

CHAPTER 2: **CARDIOVASCULAR ASSESSMENT**

INTRODUCTION

A well-organized and comprehensive assessment will provide the nurse with valuable information about the patient. Nurses at the bedside are the eyes and ears of the health care team twenty-four hours a day, seven days a week. An astute nurse with good assessment skills can recognize subtle changes in the patient's status, respond quickly to those changes, and notify the appropriate member of the health care team as needed. The assessment also provides the basis for the development of a nursing plan of care aimed at meeting mutually agreed upon goals with the patient.

HEALTH HISTORY

The health history provides information that drives the physical assessment as well as the diagnostic studies and treatment of the patient. The health history should encompass the physiological and the psychosocial aspects of the patient. During the process of collecting the health history, the nurse has the opportunity to develop a relationship with the patient that will lay the groundwork for future patient nurse encounters. In the acutely ill cardiac patient, the interview process may be brief, as acute interventions may be required; however, the health history is an important part of the assessment and should not be eliminated, as it may provide key information that may influence the treatment strategies.

History of Present Illness

- ◆ Chief Complaint/Present Illness
 - ❖ Determine why the patient is seeking help from the medical profession.
 - ❖ Ask the patient to use his or her own words to describe why he or she is seeking assistance.
 - ❖ Presenting Symptoms
 - ☆ Ask the patient to describe the symptoms associated with the illness.
 - ☆ Initiate a discussion of symptoms that should include a systemized approach to evaluating the symptoms. Utilization of the letters NOPQRST helps remind the interviewer of the appropriate questions to ask.
 - ★ N = Normal: What is the patient's baseline? How does he or she normally feel? Is this an exacerbation of an already occurring illness or is it new?
 - ★ O = Onset: When did the discomfort or symptom begin?
 - Sudden or gradual?
 - Time of day?
 - Hour of day?
 - ★ P = Precipitating, provoking or palliative factors?
 - Precipitating (triggers): Stress, food, activity, position changes, movement, or deep breath?
 - Provoking factors: Does anything make it worse, such as movement, deep breaths or palpation?
 - Palliative: Does anything make it better?