Principles of Patient and Family Assessment

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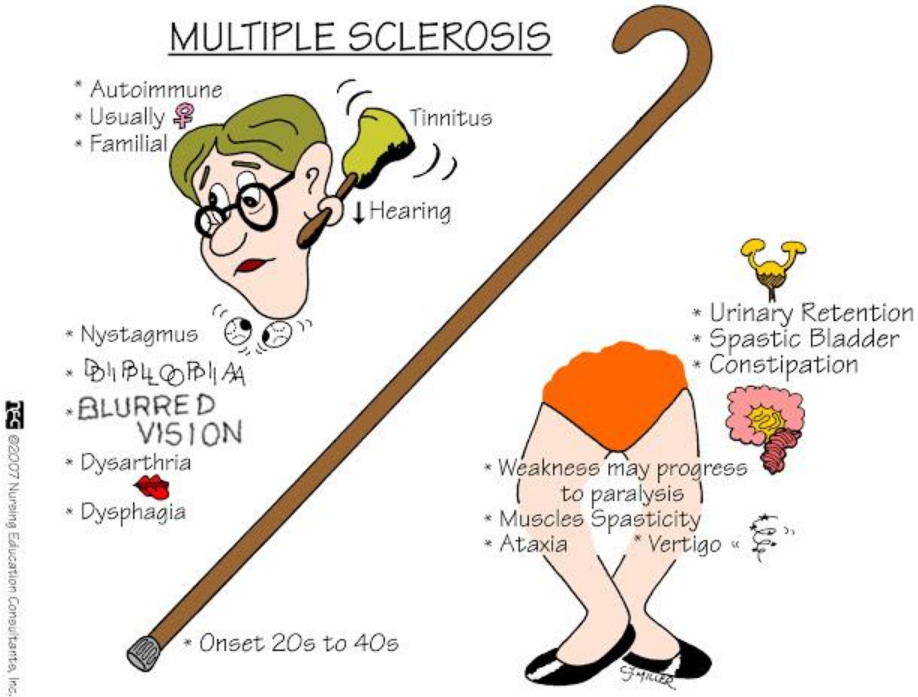
Chronic and life-threatening illnesses

- The chronically ill patients experience continuous or episodic declines throughout the illness trajectory.
- The focus of care: palliative rather than curative (reduction of symptoms, improvement of QoL)
- AIDS; cardiovascular, hepatic and renal diseases; diabetes; and neurological disorders (multiple sclerosis, cerebral palsy, Parkinson's disease, cancer, and sickle cell disease.


MULTIPLE SCLEROSIS
* Autoimmune
* Usually ♀
* Familial
Tinnitus
↓Hearing
* Nystagmus
* DIPLOPIA
* BLURRED VISION
* Dysarthria
* Dysphagia
* Urinary Retention
* Spastic Bladder
* Constipation
* Weakness may progress to paralysis
* Muscles Spasticity
* Ataxia
* Vertigo
* Onset 20s to 40s
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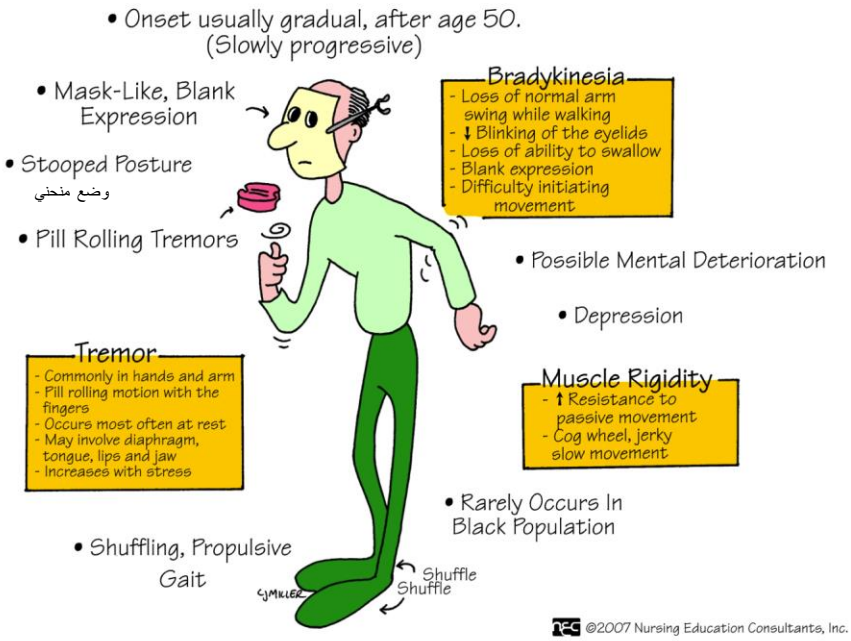
PARKINSON'S DISEASE
• Onset usually gradual, after age 50. (Slowly progressive)
• Mask-Like, Blank Expression
• Stooped Posture
وضع منحني
• Pill Rolling Tremors
Bradykinesia
- Loss of normal arm swing while walking
- ↓ Blinking of the eyelids
- Loss of ability to swallow
- Blank expression
- Difficulty initiating movement
• Possible Mental Deterioration
• Depression
Tremor
- Commonly in hands and arm
- Pill rolling motion with the fingers
- Occurs most often at rest
- May involve diaphragm, tongue, lips and jaw
- Increases with stress
Muscle Rigidity
- ↑ Resistance to passive movement
- Cog wheel, jerky slow movement
• Rarely Occurs In Black Population
• Shuffling, Propulsive Gait
Shuffle
Shuffle
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Chronic and life-threatening illnesses

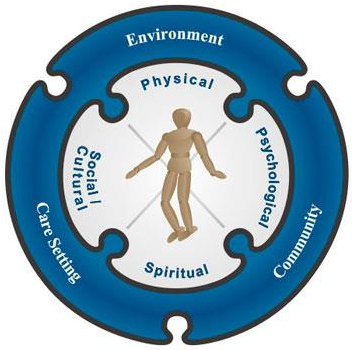
- Persons diagnosed with a chronic or life-threatening illness describing the status of the disease during a cancer illness as
  - *"remission," "partial remission," "stable disease," "recurrence," "relapse," and "metastasis." "exacerbation" and "recovery." Patients*

Quality of Life Assessment

- Assessment is key to appropriate NCP
- The need to maximize your listening skills, judgments.
- Remember that the goal is enhancing quality of life.

Quality of Life Assessment

- Ferrell's quality-of-life framework is used to organize the assessment
  - Physical domain
  - Psychosocial domain
  - Spiritual domain



physical assessment

- provides a baseline of symptoms
- monitors symptoms changes and the emergence of new symptoms
- The effectiveness of symptoms treatments
- Impact of symptoms on the patient's quality of life.
- uncover problems in the psychosocial and spiritual domains.
- focuses primarily on organ systems and symptoms related to their functioning.

physical assessment

- ***Historical information*** from the record (previous assessments done by care team, including diagnostics)
- ***Subjective information*** from the patient
- ***objective information*** by physical examination.

Psychosocial Assessment

- Persons diagnosed with a chronic or life-threatening illness experience many losses.
- Responses to illness
- Coping styles
- ***key elements of psychosocial assessment***:

(1) conducting the psychosocial assessment,

(2) distinguishing nonpathological grief from depression,

(3) doing a general mental status assessment.

Psychosocial Assessment

Box 4.1 Questions for self-awareness prior to palliative nursing assessments

What do I believe about …?

- quality of life
- suffering
- patient autonomy
- pain and treating pain
- death and dying
- advance directives
- code status
- organ donation
- funerals / burial / cremation
- cultures other than my own
- the use of:
  - ✓ CPR
  - ✓ life support / ventilators / tracheostomies
  - ✓ artificial nutrition at end of life / feeding tubes (NG, OG, PEG)
  - ✓ artificial hydration at end of life
  - ✓ drugs that could hasten death

Table 4.1 Framework for Psychosocial Assessment

Determining the types of losses:		
Physical losses	**Psychosocial losses**	**Spiritual losses**
Energy	Autonomy	Illusion of predictability/ certainty
Mobility	Sense of mastery	Illusion of immortality
Body parts	Body image alterations	Illusion of control
Body function	Sexuality	Hope for the future
Pain	Relationship changes	Time
Sexuality	Lifestyle	
	Work changes	
	Role function	
	Money	
	Time	

Continue

Determining the types of responses to loss:	
Observing emotional responses	**Identifying coping styles**
Anxiety	*Functional:*
Anger	Normal grief work
Denial	Problem-solving
Withdrawal	Humor
Shock	Practicing spiritual rituals
Sadness	*Dysfunctional:*
Bargaining	Aggression
Depression	Fantasy
Acceptance	Minimization
	Addictive behaviors
	Guilt
	Psychosis

Continue

Determining personal needs:	
Assessing the need for information	**Assessing the need for control**
Wants to know details	Very high
Wants the overall picture	High
	Moderate/average
Wants minimal information	Low
Wants no information, but wants the family to know	Absent, wants others to decide

Psychosocial Assessment

Parameters to assist patients and families in coping:

- the need for information
- the need for control in making decisions.
  - Indicators of a person's need for control may include:
- An expressed need for information.
- Comfort in asking questions.
- A willingness to assert their own needs and wishes
- Initiative taken to research print and Internet resources on the illness and treatment.

Psychosocial Assessment

- Grief is a normal reaction to loss, however, ineffective adaptations or coping can indeed lead to depression.

Table 4.2 Differentiating normal grief from depression

Parameter	Normal grief	Depression
Course	Self-limiting but recurrent with each additional loss	Frequently not self-limited
Preoccupation	Preoccupied with loss	Self-preoccupied, rumination
Emotions	Emotional states variable	Consistent dysphoria or anhedonia (absence of pleasure)
Sleep	Episodic difficulties sleeping	Insomnia or hypersomnia
Energy	Lack of energy, slight weight loss	Extreme lethargy, weight loss
Losses	Identifies loss	May not identify loss or may deny it
Crying	Crying is evident and provides some relief	Crying absent or persists uncontrollably
Social interaction	Socially responsive to others	Socially unresponsive, isolated
Dreams	Dreams may be vivid	No memory of dreaming
Anger	Open expression of anger	No expression of anger
Intervention	Adaptation does not require professional intervention	Adaptation requires professional treatment

Psychosocial Assessment

- Perform Mental health screening assessment to determine the most appropriate referral.

Table 4.3 General mental health assessment

Appearance	**Psychomotor behavior**
Hygiene	Gait
Grooming, makeup	Observable symptoms (tics, tremors, perseveration, pilling)
Manner of dress (appropriate, inappropriate)	Movement (akathisias, dyskinesias)
Posture	Coordination
Body language	Compulsions
Mood and affect (congruence)	Energy
Interview behavior	
Specific feelings expressed	**Speech**
Facial expressions	Pressured, slow, rapid
	Goal-oriented, rambling, incoherent, fragmented, coherent
Intellectual ability	Relevant, irrelevant
Attention (distractibility)	Poverty of speech
Concentration	Presence of latencies (delayed ability to respond when conversing)
Concrete/abstract thinking	
Comprehension	**Thought patterns**
Insight into situation, illness	Loose, perseverating
Judgment	Logical, illogical, confused
Educational level	Oriented, disoriented
	Poorly organized, well organized
Sensorium/level of consciousness	Tangential, circumstantial
Alert	Preoccupied, obsessed
Drowsy	Paranoid ideas of reference
Somnolent	Delusions
Obtunded	Hallucinations
Stuporous	Blocking, flight of ideas
Unresponsive	Neologisms (made-up words)
	Word salad (meaningless word order)
	Presence of suicidal or homicidal ideation, plan, access to means

Spiritual Assessment

Later …

Review of patient's Record

- Before meeting a patient or family member: the initial nursing database.
- Also, palliative care patients are not having the energy or patience
- focuses assessments and increase the effectiveness of the time spent with patients and their families.

Review of patient's Record

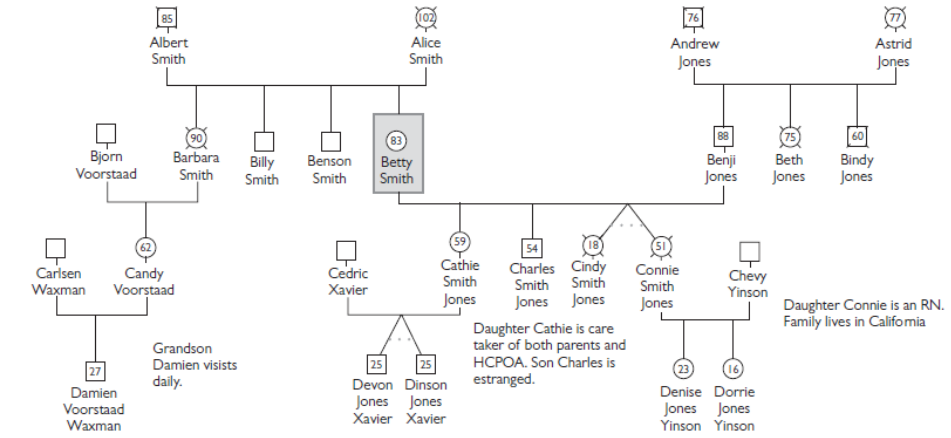


Figure 4.1 An example genogram. Most assessment genograms will be handwritten. Source: Illustration courtesy of John D. Chovan.

Review of patient's Record

- Primary Point of Contact: surrogate / Healthcare Power of Attorney,"
- Religious Affiliation
- Advance Directives
- Recent Health Trajectory – history of present illness = review of systems, and physical examination.
- Medical services such as dietary, respiratory therapy, physical and occupational therapy, and speech therapy.
- *Medications*
- *Complementary Therapies*

The initial face-to-face encounter

- Meets the patient and family and establishes a trust relationship / rapport:
- Caring for the patient
- Use hand sanitizer or wash hands within patient's and family view to demonstrate professionalism and safety.
- Verify that this is the correct patient
- Begin the interview, "Good morning. What is your name?"
- Introduce your-self - name, role.
- Determine how the patient would like to be addressed
- Identify the other persons in the room

The initial face-to-face encounter

- Explain the purpose of the interaction and the time
- Ask the patient's permission
- Give her/him an opportunity to use the restroom, and excusing others to leave the room
- Set near the patient, maintain eye contact.

Completing the nursing database

Complete database using interview, observation, and assessment techniques drawn from all three domains.

- Invite the patient to describe how he or she learned of the illness.
- Do not interrupt the patient too often use communication techniques (probing, reflecting, clarifying, responding empathetically, and ask open-ended questions)
- Proceed through the physical assessment.
- Offer help
- close the initial interview by summarizing

Quality of Life Assessment

- Assessments are examined at four critical stages:
  - At the time of diagnosis
  - During treatments
  - After treatments
  - During active dying

Assessment at The Time of Diagnosis

The goals are as follows:

1. Determine the baseline health of the patient and family.
2. Document problems and plan interventions to improve QoL
3. Identify learning needs to guide teaching that promotes self-care.
4. Recognize patient and family strengths to reinforce healthy habits and behaviors
5. Detect when the expertise of other health care professionals is needed

Assessment During Treatments

- The goals are as follows:

1. Assess the patient's systems in all domains that are at risk for problems
2. Record the current and potential problems and plan early interventions with the patient and family.
3. Ascertain the need for teaching
4. Reinforce patient and family strengths, healthy habits, and behaviors to maximize well-being.
5. Recognize when other health care professionals' expertise is needed and make appropriate referrals

Assessment After Treatments

The goals are as follows:

1. Examine the benefits and burdens of all interventions
2. Determine the current physical problems that are most distressing to the patient and family, and plan rehabilitative interventions.
3. Assess functional status and disease process to determine when a hospice referral is appropriate.
4. Assess learning needs and provide teaching to aggressively manage problems
5. Continue to reinforce patient and family strengths, healthy habits, and behaviors to enhance well-being and to prevent problems.

Assessment During Active Dying

The goals are as follows:

1. Observe for signs and symptoms of impending death, aggressively managing symptoms and promoting comfort
2. Determine the primary source of the patient's and family's suffering and plan interventions to provide relief.
3. Identify the primary sources of strength for the patient and family members so that they can be used to provide support.
4. Ascertain the patient's and family's readiness and need for teaching about the dying process.
5. Look for ways to support the patient and family to enhance meaning during this intense experience.

Cultural Competence

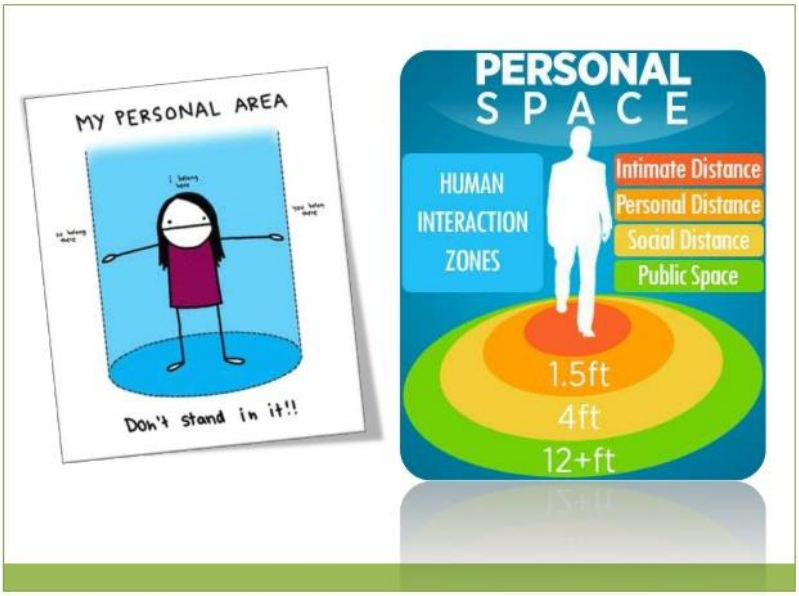
- Cultural competence has been defined as "an educational process, which includes the ability to develop working relationships across lines of difference.
  - **self-awareness**
  - **cultural knowledge about illness and healing practices**
  - **intercultural communication skills**
  - **behavioral flexibility**

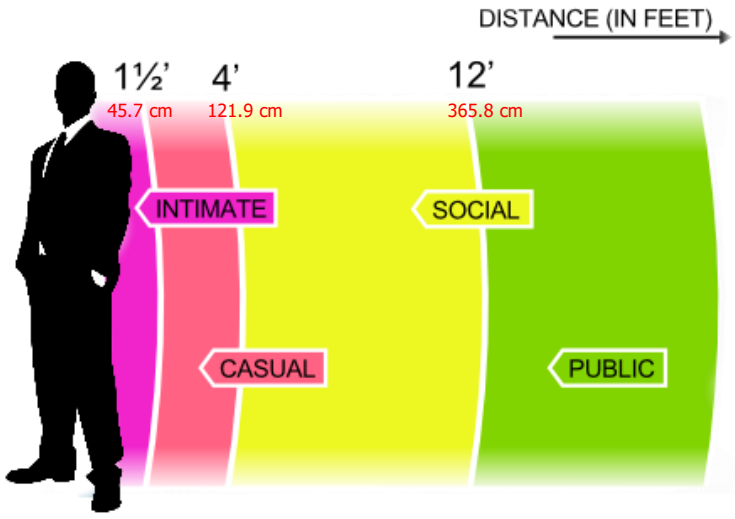
Cultural Competence

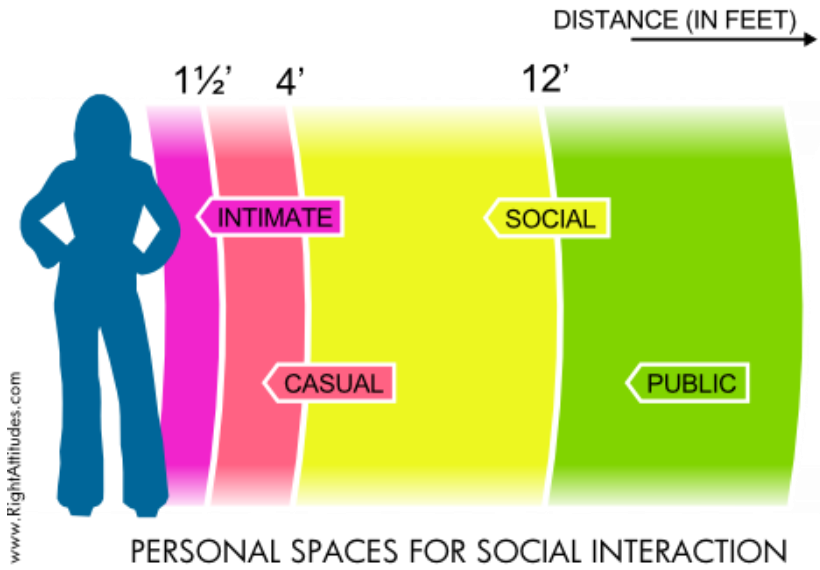
- The health team should concentrate on the following:
  - Being aware of one's own ethnocentrism
  - Assessing patient's and family's beliefs about illness and treatments.
  - Considering patient and family as teachers and guides
  - Asking about the patient's personal preferences
  - Respecting cultural differences regarding personal space and touch
  - Determining needs regarding health related information
  - The use of complementary health care practices and Incorporating them into the plan of care.

Cultural Competence

- Respecting cultural differences regarding personal space and touch


MY PERSONAL AREA
Don't stand in it!!
PERSONAL SPACE
HUMAN INTERACTION ZONES
Intimate Distance
Personal Distance
Social Distance
Public Space
1.5ft
4ft
12+ft


DISTANCE (IN FEET)
1½'
45.7 cm
4'
121.9 cm
12'
365.8 cm
INTIMATE
CASUAL
SOCIAL
PUBLIC



PERSONAL SPACES FOR SOCIAL INTERACTION