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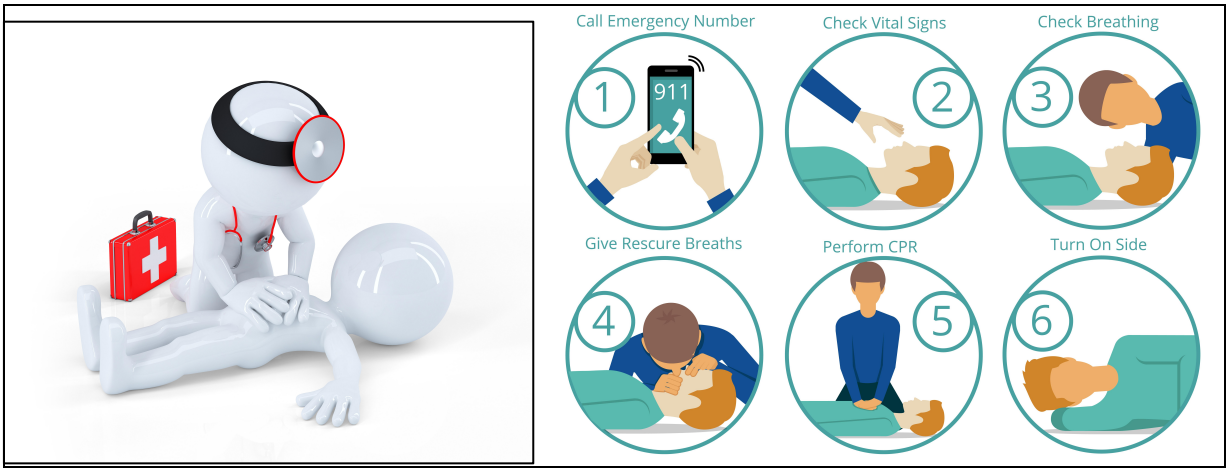
Midnimo Healthy Science Collage

EMERGENCY ACTION PLAN COURSE



ACADEMIC OFFICE OF MIDNIMO COLLEGE

Email: Contact@midnimocollege.so

www.midnimocollege.so

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EMERGENCY ACTION PLAN

Contents Book

What is emergency nursing?

Emergency nursing involves the episodic care of people with physical and / or psychological health problems. These health problems: (1) may result from injury and / or illness, (2) are usually acute, and (3) require further, often immediate, investigation and / or intervention. Emergency nurses care for people of all ages, and work with conditions which may affect any - or, indeed, all - of the body's systems. Often (though not always), patients requiring emergency care are physiologically (or psychologically) unstable, have complex health and other needs, and require intensive nursing care. As with all nursing care, emergency

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nursing care is provided in a way that is *patient centred* - that is, focused on the individual patient and their unique needs, wants and preferences.

PRINCIPLES AND PRACTICE OF FIRST AID

WHAT IS FIRST AID?

FIRST Aid is help given in the case of an accident before or when doctor or an ambulance officer is not available

Medical Aid

Normally follows first aid and is given by a doctor or ambulance officer either at the accident scene in the home or at the hospital.

The Objectives of first aid

The aim of first aid is save lives

. How to Do

1: make sure that the victim has clear airway and is breathing

2: check circulation by feeling for the pulse

3: Stop any bleeding

4: Treat other injuries in order of importance

Prevent further injury

1: Never move a victim there is obvious danger

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2: if moving a victim be gently to avoid further injury

Promote Recovery

A: Treat injuries in the right order

B: Comfort and reassure the victim

C: Give protection from the weather

Send for medical Aid and transport the victim To medical Care

1: As soon as possible ask someone to call an ambulance, doctor, or arrange transport.

2: Always stay with the victim while waiting for help or transport the victim to medical aid.

First Aiders need to observe the following

1: History

2: symptoms

3: signs

Steps in the Emergency Action Plan

1) Get Help/ Call for Help

As soon as you have seen the accident or disaster calls another person to call police or an ambulance.

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Emergency telephone calls

1: Call the correct number.

2: Give you name and number you are calling from

3: Give an adequate description of the address location of the emergency.

4: Do not hang up until the police have asked you all their questions.

Emergency Number

Call from any telephone you may have wherever you are in the country

It is recommended that you check and carry the emergency numbers of the local police with you on your holidays or when you traveling.

2**: Safety at the scene**

1: is the area safe?

2: Quickly check for any danger to you self and the victim.

3: if there is danger, remove it or move the victim to safety. if serious injuries are suspected ,carefully move the victim and void bending the body.

4: you may not see every victim at first, so look around quickly and carefully for others.

Bystanders may be able to tell you what happened, they can also:

A: help protect the scene

B: Call the emergency personnel or arrange the transport needed

C: Look for and provide first aid materials

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3: **RESPONSE**

If the victim is conscious do the following ask the victim?

1: what happened?

2: where it hurt:

3: Can you breath?

4: How many victims are there?

If the victim is unconscious check airway, breathing and circulation.

4: BLEEDING

As part of your initial check, look for and immediately stop any bleeding, as this can be life threatening.

If too much blood is lost from the body through a wound or injury the victim may be dying.

HOW TO STOP THE BLEEDING

Always stop bleeding quickly*:*

1: Stop the flow of blood by placing at the thick dressing firmly on the wound.

2: Try to avoid contact with blood by using gloves or an improvised barrier between your hands and the wound.

3: Keep firm pressure on the wound, with the victim at rest

4: if the wound is on hand or leg the injured is should be elevated.

5: Support Head and Neck

(Ask the victim not to move)

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1: Support the victim's head and neck if the accident involved a large fall or a car accident or speed.

2: keep the as still as possible until transport has arrived.

3: Neck damage is not always seen.

6: Secondary survey

(Check the victim for other injuries)

A head to toe check should be completed carefully to find any other injuries. All bleeding should be managed immediately and other injuries should be noted and managed after the survey is completed.

How to perform a secondary survey

Move the person as little as possible to avoid causing further injuries. Begin your survey at the head and work towards the feet.

If at any time during the survey the victim's breathing becomes difficult or he become unconscious place the victim in the recovery position.

Survey the body for deformity, swelling, pain, bleeding, skin color and temperature

HEAD: Gently run your hands over the scalp looking for abnormality;

EYES: Examine both together comparing the pupils and note whether they are same size. Look for blood in the white part of the eye.

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NOSE: check for signs of blood and clear fluids as this may come from inside the head.

FACE: look at color, dryness, and temperature.

EARS: check for blood and clear fluids as this may indicate a serious head injury.

NECK AND SPINE: loosen tight clothing around the neck feel gently for any deformity that may indicate a fracture.

LOWER BACK: pass your hands gently under the hollow of the back and without moving the victim or removing the clothing, feel along the lower back for blood and any abnormalities.

TRUNK: check the chest for any sucking, wound, feel the ribs for depression that may indicate a fracture

HANDS: examine the arms for swelling or deformity that may indicate a fracture, or bleeding.

LEGS: check the pelvis, femora, patella and feet looking for abnormalities.

REMEMBER: use two hands so you can compare both sides of the body at the same times.

7: HISTORY

Ask the victim to explain exactly what happened

1: **Allergic**: Don you have any allergic?

2: **medications**: Are you taking any medicines?

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3: **past medical history**: Do you have any conditions we should know about?

4: **Last meal**: when was your last meal?

5**: Event leading to accident**: what where you doing before the accident and how did you come to be in the accident?

Document all the information you can for the medical staff and when you arrive at the hospital.

8: **Transportation**

Remember, transport the victim with great care keeping the body as still as possible.

1: the victim needs to be seen by a doctor or medical facility quickly.

2: Ideally the victim should be transported by ambulance. However another car may be used if the ambulance is not available.

3: Drive carefully do not cause another accident

4: Use moving technique that will not cause further injury.

Management of the unconscious person

Unconscious

The brain is the nerve centre of the body. Nerve fibers link the brain with all parts of the body.

During sleep, the brain stays active in order that vital functions, such as breathing, heart beating and circulation. However, in case such as head

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injury, electric shock or poisoning when the brain is unable to work properly, the victim will become unconscious.

A person is *unconscious if there is not response to the spoken word or to command.*

Check Airway

Open the airway and clear the mouth of any solid material such as sand, vomit, blood, and broken teeth if resuscitation is needed.

Check Breathing

1: Can you **see**? Or **feel** movement of the lower chest and abdomen.

2: Can you **hear**? Or **feel** the air the victim's mouth.

3: Check for ten seconds.

4: If there are no signs of breathing **Start Expired Air Resuscitation (E.A.R)**

5: If the victim is breathing, roll on his side, then look for and treat any injury.

All unconscious people must be placed in the side recovery position to keep their airway clear. Support the head and neck at all times.

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Check circulation

If the victim is breathing and there is a pulse.

Briefly check for any other injuries.

Loosen ant tight clothing at the neck and check for identification.

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Do not allow any food or drink to be given to an unconscious person.

Stay with an unconscious person until skilled help arrives or transport has been arranged.

While waiting, note any changes in conditions such as a breathing difficulties, poor color, restlessness etc. when help arrives or you arrive at the hospital report any changes that you have seen.

Steps in the Recover position

The recovery position is the safest position for the people that are unconscious.

Unconscious causalities who are breathing and whose hearts are beating should be placed in this position. This side position helps to assist the maintenance of an open airway; the tongue cannot fall to the back of the throat. This allows vomit and other fluids to drain freely from the victim's mouth.

Step one: check response. If no response, open airway

Step two: Tilt head to open airway

Step three: place the arm closest to you a cross the chest

Step four: lay the other arm away from the body

Step five: cross the legs.

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Step six: support head and neck and gently roll the victim on his side holding his cloths.

Step seven: Once on the side gently tilt head back and open airway.

Step eight: Take the patella to help and support the victim's position.

Monitor the victim's breathing and circulation and check for other injuries.

Stay with the victim until transfer to medical aid.

Resuscitation

Expired Air Resuscitation (E.A.R)

The process of breathing in which oxygen is supplied to the body and carbon removed is called **Resuscitation.** Ever cell of the body needs a constant supply of oxygen. If the vital centers of the brain and heart are kept short of oxygen for more than a few minutes, serious damage may occur. The victim will become unconscious and breathing will stop. Next the heart stops beating and death occurs. It vital that resuscitation be started immediately.

Remember, after you have checked the following:

Safety, is the area safe?

Response, is there no response?

Airway, is clear airway?

Breathing, check for 10 seconds look, listen and feel

If there is no breathing start (EAR)

If there is no pulse start external cardio compression (ECC)

If there are not both start cardio pulmonary resuscitation (CPR)

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Obtaining a Health History

Introduction

The collection of a health history from a patient - that is, subjective data which focuses on the patient's symptoms - is the first step in health observation and assessment, and is a fundamental skill for nurses working in all clinical areas. This chapter introduces the knowledge and skills required by nurses to collect a comprehensive health history from a patient. It begins with an explanation of the place of health history in the health observation and assessment process, a description of the different types of health histories and their uses, and a detailed overview of the components of a comprehensive health history. This chapter goes on to explain the importance of therapeutic communication and rapport in the health history interview, and the use of questioning, interpersonal skills and other communication techniques to facilitate data collection. Finally, this chapter considers a variety of barriers and challenges to effective communication in the health history interview, and how nurses can respond effectively to these.

Learning objectives for this chapter

By the end of this chapter, we would like you:

- To explain the place of the health history in the health observation and assessment process.
- To discuss the different types of health histories, and their uses in different clinical contexts.
- To list the components of a comprehensive health history.

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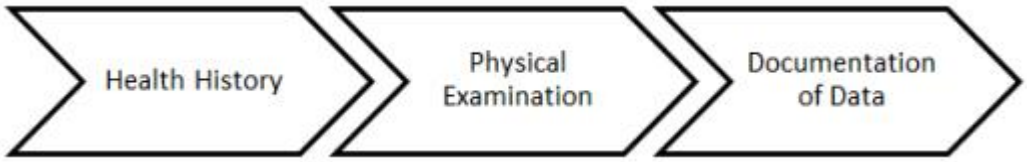
- To explain the use of therapeutic communication and rapport in the health history interview.
- To describe the importance of effective questioning, and the use of a variety of interpersonal skills and communication techniques, in the health history interview.
- To describe the various barriers and challenges to effective communication in the health history interview, and effective responses to these to facilitate data collection.

The health history

As you saw in the previous chapter of this module, health observation and assessment involves three concurrent steps:



The first of these steps, and the focus of this chapter, is the health history. This involves collecting *subjective* data - that is, data about a patient's *symptoms* (i.e. what the patient experiences). A variety of other important information is also collected during the interview - including, for example, information about a person's health-related values, beliefs and attitudes, their current health-related practices, the socioeconomic, cultural and other factors impacting on their health, and their willingness and capacity to make health-related changes, etc. Data is collected via an *interview* with the patient and / or significant others. Data

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collected at this stage may be *primary* (i.e. obtained from the patient themselves) or *secondary* (i.e. obtained from another person, such as the patient's family member or carer, etc.). In acute situations, the patient's health history may be communicated by another health care provider - for example, an emergency paramedic.

Health history is obtained through an interview between a nurse, the patient and significant others (where appropriate). The nurse's role in the interview process is to: (1) facilitate discussion to collect health-related data, and (2) record this data. Data collected during a health history interview informs both the subsequent physical examination of the patient, and also the health care which is provided to that patient.

In many clinical settings, patients are asked to complete a questionnaire as part of the process of collecting their health history. Health history questionnaires typically consist of a series of simple yes / no questions, often related to the specific symptoms and risk factors associated with common disease (e.g. cardiovascular disease, respiratory disease, diabetes, etc.). It is important for nurses to realise that health history questionnaires do *not* replace or preclude the need for the health history interview. Although these questionnaires can be useful tools for collecting data related to a person's health history, and can prompt a patient to think deeply about their past medical problems and symptoms, they only collect superficial information which should then be further investigated by a nurse in a conversation with a patient.

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Types of health histories

It is important for nurses to note that there are a number of different types of health histories which may be collected from a patient:

- A comprehensive health history. This collects detailed information about a patient - including their biographical data, present health status, past medical history, family history, personal situation and a review of all body systems. It is usually completed on admission to a health care facility and during a general health check-up.

- A rapid or focused health history. This collects specific information about a clear health-related issue or need with which a patient presents. The information gathered is used to inform the immediate care of the patient.

The type of health history collected from a patient depends on: (1) the context in which the patient has presented, and (2) the patient's health care issues and needs. This module will focus on teaching the knowledge and skills required to collect a comprehensive health history from a patient, as it is this knowledge and these skills which also underpin the collection of a rapid or focused health assessment.

Components of a health history

A health history interview typically consists of three distinct sections: (1) introduction, (2) discussion, and (3) summary. Each of these sections is described following:

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ntroduction Section	Discussion Section	Summary Section
• Nurse introduces self and role to patient. • Nurse explains the purpose of the interview. • Nurse explains the process of the interview (e.g. what the patient should expect).	• Nurse facilitates discussion to collect health-related data. • Discussion is patient-centred - that is, focused on the person and their issues / needs. • Nurse uses various communication, inter-personal techniques.	• Nurse summarises the key data collected. • Nurse allows the patient to clarify data, where required. • Nurse explains how this data will be used to inform the health care provided.

All health history interviews begin with the nurse introducing themselves to the patient (and others present in the interview, if relevant), and explaining their role in the provision of the patient's health care. Adult patients should be addressed by their title and surname, until they inform the nurse of their preferred name and provide the nurse with permission to use it. It is usually acceptable, and preferable, to address adolescents and children by their first name. Nurses explain why the interview is being conducted, and also the processes involved. The aim of this explanation is to prepare the patient and to enhance their comfort in sharing health-related information.

The next section of the interview, the discussion section, is where the nurse focuses on facilitating discussion with the patient to collect health-related data. The nurse uses a range of questioning and other communication techniques -

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discussed in detail in the following section of this chapter - to collect the information required to inform the physical examination and the subsequent provision of the patient's health care. This discussion is patient-centred - that is, it focuses on the person and their unique issues and needs. Patients are encouraged to share their perceptions and experiences in their own words, without interruption, judgement or interpretation from others (including the nurse).

The nurse focuses on collecting the following information:

Component	Examples of Data Included
Biographical information	• Name, gender, date of birth. • Address, contact telephone number. • Details of contact person / next of kin. • Other appropriate information to inform care - for example, the patient's religion, e occupation, marital status, etc.
Reason for seeking health care	• The patient's chief complaint or presenting problem. • This should be recorded in the patient's own words. • If the patient has more than one complaint / problem, record all of them. • If a patient's problem is urgent (e.g. pain, dyspnoea, injury, etc.), the interview shou and care provided.
History of presenting illness	This is best achieved by assessing the patient's symptoms; this can be done using a strateg the mnemonic 'OLD CARTS':

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O = onset	• When did the symptoms begin? • Did they develop suddenly or over time? • Where was the patient / what were they doing when th started?
L = location	• Are the symptoms located in a specific area? • Is this area specific or generalised? • Does the symptom radiate to another location?
D = duration	• How long do the symptoms last? • Are they changing over time? • Are they constant? If so, does their severity fluctuate? • Are they intermittent? If so, how often do they occur, a in between episodes?
C = characteristics	• Describe what the symptom feels like (i.e. the sensatio aching, throbbing, itching, tingling, etc.). • Describe what the symptom looks like (i.e. colour, textu etc.)
A = aggravating / alleviating factors	• What makes the symptoms worse? • What makes the symptoms better? (E.g. physical factors [activity, position, etc.], psychological fa environmental factors, etc.).

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	R = related symptoms	• Do other symptoms occur at the same time (e.g. pain, r
	T = treatment	• What treatments have you tried? • How effective have these treatments been?
	S = severity	• Describe the size, extent or amount. • Rate the symptom on a scale of 0 to 10. • Does the symptom interrupt the person's activities of d
Present health status		• The patient's pre-existing health conditions. • The patient's current medications (prescription, over-the-counter • The patient's allergies. • The patients' current health-related practices.
Past health history		• Significant childhood illnesses. • Previous hospitalisations for surgery, accidents, illnesses, etc. • Immunisation status. • Most recent physical examinations, and findings. • Obstetric history, if relevant (*gravidity*, *parity*, etc.).
Family history		• Diseases affecting biological relatives - parents, grandparents, aunts / uncles, sibl • Genetic conditions known to be present in the family.
Personal and psychosocial		• Personal status (e.g. education, occupation, etc.). • The patient's important family / social relationships.

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history	• The patient's diet / nutrition and exercise status. • The patient's functional ability and mental health. • The environment in which the patient lives / works / learns. • The patient's health-related values, beliefs and attitudes. • The socioeconomic, cultural and other factors impacting on healt • The patient's willingness / capacity to make health-related change
A review of the patient's body systems	The patient should be questioned about abnormalities or concerns in each of their body sy integumentary system, the cardiovascular system, the immune / lymphatic system, the en nervous system, the reproductive system, the respiratory system, the musculoskeletal syst system and the urinary system. The patient should also be asked about any general or syst they experience (e.g. fatigue, etc.).

It is important to highlight that many health care organisations have standardised templates which nurses can use to guide their collection of this data during a health history interview. Nurses must ensure they are familiar with the location of these templates, how to access them, and how they are expected to apply them in practice. Practicing using these templates (e.g. on family, friends, colleagues, supervisors, etc.) can be useful in helping a nurse to gain confidence and competence.

The final section of the interview is the summary section. Nurses should summarise the key data collected during the interview - that is, the main points that the patient has communicated. The patient should be encouraged to clarify any errors or inaccuracies in the information the nurse has collected; often, errors occur when a nurse incorrectly interprets the information provided by a patient

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(note that barriers to communication when collecting a health history will be described in detail in a later section of this unit). The nurse should also explain to the patient how the information gathered during the health history interview will be used to inform the healthcare provided to them. Although it is brief, the summary section of the health history is important because it provides a patient with a sense of validation that the nurse understands, and will respond appropriately to, their health issues and needs.

Therapeutic communication and rapport

The nurse's effective use of communication techniques, underpinned by *therapeutic communication* practices, is the single most important factor in the success of a health history interview. Therapeutic communication focuses on developing *rapport* with a patient - that is, a trusting relationship with a patient which facilitates their comfort in sharing personal information. There are a number of important factors which impact on the development of rapport in the health care setting:

- The physical setting in which a health history interview is conducted. This can have a significant impact on the quality of the exchange of information between a patient and a nurse. Ideally, a health history interview should be conducted in an area which is private, quiet, free from distractions and comfortable.

Privacy is crucial in facilitating a patient's ease in discussing personal information. Patients may be unwilling to share sensitive information in an open and honest

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way if they are fearful of being overheard by others (including their family / friends, members of the public and / or health care providers). Ideally, health history interviews are conducted in private examination rooms; however, depending on the clinical context in which a nurse works, this may not always be possible, and a nurse may have to instead draw curtains around a cubicle or pull chairs to a quieter part of a larger treatment room, etc. The nurse should carefully consider whether the presence of the patient's family or significant others is appropriate during the interview. If the nurse judges that the presence of these people may impede the patient sharing sensitive information, these people should be invited to wait in a visitors' room or other location whilst the interview and physical examination are being conducted.

The location in which an interview is conducted should be quiet and free from distractions. Interruptions should be avoided to the greatest possible extent - for example, a nurse should avoid an area which must be frequently accessed by other staff or an area which is adjacent to a thoroughfare. Any unnecessary equipment in the interview space - including telephones and pagers, etc. - should be turned off, and removed if possible. Nurses may consider placing an 'Interview / Examination in Progress' sign on the door or curtain to discourage interruptions.

To facilitate a patient's ease in discussing personal information, they must also be physically comfortable throughout the interview. Wherever possible, the nurse should allow patients to remain in their own clothes for the interview (and change into a hospital gown immediately prior to the physical examination). The nurse should sit at a distance and angle from the patient which respects their personal

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space, whilst still promoting the flow of conversation. When planning for the patient's comfort, the nurse should also consider the seating provided, the temperature and lighting of the room, and the patient's access to water and toilets (if required).

- The professional behaviour of the nurse conducting the interview. Again, this can have a significant impact on the quality of the exchange of information between a patient and a nurse. The nurse's demeanour should be professional yet warm, and they should practice a variety of interpersonal skills to develop rapport (discussed in detail in a later section of this chapter). The nurse should focus on the patient, and on understanding the patient's experiences and perspectives, without interruption, judgement or interpretation. The nurse must demonstrate a genuine interest in the patient, treat the patient with acceptance and respect, and focus on the patient's individual health-related issues and needs.

- The individual variables of the patient participating in the interview. This is another factor which can have a significant impact on the quality of the exchange of information between a patient and a nurse. Patients who are very physically or psychologically unwell, who are experiencing extremes of emotion (e.g. sadness, anger, anxiety, etc.), or who are otherwise uncomfortable (e.g. cold, thirsty, hungry, in pain, etc.) may not be able to participate effectively in a health history interview. In these situations, nurses should focus on collecting only the data required to provide

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immediate care, and return to complete a more comprehensive health history interview when the patient is more prepared to participate. Again, barriers to communication when collecting a health history interview will be described in detail in a later section of this unit.

Questioning, interpersonal skills and other communication techniques

Questioning is a key communication skill used by nurses during the health history interview. Questioning occurs in two equally-important parts: (1) asking the patient for information, and (2) listening carefully to the patient's response. There are two key types of questions a nurse may ask during a health history interview:

- Open-ended questions. These are broadly-stated questions which encourage a detailed multi-word response. Consider the following example:

Example

Nurse:	"How have you been feeling these past few weeks?"
Patient:	"Well, I'm quite fatigued. I've been having a lot of trouble sleeping. I wake up in the mo still feel tired."
Nurse:	"Okay. Can you tell me more about what this fatigue is like?"
Patient:	"Well, it's worse in the mornings. I feel exhausted from the moment I wake up. My hea muscles ache…"

Open-ended questions are useful when a nurse wishes to collect general data about a patient's symptoms, their health-related values, beliefs and attitudes, their current health-related practices, the socioeconomic, cultural and other factors impacting on their health, and their willingness and capacity to make

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health-related changes. However, a nurse should be careful to ask open-ended questions in a way which facilitates the collection of the data required. For example, a question such as: "Tell me a little about yourself" is too broad for a health history interview; it will likely result in the patient providing the nurse with information which is irrelevant to their health care.

- Closed-ended questions. These are specific questions which encourage a one- or two-word answer. Consider the following example:

Example

Nurse:	"Do you ever experience pain?"
Patient:	"Yes, sometimes."
Nurse:	"Would you describe it as sharp, dull or aching pain?"
Patient:	"Mostly aching."

Closed-ended questions are useful in collecting information about a specific topic, to clarify information gathered during open-ended questioning and in urgent situations where information is required rapidly. However, a nurse should be careful to avoid drawing inaccurate conclusions from the short answers a patient provides to closed-ended questions.

In addition to questioning, there are a variety of other communication strategies a nurse should use when collecting data from a patient during a health history interview. These skills include:

- Acknowledgement and encouragement. A nurse may acknowledge what a patient has said by using intonations that demonstrate interest and

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understanding (e.g. "Okay", "Mmm", etc.). A nurse may encourage a patient to continue discussing a topic by using phrases such as: "Could you tell me more about that?", "Please go on", etc.

- Active listening. This involves listening fully to the patient with the aim of identifying, understanding and acknowledging the (often subtle) message/s they are communicating.

- Clarifying. This involves using a question to prompt a patient to further explain something they have mentioned. It is typically used when the information a patient provides is unclear or ambiguous.

- Empathy. This involves attempting to understand how the patient may be feeling, and to convey this understanding to the patient. It is important to remember that a nurse can never completely understand how another person is feeling, even if they have experienced a similar situation themselves or have cared for other patients in similar situations. Nurses can, however, communicate what they understand about the patient's experience - for example: "I can see this is very difficult for you".

- Restatement. This involves repeating what a patient has said, using different words. Often, restatement is used to confirm or clarify the information provided by a patient. It is used to validate that the patient has been heard and understood.

- Summarising. This involves stopping a conversation with a patient to review the key points covered. It is particularly useful when patients provide a

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'rambling' response to a question, or do not provide information in a sequential order. Summarising is also useful in ensuring the nurse understands the information the patient has provided, and in confirming to the patient that they have been heard and understood.

When communicating with patients, including when conducting health history interviews, it is important for nurses to realise that people are not always direct in saying what they mean. Nurses must be conscious of picking up on 'cues', or subtle hints which suggest the patient may have an underlying concern they are finding difficult to discuss. There are a number of cues seen commonly in health care settings:

- A patient may use indeterminate statements (e.g. "I manage", etc.).
- A patient may use neutral statements (e.g. "I had surgery", etc.).
- A patient describes psychological symptoms, such as 'worry' or 'stress'.
- A patient is unclear or evasive about the symptoms or concerns they experience.
- A patient may be vague or indirect when answering a nurse's questions.

If a nurse identifies one of these cues, they should question the patient in a respectful and sensitive manner to further explore the topic - if it is appropriate and relevant to do so.

There are also a number of general strategies nurses should use when questioning patients during a health history interview:

- Questions must be clearly spoken, so that they are understood by patients.

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- Avoid medical language / jargon, and define words the patient does not understand.
- Use terms and phrases familiar to the patient, wherever possible.
- Adapt questions to the patient's own level of knowledge and understanding.
- Encourage patients to be specific / detailed in their responses to questions.
- Ask one question at a time, and wait for a reply before moving to the next question.
- Be attentive to the patient's reactions / feelings in relation to the questions asked.
- Explain the need for asking about sensitive topics (e.g. sexuality, violence, drugs, etc.).

Barriers to effective communication

It is important for nurses to recognise that there are a variety of barriers that diminish the quality of the data collected during a health history interview - for example, by interrupting the flow of the interview or impairing the rapport between the nurse and the patient, etc. The key barriers - which nurses conducting health history interviews must take care to avoid - are described in the following section:

- Use of medical terminology / jargon. This can be confusing to a patient; however, many patients feel too embarrassed to ask for clarification. This can lead to the collection of inaccurate data.

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- Expressing value judgements. If a patient feels judged by a nurse during the interview, they are likely to respond in an angry, guilty or defensive way. In doing so, they may provide the nurse with incorrect information.

- Interrupting the patient. Although they are often pressured for time, nurses should avoid finishing the patient's sentences, completing the patient's thoughts and changing the topic before a patient has finished giving information, etc. This may result in the information being provided by the patient being interpreted inaccurately.

- Being authoritarian or paternalistic - that is, where a nurse takes the approach of 'knowing what is best' for the patient. Nurses in all health care settings must remember that a person's health is their own responsibility. Acting in an authoritarian or paternalistic way risks disengaging the patient, which will result in the collection of poorer-quality data.

- Using 'why' questions. Many patients feel threatened when asked these types of questions, and they are likely to respond in an angry, guilty or defensive way. In doing so, they may provide the nurse with incorrect information.

It is important to note that there are a variety of other challenges a nurse may encounter when completing a health history interview. These challenges, and how a nurse may effectively manage them, are described following:

- The patient asks the nurse a personal question. In some situations, it may be appropriate for a nurse to briefly share a personal experience; indeed,

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this may help to build rapport with the patient. However, the focus of the interview should be rapidly directed back to the patient.

- The patient is silent in response to a question. This can be awkward for nurses. However, allowing the patient to be silent for a short period can be useful, as it allows them time to gather their thoughts and plan a response.

- The patient displays emotion - for example, anger or sadness. The nurse should acknowledge the patient's emotion, and allow the patient to experience it. It is often appropriate to discontinue the interview to allow the patient to recover, before recommencing and exploring the reason for the emotion (if appropriate).

- The patient is overly-talkative. This is problematic because it can result in the collection of large amounts of irrelevant data, whilst important data may be overlooked. Nurses should tactfully redirect the conversation, and use closed-ended questions to focus the conversation.

- The patient speaks a language other than English. In this situation, nurses have a responsibility to access the services of a qualified health interpreter. Nurses should familiarise themselves with their organisation's policies and procedures for doing so. Remember: using a patient's family / friends to interpret may violate the patient's right to privacy and confidentiality, and should be avoided.

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Conclusion

As you have seen in this chapter, the collection of a health history from a patient - that is, subjective data, which focuses on the patient's symptoms - is the first step in health observation and assessment, and a fundamental skill for nurses working in all clinical areas. This chapter has introduced the knowledge and skills required by nurses to collect a comprehensive health history from a patient. It began with an explanation of the place of health history in the health observation and assessment process, a description of the different types of health histories and their uses, and a detailed overview of the components of a comprehensive health history. This chapter went on to explain the importance of therapeutic communication and rapport in the health history interview, and the use of questioning, interpersonal skills and other communication techniques to facilitate data collection. Finally, this chapter considered the variety of barriers and challenges to effective communication in the health history interview, and how nurses can respond effectively to these. In completing this chapter, you have equipped yourself with the knowledge and skills necessary to collect a comprehensive health history from a patient.

Reference

1. SRCS/ICRC Somalia mission.

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