Bates' Nursing Guide to Physical Examination and History Taking

3RD EDITION

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My heartfelt appreciation and unwavering love for my family:
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throughout my nursing career.
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PREFACE

Bates' Nursing Guide to Physical Examination and History Taking is relevant to the diverse health care arena. Nurses are at the front lines, coordinating and providing holistic care for patients in a multitude of health care delivery systems. The ever-changing world paired with complex patient needs present nursing the opportunity to lead the coordination and provision of holistic care for patients in many venues. Assessment is a key nursing responsibility that ensures the patient receives optimal care. The text provides assessment tools to assist the student with obtaining a thorough history and performing a comprehensive physical examination of each patient. The student will learn how to utilize communication techniques, ask the pertinent subjective questions, and recognize verbal and nonverbal cues while eliciting information related to patient concerns in each body system. The student will utilize subjective findings and critical thinking skills to prioritize and guide the physical examination. The history taking paired with objective findings obtained during the assessment will provide the basis for the analysis and development of the plan of care. Salient points related to health promotion and disease prevention are highlighted for nurses for educating patients, families, and communities.

Bates' Nursing Guide builds on student's knowledge of human anatomy and physiology relevant to the acquisition of patient assessment skills. Throughout the book, the focus and emphasis are the "healthy" patient with common findings or diseases rather than the rare or obscure disorder. Occasionally, physical signs of rare disorders are included if they hold a solid niche in classic physical examination or represent a disorder that is critical to the life of the patient. Each chapter reflects current information, listing key citations that closely align content with new evidence from the health care literature. Coordinating colors help readers find chapter sections and tables more easily and highlight insets of key material and special tips for challenging aspects of examination such as the cranial nerves or assessing lung fields.

BATES' NURSING GUIDE: HIGHLIGHTS

The book is divided into three units: *Foundations, Body Systems*, and *Special Lifespan Considerations.*

Unit 1, Foundations

- *Chapter 1, Introduction to Health Assessment and Social Determinants of Health,* presents the role of the nurse in assessment, including the concept of health and what defines a "healthy" individual. The indicators and

purpose of Healthy People 2030 are identified, as are the components of a health assessment in relation to where a person lives and how this intertwines with health risks and outcomes.

- *Chapter 2, Critical Thinking and Clinical Judgment in Health Assessment* focuses on how to think "like a nurse," utilizing a case study approach to implement the nursing process.

- *Chapter 3, Interviewing and Communication,* leads the nursing student through therapeutic communication techniques, shares mnemonics for assessment questions, and identifies strategies for handling difficult patients.

- *Chapter 4, The Health History,* describes the different types of health histories, the purpose for each, and the components of a comprehensive health history.

- *Chapter 5, Cultural and Spiritual Assessment,* explains why culture and spirituality are important in the health assessment and case studies demonstrate cultural humility.

- *Chapter 6, Physical Examination: Getting Started,* introduces a logical sequence of the physical examination with an explanation of the techniques and visualization of the equipment.

- *Chapter 7, General Survey Including Vital Signs and Pain,* and *Chapter 8, Nutrition and Hydration* continue the process of data collection and expand the process of clinical reasoning for nurses.

Unit 2, Body Systems

Chapters 9 through 21 are devoted to the techniques of the regional examination of each of the body systems. These chapters are arranged in a "head-to-toe" sequence, just as the patient examination should flow. Each chapter contains:

- A review of relevant anatomy and physiology

- Key questions for a relevant nursing health history

- Updated information for health promotion and counseling

- Well-described and well-illustrated techniques of examination

- Extensive citations from the clinical literature

- Tables to assist nursing students in recognizing and comparing normal and abnormal findings

The unit concludes with *Chapter 22, Putting the Physical Examination All Together,* which assists the student nurse in performing a "head-to-toe" examination following a systems integration sequence. Students frequently need this step-by-step guidance as they learn new skills and process how the objective data are collected in a systematic manner.

Unit 3, Special Lifespan

Chapter 23, Assessing Children: Infancy through Adolescence, and *Chapter 24, Assessing Older Adults* relate to special ages in the life cycle and how the assessment techniques and physical examination findings may differ.

This textbook is written for the undergraduate nursing student and geared to the generalist nurse. The focus of the book is **nursing** physical examination and history taking. The health history and the physical examination are both essential for patient assessment and care.

Students are advised to return to chapters, especially in the *Foundations* unit, as they gain additional experience with patients. Each patient brings a unique background and set of abilities, ideas, issues, coping mechanisms, and family and community dynamics to the health care setting. These attributes mixed with a disease process can be confounding to even the seasoned nurse.

Students may study or review the "Anatomy and Physiology" sections according to their individual needs. They can study the "Physical Examination" sections to learn how to perform the relevant examination, practice it under faculty guidance, and review the section again afterward to consolidate their learning.

Students and faculty will benefit from identifying common abnormal findings, which appear in two places. The red marginal text of the "Physical Examination" sections presents possible abnormal findings. Tables in each chapter will deepen students' understanding of important clinical conditions, what they should be looking for, and why they are asking certain questions. However, students should not try to memorize all the detail that is presented. As students work to master the skills of assessment, they should return to the related signs and remember ideal findings.

As students progress through each body system, they should study the documentation for the sample patient, Mrs. N, found in Chapter 2, *Critical Thinking and Clinical Judgment in Health Assessment.* Students should make frequent references to the sections in each of the body systems chapters titled "Recording Your Findings" that display samples of a patient record. This cross-checking will help students learn how to describe and organize information from the interview and physical examination into an understandable documentation format. Furthermore, studying Chapter 22, *Putting the Physical Examination All Together,* will help students integrate the body systems examinations into a coordinated head-to-toe physical examination.

STUDENT AND INSTRUCTOR RESOURCES

Student Resources

Student resources to accompany this text are available online at thePoint®.

Resources include journal articles, NCLEX-style review questions, a Spanish-English audio glossary, Watch and Learn video clips, and Concepts in Action animations.

Instructor Resources

Instructor resources are also available on thePoint® and include the following:

- Test Generator containing over 400 multiple choice questions
- PowerPoint presentations
- Image Bank featuring all of the figures from each chapter
- Guided Lecture Notes for presenting key information to your students
- Assignments and Prelecture Quizzes for gauging student understanding
- Discussion Topics to encourage critical thinking
- Case Studies providing real-life application of concepts

A FULLY INTEGRATED COURSE EXPERIENCE

We offer an expanded suite of digital solutions to support instructors and students using *Bates' Nursing Guide to Physical Examination and History Taking,* 3rd edition, that elevate the learning experience. To learn more about any of these solutions, please contact your local Wolters Kluwer representative.

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- Unmatched support includes training coaches, product trainers, and nursing education consultants to help educators and students implement CoursePoint with ease.

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To our students, past and present, who inspire us to write and educate the nurses of the future.

CONTENTS

UNIT 1

Foundations

1 INTRODUCTION TO HEALTH ASSESSMENT AND SOCIAL DETERMINANTS OF HEALTH

KEY TERMS

health	nursing health assessment	social determinants of health (SDOH)

Learning Objectives

The student will:

1. Define and identify social determinants of health.
2. Define health and health assessment.
3. Explain the components of the health assessment.
4. Identify the health indicators and purpose of *Healthy People 2030*.
5. Define the nurse's role in assessment.

Health assessment is an integral part of nursing practice. There are over 3.8 million registered nurses nationwide working in a variety of capacities (Smiley et al., 2018). Nurses are visible in both inpatient and outpatient facilities, homes, work sites, and in various community settings. Every nurse, no matter where the practice is situated, is assessing health (American Association of Colleges of Nursing, 2008).

Social determinants of health (SDOH) are proven to affect a person's health and are the effects of where people work, live, play, and learn (Centers for Disease Control and Prevention, 2020). SDOH are associated with health risks and outcomes. If a person lives at the poverty level, it limits accessibility to safe neighborhoods, nutritious foods, and education, all

factors in better health outcomes (Hahn et al., 2018). Addressing SDOH positively impacts the health of people and their communities and takes a step forward in achieving health equity.

In nursing, regardless of which career path you take, assessment techniques are essential. Astute attention to details, use of appropriate questions, and a keen awareness of what a person says and does shape the plan of care to optimize each individual's health status throughout the lifespan.

HEALTH

There are eight dimensions to health. **Health** is a relative state in which a person strives to meet their potential and includes the areas of wellness with the ultimate goal of improving health. The eight dimensions are: physical, emotional, social, spiritual, environmental, intellectual, financial, and occupational (U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration [SAMHSA], 2016). Health is the sum of these and is not solely defined as the absence of disease or eating right, but rather by the contributions of all dimensions. The health care team must take into account all of these domains (Fig. 1-1).

FIGURE 1-1 Collaboration to determine the best assessment strategies (wavebreakmedia/Shutterstock).

Health is influenced by all eight dimensions (Fig. 1-2, Box 1-1). A person's ability to adapt while not compromising the different components is important for health maintenance. Health is not a constant and cannot be taken for granted. The ability to juggle and align the eight dimensions in a harmonious network leads to a healthy state for an individual.

In all aspects, it is best to work with the patient to enable partnering in choices. This allows the patient to make decisions regarding health care. The more a patient participates in these decisions, the better the outcomes are for a long-term healthier lifestyle. Reminding ourselves of the social determinants of health and how they may affect each person individually is important in determining the plan of care.

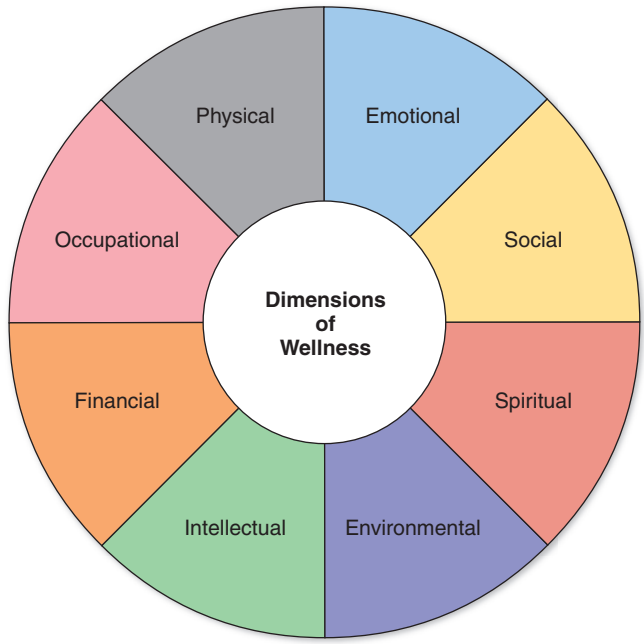

FIGURE 1-2 Eight dimensions of wellness.

BOX 1-1 EIGHT DIMENSIONS OF HEALTH AND WELLNESS

Physical wellness takes into consideration multiple areas including activity level and exercise, proper nutrition, and sleep. It also looks at promoting healthy coping behaviors and identifying nonhealthy behaviors such as smoking, excess caffeine intake, or substance abuse.

Emotional health is the ability to handle life and its challenges that may arise. The ability to be resilient and use coping mechanisms effectively, including strong relationships with others, are recognized.

Social wellness is a sense of inclusiveness and connection. If a patient feels isolated, figuring out family dynamics and a potential support system are important. Providing information about self-help groups, health resources, and local organizations can promote additional avenues for socialization.

Spiritual health involves a person's sense of values and beliefs. A patient may wish to speak with a spiritual advisor or may utilize meditation or some other form of self-care. Often, it is best to broach this topic and let the patient take the lead on how to handle spiritual care, as this dimension is individual.

Environmental wellness encompasses the patient's surroundings, which may be in the home or outside and can affect health. Neighborhood safety related to violence or inside the home related to physical or sexual abuse are examples of factors to assess. Overall disorganization may negatively influence how one feels and affect health.

Intellectual wellness is the ability to advance knowledge and is different for each person. A patient may need guidance in areas to enhance this component and suggestions might be to read, engage in a new hobby, tutor others, or learn a new language.

Financial aspects of health are often stressful. Finances for the basics such as shelter, food, and health care may be lacking. Insurance may not cover all facets of care or specific providers. Illness often leads to decreased income with increased costs for care and medication.

Occupational wellness involves the work milieu, including the type of job, relationships with coworkers, and management of stress levels. This is important in conjunction with a healthy work–life balance.

HEALTH ASSESSMENT

The **nursing health assessment** entails both a comprehensive health history and a complete physical examination, which are used to evaluate the health status of a person. The ability to solicit information, understand the findings, and apply knowledge can initially be daunting to the new nurse. The nursing health assessment involves a systematic data collection that provides information to facilitate a plan to deliver the best care for the patient.

The first part of the health assessment is the health history, which also incorporates the eight dimensions. The nurse asks pertinent questions to gather data from the patient and/or family. Past medical records may also be used to collect additional information. Learning about the patient's physical, emotional, social, financial, occupational, environmental, intellectual, and spiritual beliefs and issues contributes to a well-rounded history.

The second component of the health assessment is the physical examination. The nurse uses a structured head-to-toe examination to identify changes in the patient's body systems. An unusual or abnormal finding may support the history data or trigger additional questions.

Concept Mastery Alert

Types of Health Assessments

When determining the type of health assessment to complete, the nurse needs to consider the patient's current situation and condition. A focused assessment is completed on a patient who has already had a comprehensive examination and is being seen for a follow-up visit. A patient who presents with a new problem of a serious or critical nature would require an emergency assessment to determine the patient's current status. However, if this patient is now stable and the acute condition has subsided, the nurse needs to complete a comprehensive health assessment to evaluate all body systems to better decide which system is contributing to the patient's current problem.

The purpose of the nursing health assessment is to determine a patient's health status, risk factors, and need for education as a basis for developing a nursing plan of care. The ability of the nurse to extrapolate the findings, prioritize them, and finally formulate and implement the plan of care is the overall goal. This is called the nursing process. The information obtained throughout the health assessment should be documented in a clear, concise manner. This information is collated in the patient's medical records.

The health assessment is similar to a puzzle. When the nurse meets a patient, it is like opening the puzzle box and dumping out the pieces. Each piece of the history and examination data represents a different aspect of the patient's life, which form a picture of who the patient is. The review of systems in the health history is like the corner and edge pieces of a puzzle that form the frame, in this case, the basis for the assessment and how to proceed with the physical examination. Once the frame is in place it is easier to complete the puzzle. Listening and understanding a patient is key to having the pieces fit (Fig. 1-3). The health assessment assists the nurse with discovering a patient's needs. As a rapport with the patient develops, more details are acquired. As the information is collated, actual health risks emerge, and eventually those last hard-to-fit puzzle pieces are found, which represent the potential health risks. This intricate puzzle is a person's life, and the pieces need to fit correctly for the person to maintain health and quality of life. As the puzzle takes shape, a picture is formed. Likewise, the nurse is able to see the patient as an individual more clearly and is able to create a specific nursing plan of care.

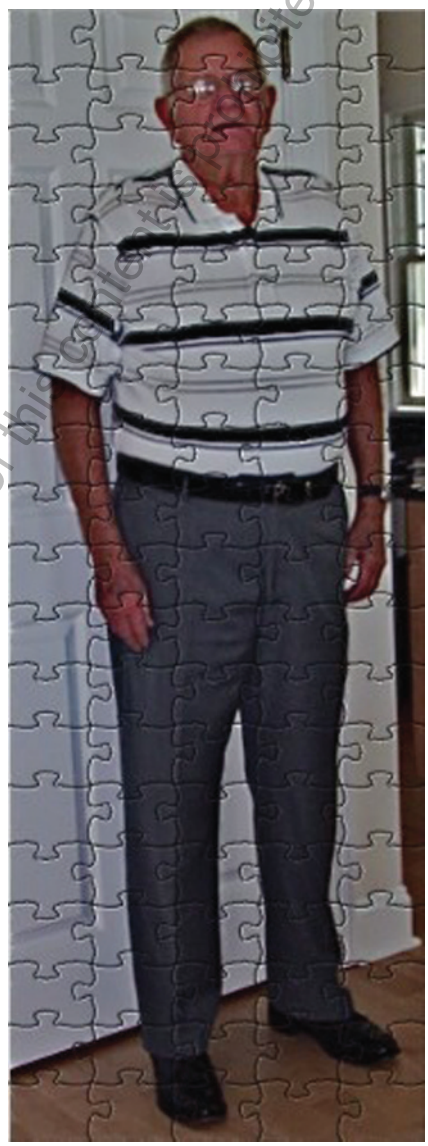

FIGURE 1-3 Individual health assessments explore the pieces of each unique puzzle.

The assessment is typically performed on the patient's arrival to a health care facility. The extent of the health assessment is determined by the acuity of the patient's condition and the site of the care. For example:

- The patient in critical condition brought into a busy emergency department would be asked basic questions revolving around the event that precipitated the admission and whether the patient is on medications, has any allergies, or has any adverse reactions. The thorough health history would be completed when the patient was stable and able to answer questions.

- The patient who has a professional relationship with the nurse and had a thorough health assessment at the initial meeting does not need to have a health history repeated on each visit. Updates based on new events would be added as necessary.

- The nursing home admission of a patient with dementia may require the health assessment information to be supplemented with information from the family, past health care providers, and/or medical records, based on the ability of the patient to remember information.

Each person needs a complete health assessment. Ideally this is done on admission, but extenuating circumstances may prohibit its completion in detail at this time. The sooner the health assessment is completed fully, the

better the nurse knows the patient, and more holistic care can be provided to ensure health promotion and quality of life.

Nursing and medical professionals both perform health assessments, and although the assessment techniques may be similar, the use is different. A medical diagnosis refers to the disease process and illness. This diagnosis is at the discretion of the physician. In contrast, the focus of the nursing analysis is on the patient's response to the medical condition or disease. An example is the medical diagnosis of hypertension; the physician focuses on figuring out the etiology of the disease and how to treat the high blood pressure using medical or surgical interventions. The nurse focuses on how to treat the patient's potential responses, such as fear of the diagnosis, risk of falling related to the potential for fainting, lack of knowledge regarding new medications, and the need for education about lifestyle changes involving diet and exercise. The nursing assessment identifies many contributing factors to the individual's health and wellness, including the eight dimensions. The health assessment facilitates data collection specific to the patient. As the nurse spends time with the patient, identification of concerns or changes are uncovered. Any deviation is noted, as are the coping mechanisms and resources the patient has available. This information is used to determine health problems or other potential problems. In the hypertension example, the patient may be a smoker or have had a family member who had a stroke related to high blood pressure. Concerns over the financial implications, inability to lift items, or dealing with stress at work might be shared. Taking all dimensions into account when developing the nursing care plan and working with the individual patient are paramount in health promotion and nursing care.

Once the plan is in place, evaluation continually occurs, and reconfiguring the plan may be necessary. The health care team meets to collaborate on plans for patients and decides the best overall care. This occurs throughout the lifespan, from the inception of life until death. The collaboration of the health care team is invaluable and may include nurses, physicians, nutritionists, social workers, physical therapists, occupational therapists, speech therapists, dentists, and more. These professionals all work together on the same team for the benefit of the patient. The partnership and coordination with all members of the team, with input from the patient as a key stakeholder and team member, is crucial to the success of the plan.

Through the health assessment, nurses detect areas of concern, requiring immediate attention, as well as health maintenance or improvement needs. Nurses have taken the lead in health promotion and disease prevention and assist patients with changing behaviors and lifestyles to obtain optimal health. Such changes enable individuals to increase control of and improve their overall health. Selecting the level of care and teaching is governed by the nurse as care is rendered. During the overall assessment of the patient, the nurse uses the findings to decide the areas that take precedence.

Health promotion and disease prevention are essential areas of patient education. Maintaining health is a balancing act influenced by behaviors and choices. Health education is a vital component of nursing practice. The

Concept Mastery Alert

Addressing Health Concerns

When the assessment uncovers possible additional health issues, the nurse should extend the allotted time to sufficiently gather additional information critical to creating an effective plan of care. The most effective time to gather such information is during the assessment that is currently being performed.

nurse assists people in making connections between a healthy lifestyle and disease prevention. Additional components that contribute to health include the individual's personality and attitude, resilience, family dynamics, access to health care and resources, nutrition, exercise, culture, and beliefs.

Healthy People 2030 is a campaign that uses a framework for improved health based on the National Health Promotion and Disease Prevention objectives set forth by the Secretary of Health and Human Services advisory committee (Hahn et al., 2018). The U.S. Department of Health and Human Services provides the data online and invites health care leaders and individuals in the community to voice their opinions regarding the focus for the next decade (Hahn et al., 2018). The national health objectives in *Healthy People 2030* are broad and take into consideration the results of the *Healthy People 2020* outcomes. These are based on current data, new developments, and challenges that are prevalent or emerging in the United States related to American risk factors, health issues, and diseases of concern (*Healthy People 2030,* 2020). The goals and objectives serve to improve the health of individuals and communities, targeting 10-year increments. The overall goal is to increase quality of life by creating guidelines for a healthy lifestyle as well as educating people and cultivating an awareness that will assist in the elimination of national health disparities. *Healthy People 2030* promotes health and disease prevention as it improves the quality and length of a person's life (*Healthy People 2030,* 2020). *Healthy People* initiatives include the SDOH and address physical and social environments to promote health for everyone as a main goal (Hahn et al., 2018).

The *Healthy People 2030* indicators pertinent to individuals are determined as the nurse completes the health assessment on each patient. Using the website healthypeople.gov, the nurse can identify health indicators, appropriate interventions, and resources (*Healthy People 2030,* 2020).

Role of the Nurse in Assessment

Nurses deliver care across the lifespan in a variety of practice arenas. A small sample of the groups served are pediatrics, geriatrics, medical, surgical, mental health, maternity, and community health. Nurses assess patient needs, develop interventions, and educate and counsel individuals, families, groups, and communities toward higher levels of health and wellness. Nurses view health as the focus with the patient, the environment, and the nurse all influencing the health status of the patient. It is crucial to use all eight dimensions that affect the patient's health, as this guides the nursing plan of care. Also important is the patient's view and definition of health. One person may view health as being free of disease. Another may indicate health as good control of blood pressure. One person has a chronic disease and the other does not, but they may both see themselves as healthy. When meeting with the patient, ask what their goals and views are:

"What would you like to accomplish during this visit?"
"Tell me how you see yourself with regard to health."
"Tell me why you are here today."

FIGURE 1-4 Nurse taking a health history (Burlingham/Shutterstock).

Focusing on the answers (verbal) and the actions (nonverbal) of the patient, the nurse is constantly assessing and formulating a plan of care so that the patient can achieve the best possible health (Fig. 1-4).

Health goes beyond the individual patient. It also encompasses the community. Nurses are involved in shaping public policy and in social, economic, and workplace decisions. For the nurse to assist a patient with health, a healthy environment must be nurtured. The community and the environment need to be defined and realistic goals set for possible change, such as access to healthy foods. In the context of environment, what does this mean? Accessibility to healthy school lunch programs and proximity to grocery stores with affordable, fresh produce. This sets a path for prevention of illness and maintenance of health and wellness. Nurses assess the individual, family, and the community; however, the focus of this text will be the assessment of the individual.

Nurses are instrumental in the care of patients. They oversee the holistic care of each patient. The nurse's initial role in health assessment is to collect data. Constant observation and attention to details and nuances are critical. Each person comes with a vast array of information and is influenced by the surroundings, including the physical, emotional, intellectual, and spiritual environments. This extensive body of knowledge and the responsibility that each patient encounter requires can seem overwhelming to the new nurse. As the nurse becomes more proficient and comfortable in the role, the knowledge base and expertise increase and foster confidence.

As a nurse, it is vital to sift through all the patient information and make decisions about what information will impact patient safety and quality of care. The ability to identify what is important on a daily basis for each

individual patient is paramount for nursing care. During the health history, the nurse asks questions to determine the health information that influences the day-to-day care and how it affects the person's quality of life.

The following brief encounter depicts the wealth of information given by one patient. During this short interaction with Mr. P., what additional questions are you forming related to his health needs?

CASE STUDY

Mr. P. arrives at the clinic with complaints of blurred vision. During the health history, the patient also confides to the nurse that he has not been able to make it to the bathroom in time and has been incontinent frequently. He verbalizes that he is upset that he is unable to see well which has slowed down his mobility. The decrease in mobility and incontinence have limited his social life with friends and he is becoming more irritable and feeling lonely. He admits to feeling like he wants to sleep all the time.

Monkey Business Images/Shutterstock.

The nurse is already formulating additional questions to correlate with the standard health history based on what the patient has disclosed. As you read through this book, you will learn more questions to ask, those that are system-specific as well as those regarding overlapping systems. How you interpret this nurse–patient interaction will be much different after you learn how to do a health assessment.

As a student nurse, you might take the encounter at face value and attribute Mr. P.'s downward spiral to his initial report of blurred vision. However, after a thorough assessment, you may uncover additional issues and determine that his vision problem is not the root of his irritability and fatigue.

There is too little information available in this scenario to determine what is going on with this patient. It is important to allot a sufficient amount of time to do a detailed health assessment. Once more details are uncovered, more possibilities arise. Mr. P. could potentially have multiple issues, such as diabetes, a brain tumor, depression, blurred vision, or benign prostatic hypertrophy. However, these discoveries will not be unearthed without more information.

Accurate health history taking and physical assessment are the foundation of nursing practice. Nurses rely heavily on these skills in all aspects of nursing. The puzzle will be pieced together during the nursing history and assessment. For example, the patient recovering from an illness or surgery needs to be carefully assessed each shift, with changes noted that may indicate potentially dire consequences.

Assessing the patient by using the eight dimensions is at the forefront of the nurse's responsibilities. Physically, the nurse may discover a change in vital signs, nausea, difficulty swallowing, or incontinence. Mentally, the patient may be experiencing changes in the level of consciousness and not know where they are or even who they are. Emotionally, is the patient more subdued, angry, or crying after a visit from a family member? The nurse will pursue the reasons behind a mood change in the patient. Could there be abuse, money concerns, or a fear of abandonment? The nurse has developed a rapport with the patient and is now able to delve into territory that may have been previously off limits. Once these issues are acknowledged, the patient can develop a healthier life with appropriate interventions and options. Developmentally, a patient may need guidance in areas such as problem solving or moral understanding. Socially, the patient may be isolated from their support system in the hospital and need additional outlets. Providing information about self-help groups or health resources can provide additional avenues for people socially. Spiritually, it is best to let the patient take the lead on how to handle spiritual care, as this dimension is personal. If the patient wishes, connecting them with clergy of the same denomination while in the hospital may be welcome, or assisting with transportation to worship services when at home may be reasonable. In all aspects, it is best to work with the patient to enable partnering in choices, addressing access and how social determinants of health may impact these choices. This allows the patient to make decisions regarding their own health care. The more a patient participates in these decisions, the better the outcomes are in the long term toward a healthier lifestyle.

Teaching opportunities for the patient and family present themselves during health assessments. The nurse uses information detected in the assessment to work with the patient to enhance quality of life. For example, the person who is overweight and has an increased body mass index might need assistance with meal planning or an exercise regimen. A plan that includes the family may be the best solution for one individual, but another may do better with an outside support group. A mutually agreed upon plan will assist the patient in maintaining autonomy to achieve the highest possible level of wellness.

The nurse's ability to detect a change in a patient's physical, emotional, environmental, intellectual, financial, occupational, social, or spiritual self, whether slight or significant, is instrumental in providing the best care. Just as a detective asks questions, the nurse finds clues and follows up on information in order to solve patient problems. Knowing how to facilitate the nursing health assessment by asking appropriate questions to obtain more information helps solve the mystery and create a nursing care plan. The care plan is evaluated periodically, and changes are made to update the plan. The nurse, like a detective, is always reassessing the patient and their case for changes in order to achieve the best results. Each relies on both the science and art of their respective profession.

The nursing process will be explained in detail in Chapter 2, "Critical Thinking and Clinical Judgment in Health Assessment."

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