group:

1. Past medical history of child.
 2. Personal and family history of child.
 3. Various health check-ups related to the growth and development of child.
 4. Immunization status of child.
 5. Nutrition level of child and his eating habits.
 6. Present condition of a child's health and his major health problems.
 7. Head-to-toe physical examination of child and a review of all systems of his body.
- 

Taking Anthropometric Measurements

□ **Definition**— A system of assessment of physical built and nutritional status of children by using measurements such as weight, height, wrist circumference, skin fold thickness, upper arm circumference, chest circumference, and head circumference.

□ **Purposes**—

1. Assess the milestones easily.
2. It help to assess the growth development.
3. It gives accurate nutritional status of an under five.
4. It determines the degree of malnutrition.

Articles:-

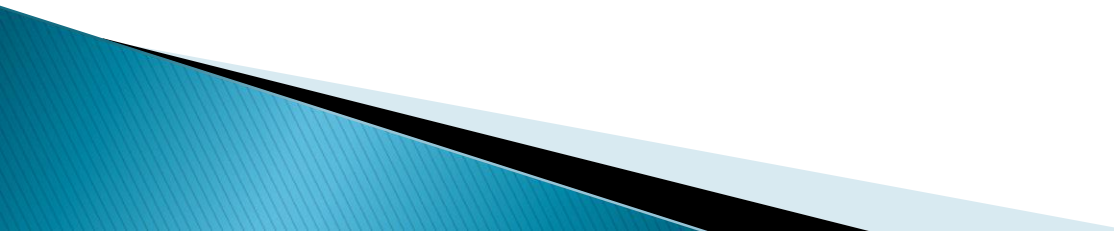
1. Weighing scale/spring balance– To weight the under five.
2. A scale– To mark the height point.
3. Measuring tape– To measure the height.
4. Growth chart– To check the actual weight with the standard curves of the growth chart.



Health Assessment of School Going Child

Health assessment of school going children is an important part of school health service. Along with community health nurse, physician and teachers also share the responsibility of this assessment. Some components of health assessment of school going children are:

1) Periodic check-up of children –

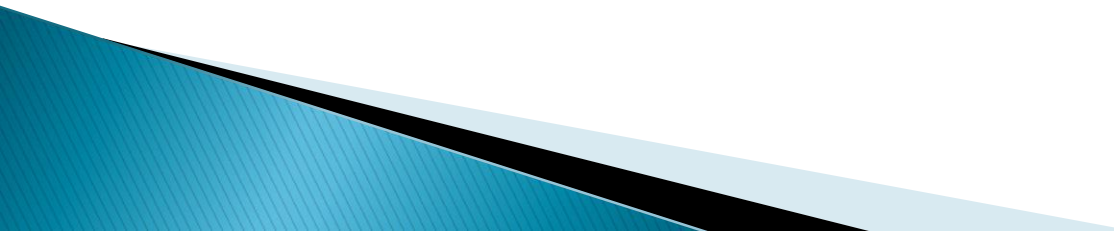
- Check-up at the time of admission
 - Health check-ups of child every fourth year.
 - Check-up at the time of leaving the school.
- 

Periodic check-up can be conducted before the completion of 4 years or even more frequently.

Check up at the time of school admission includes, measuring the height and weight, dental check-up, eye check-up, speech and hearing check-up, finding out the presence of worms in abdomen, conducting routine test of blood and urine, and finding about unknown, disease or disorder that the child has been suffering from.

2) Nutritional Assessment—

This includes assessment of food, child gets at home and the supplementary meals given in school.



3) Daily Examination—

Daily examination of child is conducted by the teachers. For this it is essential that the teachers be trained in diagnosing the illness and providing routine treatment. During daily examination it is necessary to keep an eye on the cold, cough, headache, skin diseases and other infections.

4) Personal and family history of children—

History can be collected through parent-teacher or parent-community health nurse meetings held at the time of admission in the school or later from time to time, which is desirable for health assessments.

5) Past Medical History—

Past medical history of the child can be procured from the child or the parents.

Thus, teachers, parents, community health nurses and doctors etc.

Health Assessment of Adult-

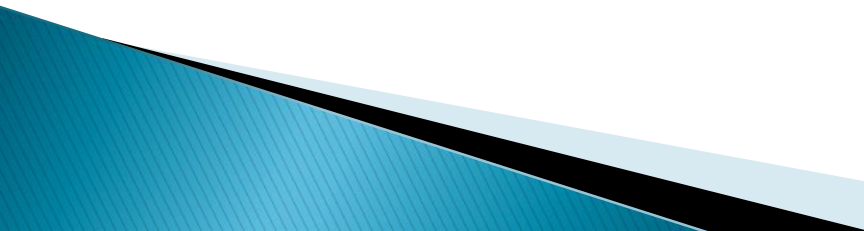
Adulthood of a person can be determined on the basis of his age and level of maturity. Generally, attaining the right to vote; after the age of 18 years, is considered to be beginning of adulthood. Adulthood can be divided in three parts:

- Young adults: 18-40 years
- Middle aged adults: 40-60 years
- Elderly adults: above 60 years of age

Complete physical check-up and history have an important place in the health assessment of an adult person. Since, complete physical development and stability is achieved in this age, it is essential to pay attention to the following steps of health assessment:

- Psychosocial development.
- Cognitive development.
- Moral and spiritual development.
- Health protection: Accidents, infections, suicide, sex related problems, drug addiction, obesity, blood pressure and mental disorders are the major health hazards of adults. It is necessary to pay attention to these in the health assessment of adults.

Health Assessment of the Aged Persons

- Taking history and complete physical check-up are the major components of the health assessment of aged persons, but it is necessary to pay attention to the following factors:
 - Old people may be suffering from more than one health problem.
 - Symptoms of disease may not be well pronounced in the old people.
 - The complaint of pain may be unbelievable, in most of the cases, because there may be a change in their attitude about the feeling of pain.
- 

- Behavior of family and society towards aged persons plays an important role in their health assessment.

Here are the important constituents of health assessment of aged persons, in the above mentioned context:

1. Assessment of Disabilities– Old persons may be suffering from physical, psychological, social and sexual disabilities or impairments.

Similarly, cooking, domestic work, shop keeping, taking medicine, managing money and conducting daily living activity (going to toilet, having bath, changing clothes, taking food etc.) may also pose problems for them.

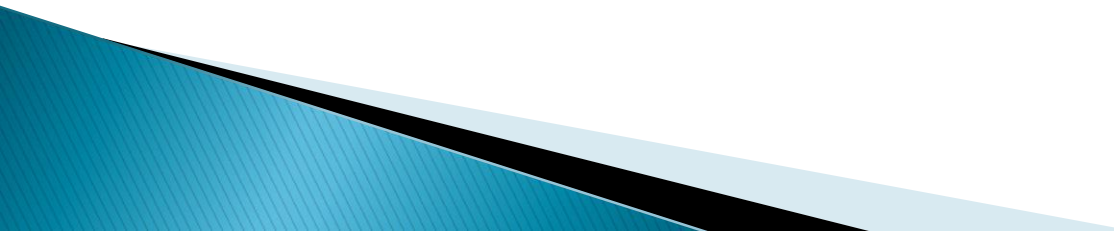
2. Past Medical History– Following can be assessed through this:

- General health and strength.
- Diseases of youth and childhood (measles, diphtheria, polio, TB, jaundice, high blood pressure, diabetes, heart diseases etc.)

- Surgery or serious accidents.
 - Allergy, emotional level.
 - Previous treatment.
3. **Personal and family history**– Here attention is paid to place of birth, domestic environment, marriage, divorce, socio-economic group, education, cultural background, position of family.

It is necessary to know the family history to find out about any genetic diseases.

4. **Review of systems**– Though, head-to-toe physical examination is desirable for correct assessment but it is not necessary to review all the systems, every time. Through physical examination, the health level can be assessed by examining all the vital organs and systems of the body. Here it should be remembered that old age is called the home of diseases, hence results of this examination help in determining many diseases or health problems.

5. **Present Illness**— Its assessment may vary with the individual, and there may be one or more reasons for it.
 6. **Chief Complaint**— while assessing the health of old people, their chief complaint should be inquired so as the priorities may be decided in the implementation of care. At the end of health assessment, community health nurse should question herself, if any information is still remaining, which should be procured by asking questions, and accordingly attempts should be made to collect related information and facts.
- 

Antenatal Health Assessment

Right from the time of confirmation of pregnancy, antenatal health assessment of the pregnant woman begins. The most important objective of antenatal health assessment is to find out the physical and psychological response of the pregnant woman towards pregnancy.

Components of antenatal Assessments :

- Taking medical history.
- Physical examination.
- Laboratory examination.
- Monitoring of growth and development of the embryo.
- Detecting risks of pregnancy.

1. Medical History– Taking medical history is an important method of data collection. In antenatal assessment, attention is paid to the following sections of medical history:

a. History regarding menstrual cycle –

- Age at which menstrual cycle started (Date of menarche)

- Regularity of menstrual cycle, flow, amount and interval.
- complications regarding menstrual cycle.

b. Obstetrical History –

- Previous pregnancy.
 - Date
 - Experiences at the time of delivery and in the post delivery period.
 - Age, sex and birth weight of the child delivered before the existing pregnancy.
- Present pregnancy –
 - Planned/unplanned
 - Signs and symptoms of pregnancy.

c. Personal and Family History –

- Social history.
- Educational standard of woman and her husband.
- Marital and sexual history.
- Occupation of pregnant and her husband.

- Habits related to exercise, rest, sleep, food.

- General status of health.

2. Physical Examination –

General Examination

- Weight and height

- Temperature, pulse, respiration, BP and pulse oximetry.

Gynaecological Examination

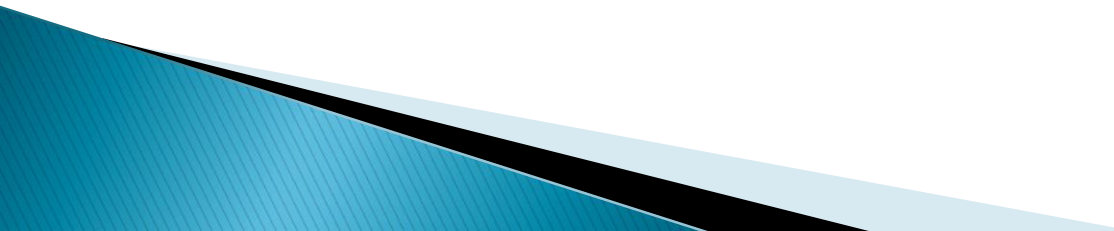
- Examination of breasts.

- Examination of abdomen and palpation

- Vaginal examination, if necessary.



3. Laboratory Examination –

- Testing haemoglobin.
 - Blood group and Rh factor.
 - WBC count DLC count.
 - Urine examination
 - PAP smear.
 - Blood sugar test.
 - Blood serum examination.
 - Stool test.
 - Chest x-ray if necessary.
 - Ultra sonography.
- 

4. Monitoring of growth and development of fetus—

- For examining the growth and development of the embryo/fetus in womb, the pregnant women should be called to the clinic in the following manner.
 - Once a month, till 30th week of pregnancy.
 - From 30th to 36th week, every 15 days.
 - After that till pain starts, once in every 7 days.

5. Detecting the High Risk Pregnancy— A high risk pregnancy can be assessed on the basis of following Factors:

- Age of the pregnant women is either below 15 years or above 30 years.
- Anemia.
- Pre-eclampsia and eclampsia.
- Antepartum hemorrhage.
- Pregnant woman suffering from heart diseases, kidney diseases, DM, TB etc.

Postnatal Health Assessment

Generally till 1 year of delivery, the mother's health is assessed. In cases of normal delivery, the nurse should make four home visits including one visit to the clinic.

In the postnatal health assessment, the child's health is also assessed along with mother's health. The woman gets psychological support if her anxieties regarding the health of the baby are eliminated and she would be more co-operation in her own health assessment.

Components of postnatal health assessment:-

- Physical examination
- Laboratory examination
- Finding out psychological responses

1. Physical Examination –

- Collecting data regarding postnatal uterus involution.
- Assessing the needs of the lactating mother, and.
- Providing health education.

The main points of physical examination include following:

General Observation :

During the entire period of physical examination, mother condition etc.

Examination of Vital Signs :

After delivery the woman's temperature, pulse, respiration and BP are to be measured. Because of the labor, temperature may be little raised after delivery.

Abdominal Examination :

Because of the prolonged distension of abdominal muscles during pregnancy, these may become weak or loose. After delivery the muscles can be brought back into its original position with proper exercises.

Breast Examination :

Breast may become heavy due to lactation. The child should be put to breast can be reduced by early as possible.

Uterus Examination :

After delivery, the size of the uterus is about the size of head of the baby.

Urinary Bladder Examination :

Just after delivery, there may be swelling in the urinary bladder, its capacity might increase but sensitivity decreases.

Pelvic Examination :

Any abnormality after 6 weeks of delivery like tear, injury due to episiotomy, etc. can be detected only by pelvic examination.

2. Laboratory Examination :-

- Blood examination (to detect anaemia)
- Urine Examination
- Sonography (if necessary)

3. Finding out psychological Responses –

❖ Developmental Approach :

- Acceptance of the baby.
- Feeling of release from the Labour pains and delivery.
- Learn to take care of newborn.

❖ Dependent Phase –

For a few days after delivery, the woman is dependent on the assistance of other people.

❖ Bonding with Infant –

Mother gazing at the infant steadily with loving eyes, hold its head close to herself, etc.

❖ Adverse Responses –

In addition to above mentioned points, in postnatal health assessment, rest, sleep, nutrition, excretion, personal health, etc. are also to be included.

THANK
YOU