ASSESSMENT OUTLINE

- Purpose of Assessment
  - Assessment (major part of nursing care) (begins nursing process) (history & exam)
    - Establishes a database of information & begins nursing process, a framework for nursing care that allows nurses to focus on clients' needs
    - Client's response to health concerns or illness
    - Ability to manage health care needs
    - Subjective & Objective data
  - Purpose-Identifies functional abilities, strengths, needs, deviations from normal, health patterns & beliefs, risk factors, and resources for support & adaptation
  - Assist client to achieve their highest possible level of health
  - Assessment Activities
    - Assessment is systematic, continuous, deliberative, & interactive
    - Collection. Organization, Validation, & Documentation of data
      - Subjective data
        - Apparent only to & can be described by the person affected
        - Includes sensations, feelings, values, beliefs, attitudes, & perceptions of personal health status & life situation
      - Objective data
        - Detectable by an observer-can be measured or tested against accepted standard
        - Can be seen, heard, felt, or smelled
        - Obtained thru observation or physical exam
      - Sources of Data
        - Primary Data-<u>CLIENT IS PRIMARY SOURCE!!</u>
        - Secondary Data-All other sources of data-family, old records, etc.

- Types of assessments
  - Types of Assessment
    - Initial Assessment
      - Performed within specified time period to establish a complete database
    - Problem –Focused Assessment
      - Ongoing process integrated with nursing care
      - Determines status of a specific problem
    - Emergency Assessment
      - Performed during physiologic or psychological crisis
      - Identify new or overlooked problems
    - Time-Lapsed Assessment
      - Occurs several months after initial assessment to compare to baseline
- Methods of Data Collection

- Subjective
  - Interview
    - Planned communication or conversation with a purpose
    - Used to ID problems, evaluate change, teach, provide support, counseling or therapy

- Objective
  - Observation
    - Observing-gathering data using the senses
    - Used to obtain the following types of data
      - Skin color (vision) Skin Temperature (touch)
      - Body or breath odors (smell)
      - Lung or heart sounds (hearing)

  - Physical Examination (*takes place after the interview process)*
    - Systematic data-collection method
    - Four Techniques (will discuss later in detail)
      - Inspection, Palpation, Percussion, Auscultation
    - Used to obtain data such as B/P, heart & lung sounds, skin temp & moisture, muscle strength

OBTAINING SUBJECTIVE DATA

The Interview

- Important aspects of the interview environment
  - Time- Client free of pain, physically comfortable, toileting done, limit interruptions
  - Place-Private, confidential, distraction free, comfortable, lighting
  - Seating Arrangement45 degree, right angle if in a chair
  - Distance-comfortable 2-3 feet
  - Language-easy to understand, no medical jargon, interpreter/translator when needed
  - Communication
    - Professional, calm, non-judgmental, active listening
    - Build rapport with patient
- Phases of the interview
  - Contract between the nurse and the patient-mutual goal optimal health
  - Orientation Phase (Opening Phase)
    - Establishes rapport & orients, explains purpose of interview (SELF-INTRO)
  - Working or Body Phase
    - Asking questions to form a database
    - Client communicates thoughts, feelings, & perceptions
    - Effective development demands use of communication techniques comfortable for both parties & serve purpose of interview
    - Questions-general to specific
    - Types of Questions
      - Closed Question
        - Restrictive limited to yes/no, short, factual
        - Less effort & info from patient

        - Examples-What med did you take? Are you having pain?
    - Open-ended Question
        - Specify broad topic to be discussed
        - Invite longer answers more info from patient
        - Examples-How have you been feeling? /What would you like to talk about today?
    - Direct or focused questions avoid rambling
- Clarifying Techniques
    - Restating-clarifying
    - Stating observations
    - Facilitation
    - Attentive listening
- Closing or Termination Phase
    - Provide clues that interview process ending,
    - Thank them for their time, express concern for welfare
    - Plan for next meeting to communicate any findings

- Health History
    - Structured conversation used to gather pertinent details about client's background and current medical status
        - P – Past medical history
        - L – Last oral intake
        - E – Events leading to illness or injury (Etiology)
        - A – Allergies & types of reactions
        - S – Symptoms or chief complaint
        - E – Each prescribed medication, OTC medications, & herbal supplements
    - Biographic data-statistical information
    - Chief Complaint-reason for seeking healthcare, recorded on own words of pt. *in quotes*
    - History of Present Illness-Progression, current status, previous treatment, symptom investigation
    - Past Medical History (PMH)
        - Birth, Growth & Development, Illness, Immunizations
        - Previous injuries, hospitalizations, surgeries, chronic medical cond.
        - Allergies, medications, dietary restrictions & preferences
        - Pain, emotional, psychiatric problems
    - Family Health History-parents, siblings
    - Psychosocial-Lifestyle Health Practice Profile-social activities, relationships, values, education level, stress & coping, developmental level
        - Smoking -# cigarettes daily (PPD) # years smoking, described in pack years
        - Alcohol. CAGE Questionnaire (C) cut (A)Annoyed(G)Guilty(E)Eye opener
    - Activities of Daily Living-description of a typical day (nutrition, activity, sleep, meds)
    - Explore medication use-Inspect bottles, verify names, compliance, etc.
    - Review of Systems (ROS)
        - Systemic method of data collection, nurse asks about normal/abnormal function
        - Subjective data related to structure & function of body

- History component-do you have or ever had?
- Question each body system-reinforce initial impressions or new questions
- Maintain a systemic approach

- OBTAINING OBJECTIVE DATA
- GENERAL SURVEY
  - Begins the moment you greet the client
  - Establish trust and build rapport using therapeutic communication
    - Verbal – words and tone, active listening
    - Non-verbal – body language
  - Quick overall assessment of client, noticing any body system issues requiring a more focused assessment
    - General appearance
    - Behavior
    - Indicators of Abuse, Neglect, and Human Trafficking
    - Body Structure
    - Mobility
    - Measurement
    - Vital Signs
    - Pain
  - General appearance
    - Symmetry
    - Swelling
  - Emotional State
    - Relaxed or restless
  - Eye contact
    - May be affected by culture
  - Level of Consciousness (LOC)
    - Orientation to Person, Place, Time, Situation (AOx4)
  - Skin
    - Warm, dry, intact? (WDI)
    - Note any lesions
  - Behavior
    - Speech
    - Mood
    - Affect
    - Personal Hygiene
      - Grooming
      - Odor
      - Dentition
  - Body structure and Mobility
    - Posture
    - Mobility
    - Range of Motion (ROM)
    - Involuntary Movements
      - Spasticity
      - Rigidity
      - Myoclonus
      - Tic

- Tremors

- Physical Examination
  - Obtained through inspection, palpation, percussion & auscultation
  - Documented as description of findings & measured against accepted standards
  - Data Collection Method -Observation
    - Gathering data using five senses & occurs whenever nurse is with patient
    - Identification, selection, interpretation
    - Use observation skills-vision, smell, hearing, touch
  - Data Collection Method-Physical Exam & Assessment
    - Performance specialized skills using senses to determine variations from normal
    - Examiner must be knowledgeable of A&P to detect normal/ abnormal findings
  - Preparation of Patient & Environment
    - Prepare patient & self, explain physical health assessment, work in an organized fashion
    - Prepare environment (See BSF pages 516-517)
    - Timing, Lighting, Equipment, Privacy, Physical Complaints, Positioning, Draping
    - Prepare patient-positions for exam (See BSF Table 30-2 p. 516)
    - Prepare exam equipment (Table 30-3, p. 517)

  - <u>Four Primary Assessment Techniques</u>
    - <u>Inspection</u>-visual examination using sight, hearing, smell
      - Critical observation
      - General, Systemic, Direct, Indirect inspection
      - Inspect for size, shape, color, position, symmetry, & abnormalities
      - General observations-appearance, distress, mood, body movement, etc.
    - <u>Palpation-</u>using hands to elicit info about skin temp, pulsations, vibrations, masses,
      tenderness, rigidity of organs or structures
      - Certain parts of hands best for specific characteristics
      - Usually follows inspection except for abdomen
      - Defines what is seen and unseen-relaxation important
      - Light palpation-light gentle pressure with fingertips or pads <1cm
      - Deep palpation-one hand on top of other 4cm, detects masses & tenderness
        - Performed by advanced practice registered nurses (APRNs)
    - <u>Percussion-</u>tapping or striking body surface to elicit sounds or vibrations
      - Tapping produces an audible vibration that reveals location, size, density of underlying structure
      - Determines tissue is fluid or air filled, or solid
      - Three Techniques-Direct, Indirect, Blunt
      - Sounds produced differ in loudness, pitch, duration, intensity

        - **Tympany**-high pitched, drum-like sound - heard over stomach, gas filled bowel
        - **Resonance**-low pitched, hollow sound - normal lung tissue
        - **Hyperresonance**-loud booming sound - over hyperinflated lung i.e. emphysema
        - **Dullness**-soft, high-pitched, thud-like sound - over dense organs i.e. liver, heart, diaphragm
    - **Flatness**-soft, high-pitched sound - over bones, muscles, tumors

Auscultation-listening to sounds produced by body using a stethoscope

- Parts of stethoscope-
    - Diaphragm- high pitched sounds, S1S2, heart, lungs, bowels
    - Bell-low pitched sounds S3S4 bruits, murmurs
    - Earpieces-outer ear canal, comfortable snug fit
    - Conduit-combo plastic, rubber, metal should be 12-14 inches

INTEGUMENTARY SYSTEM

- ROS – SUBJECTIVE
    - Do you have
    - Any skin color changes, moles, lesions, rashes, or changes in the skin?
    - Scars, trauma, incisions?
    - Family history of skin cancer or psoriasis?
    - Unusual hair growth or loss?
    - Changes in finger or toenails - Break easily or thick?
    - Do you wear sunscreen?
    - Check allergies, medications, herbal preparations, & underlying diseases
- PHYSICAL ASSESSMENT – OBJECTIVE
    - **Inspection**
        - Skin color-pink, pale, jaundiced, cyanotic
        - Observe breakdown, excoriation, infection
        - Lesions, rashes, erythema, vitiligo, wounds, bruising, moles, scars
        - Hair color, cleanliness, distribution
        - Nails-shape, grooming, color, clubbing
    - **Palpation**
        - Skin temp with back of hands
        - Edema –fluid under skin
        - Turgor-gently pinch forearm 1-3 second return, can use sternum in elderly
        - Use finger tips & pads to check for rough/smooth
        - Palpate borders of lesion (papular/macular)
        - Grasp hair noting color, texture, fall out easily?
        - Nail texture, adherence
        - ***Capillary refill***
        - EDEMA
            - **Pitting**
            - Slight Indentation.

- 10lbs of fluid retained.
- +1 2mm indentation
- +2 4mm indentation
- +3 6mm indentation
- +4 8mm indentation
- **1 kg. (2.2 lbs.) = 1000 ml**
- **Brawney**
- Tissue so swollen it can't pit.

▪ TURGOR
- Grasp fold of skin on anterior forearm or sternum
  - Elastic springs back
  - Tenting is slow to return
- Normal – Resumes shape in seconds
- Dehydration – Takes up to 20 – 30 seconds; decreased turgor is a late sign of dehydration

o BRADEN SCALE

HEAD, NECK, AND NEUROLOGICAL SYSTEM
HEAD

- **ROS (subjective)**
  - Any trauma to head, history of pain, headaches, dizziness, LOC, seizures, surgery?
- **Inspection & Palpation (objective)**
  - Nurse inspects & palpates anatomical structure of head, eyes, ears, nose, mouth, pharynx, neck simultaneously.

EYES

▪ **ROS: (subjective)**

- History of eye disease/infections ?
- Cataracts, glaucoma?
- Surgery? Blindness? Trauma?
- Diabetes? Hypertension?
- Pain? Blurred or double vision?
- Burning, tearing, drainage, itching, dryness?
- Flashing lights, halos?
- Glasses or contact lenses?

▪ **Physical Assessment or Exam (objective)**
- **Inspection**
  - Inspect eyes, eyelids, eyebrows, eyelashes
  - Inspect skin around eyes for erythema, scaling, or drainage
  - Inspect color of iris, sclera, conjunctiva
  - Check pupils for constriction/dilation
    - **PERRLA (pupils equal round react light accommodation)**
    - **NORMAL SIZE OF PUPIL 3-5MM**
  - Symmetry-placement on face
  - Check lids for drooping **(ptosis)**
  - Check for discharge

- Describe color, thick or thin

EARS

- **ROS: subjective**
  - HOH? Ringing,buzzing,discharge, earaches?
  - Hx. of infections? Surgery? Hearing Aids?
  - Exposure to loud noises?
- **Physical Assessment objective**
  - Inspect external ear/ auricle for color, symmetry of size & position.
  - Palpate for tenderness, texture, elasticity
  - **Hearing (hear spoken word?)**
  - **Otoscope (examine inner ear)**

NOSE

- **ROS: subjective**
  - History of trauma
  - Sinus problems
  - Allergies, difficulty breathing thru the nose
  - Nosebleeds
  - Medications
  - Difficulty with smelling (anosmia-no smell)
  - Snoring
  - Frequent colds
  - Surgeries
- **PA objective**
  - **Inspect**
    - **External nose** for deviation in shape, size, color, flaring, or discharge from nares, lesions
    - **Mucosa** for color, lesions, discharge, bleeding
  - **Palpate**
    - **Lightly palpate** external nose for tenderness, masses, displacement of bone/cartilage
    - **Palpate** sinuses for tenderness

MOUTH & PHARYNX

- **ROS: subjective**
  - Routine pattern of dental care?
  - Ulcers or lesions?
  - Dentures?
  - Medications?

- History of dental or gum disease?
- Ability to taste?
- Sore throats? Hoarseness?
- Snoring?
- Smoking?
- Surgery (T&A), or other?

- **Physical Assessment: objective**
  - Inspect
    - Outer lips for symmetry, contour, texture (purse lips)
    - Teeth, dentures, gums.
    - Uvula, tonsils, hard & soft palate.
    - Inspect & palpate tongue, & inner lips.

NECK

- **ROS**: **subjective**
  - Neck lumps
  - Pain, Stiffness
  - Thyroid problems
  - Medications
  - Surgeries, Treatments, Infections
  - Voice changes, Swallowing problems
  - Jugular vein distention (JVD)
- **Physical Assessment: objective**
  - **Inspect**
    - Neck muscles
    - Observe head movement, symmetry, masses, scars, pulsations, swelling
    - Palpate lymph nodes, trachea, thyroid gland.
    - Observe carotid artery, jugular vein.

ABDOMEN

- ROS
  - Abdominal pain
    - Note location, onset, sequence, chronology, quality, frequency, & any associated symptoms
  - Change in bowel pattern or appetite, diet preference, etoh intake
  - Upper GI symptoms
    - Indigestion, Nausea/Vomiting (N/V), heartburn, belching, swallowing difficulty
  - Lower GI symptoms
    - Pain, cramps, diarrhea, constipation, gas, blood in stool
  - Jaundice or hernias
  - Previous problems, treatments, & surgeries
- Inspection
  - Standing next to patient, assess:
    - Overall contour and symmetry
      - Flat / round / protuberant

        - Skin for scars, rashes, striae, scars
        - Masses
        - Umbilicus shape & location
        - Observe abdominal movements with respiration, peristalsis, or aortic pulsations

- Auscultation
    - Listen for bowel sounds, vascular sounds & peritoneal friction rubs
    - Bowel Sounds
        - Clicks and gurgles, growling
        - Normally heard every 5 – 15 seconds
            - Listen for a full 5 minutes *in each quadrant* before documenting absent
        - Borborygmus – loud intestinal rumbling
    - Chart bowel sounds as
        - Audible
        - Hypo- or hyper- active
        - Absent
- Vascular Sounds
    - Bruit
        - Rushing or blowing sound
        - Can be a sign of arterial narrowing
        - Have patient hold their breath
        - Listen with bell of stethoscope over each carotid artery in turn
    - Thrill
        - Vibrating sensation that accompanies a bruit
        - If you hear a bruit, validate by palpating gently to determine presence of thrill
    - Peritoneal Friction Rub
        - Grating sound like rubbing two pieces of leather together
        - Peritoneal inflammation – over peritoneum
        - Organ inflammation if heard over organ i.e. Liver
- Palpation
    - Detect tenderness, masses, distension
    - Light to detect tenderness
- Deep to feel organs
- Percussion
    - Tympany
        - Gas in stomach and intestines
    - Dullness
        - Decrease, absence, or flatness of resonance over solid masses or fluid
- Percuss liver & spleen to determine organ borders

URINARY ASSESSMENT

- ROS

- Hx of dysuria, pain, polyuria, hematuria, frequency, incontinence
- Hx of flank pain, Urinary Tract Infections(UTI), kidney or bladder disease or surgery

- Physical Assessment
  - Palpate bladder for distension
    - A tense smooth round mass above symphysis pubis indicates urinary retention
  - Palpate flanks for kidney inflammation / tenderness

SEXUAL HISTORY

The Five P's

- 1. Partners:
  - Male, female, both, number past 2 months & past 12 months
- 2. Practices:
  - If>1 partner past 12 months or multiple partners-type of sexual contact, risk factors (drugs, trading sex)
- 3. Protection from STIs:
  - Protection & what type, condom usage
- 4. Past history STIs:
  - Current or former partners have hx & if treated
- 5. Pregnancy Prevention:
  - Planning pregnancy, preventive measures if not planning

CARDIAC SYSTEM

BLOOD FLOW THROUGH THE HEART

Blood travels through your heart and lungs in four steps:

- The right atrium receives oxygen-poor blood from the body and pumps it through the tricuspid valve to the right ventricle.
- The right ventricle pumps the oxygen-poor blood through the pulmonary valve to the lungs.
- The left atrium receives oxygen-rich blood from the lungs and pumps it through the mitral valve to the left ventricle.
- The left ventricle pumps the oxygen-rich blood through the aortic valve out to the rest of the body.

- ROS
  - Hx of heart issues
    - Angina, Arrhythmias, Myocardial Infarctions (MI), Hypertension (HTN), High Cholesterol, Coronary Artery Disease (CAD), Stroke (CVA
  - Last BP, Electrocardiogram (ECG), Stress test
  - Lifestyle risk factors
    - Smoking, high fat / salt diet, exercise, obesity, etoh, stress
  - Symptoms
    - Fatigue, dyspnea, orthopnea, edema, cough, palpitations, syncope

- PHYSICAL ASSESSMENT
- Inspection
  - Supine position with Head of Bed (HOB) slightly elevated
  - Normal skin color for race
  - Capillary refill (<3 seconds is normal)
  - Symmetry of thorax, noting any distortions
  - Precordial pulsations (Point of maximal impulse (PMI) should not be visible)
  - Nail beds (color, clubbing)
  - Jugular Venous Distension (JVD) with HOB at 45 degrees
- Palpation
  - PMI palpable?
  - No thrills or heaves
  - Slight palpable pulsations of aorta in epigastric area are an expected finding
  - Carotid and extremity pulses 2+ and equal
  - No pedal edema
  - Skin temperature
- Auscultation
  - Systematic assessment
  - Patient supine with HOB elevated slightly, then left lateral, then sitting up leaning forward
  - Check apical pulse for rate, rhythm, & clarity of tones – report abnormalities
  - Remember Ape to Man (Aortic, Pulmonic, Tricuspid, Mitral)
  - Aortic 2nd ICS along right sternal border
  - Pulmonic 2nd ICS along left sternal border
  - Tricuspid 3rd – 5th ICS along left sternal border
  - Mitral 4th – 5th ICS along mid-clavicular line

- PERIPHERAL VASCULAR
- ROS
  - Hx of heart disorders, varicosities, arterial disease, HTN
  - Swelling or edema of legs/feet, painful cramping, leg sores, changes in color or texture of legs or feet
  - Lifestyle
  - Exercise & activity pattern & tolerance
  - Risks – etoh, smoking, Diabetes
  - Circulation issues – cold extremities, painful to walk
- PHYSICAL ASSESSMENT
  - Inspect skin & tissues to determine perfusion
    - Note temperature, color, edema, & any skin changes
  - Palpate carotid, temporal, brachial, radial, femoral, popliteal, dorsalis pedis, & posterior tibial pulses
    - Palpation may prove difficult in the presence of diminished Cardiac Output (CO)
  - Peripheral Pulses
    - Palpate on both sides simultaneously (except carotids)
      - Check rate, strength, regularity
        - May need Doppler

        - Check BP
        - Assess capillary refill
        - Assess hair growth
        - Assess Homan's Sign
            - Severe calf pain with forceful dorsiflexion = (+) Homan's sign
                - Indicative of Deep Vein Thrombosis (DVT) blood clot
    - Homan's Sign
        - Deep calf pain upon dorsiflexion of ankle is indicative of DVT
    - Peripheral Pulse Grading Scale

0	Not palpable
1	Difficult to palpate, thread, weak, easily obliterated with pressure
2	Difficult to palpate , may be obliterated with pressure
3	Easy to palpate, not easily obliterated with pressure (NORMAL)
4	Strong, bounding, not obliterated with pressure

- Jugular venous distension (JVD)
    - A clue to the functioning of the right side of the heart & venous pressure
        - Bilateral (b/l) may indicate right-sided heart failure
    - Normally external neck veins are distended / visible when lying, but invisible and flat when standing

RESPIRATORY SYSTEM
THORAX & LUNGS

- **ROS subjective**
    - Difficulty breathing, SOB?
    - History infection, wheezing, asthma, bronchitis, pneumonia, TB, COPD, chest/lung surgery, cough?
    - Recent chest x-ray (CXR)
    - History of smoking
    - Type, duration, how many PPD?
    - Exposure to environmental toxins
    - Asbestos exposure

- Physical Assessment (PA) Objective
    - **Inspection**
        - Compare side to side
        - Compare top to bottom
        - Visualize underlying tissue
        - Anterior assessment
            - lying supine or sitting
        - Posterior assessment-sitting
        - Rate, rhythm, depth, effort of respirations
        - Normal respiratory rate 10-20 @ rest occasional sigh
        - Inspect shape & symmetry of chest
        - **CRAMP**
        - **C**hest Wall Symmetry
        - **R**espiratory Rate Rhythm Depth
        - **A**ccessory Muscle Use
        - **M**asses or Scars

        - **P**aradoxical Movements / **P**osture
    - Palpation
        - Identify tender areas
        - Assess observed abnormalities
        - Respiratory excursion
        - Assessment of tactile fremitus
        - Assess for crepitus
    - **Percussion**
        - Determines if underlying tissue is air-filled, fluid-filled, or solid
    - **Auscultation**
        - Assessing air flow thru tracheobronchial tree
        - Compare symmetrical lung areas side to side from top down
        - Have patient breathe with mouth open for best sound
        - Listen for one full breath in each location
        - Assess breath sounds.-pitch, intensity, duration of inspiration & expiration
        - Check spoken/ whispered word
    - BREATH SOUNDS
    - Normal Breath Sounds
        - Heard over entire lung field
        - Consist of 2 phases – Inspiration (I) & Expiration (E)
        - Primary source is the turbulent flow of air in larger airways
        - Breath sounds auscultated in a specific lobe result from air entry into that lobe
    - Bronchial
        - High-pitched
        - Loud “harsh” sounds
        - Created by air moving through the trachea
        - Sound like air flowing through a hollow pipe
        - I/E ratio 1:2
        - Gap between I and E
        - Place stethoscope next to the trachea
- Bronchovesicular
    - Medium pitch & intensity
    - Blowing sounds
    - Created by air moving through larger airway (bronchi)
    - I/E ratio 1:1
    - Place stethoscope lateral to sternum at 1st & 2nd intercostals and between scapula
- Vesicular
    - Soft-intensity, low-pitched
    - Gentle sighing sounds
    - Created by air moving through smaller airways (bronchioles & alveoli)
    - I/E ratio 5:2
    - Heard over all lung fields except over major bronchi

ADVENTITIOUS BREATH SOUNDS

- Crackles (Rales)
  - Intermittent, bubbling, hi-pitched, non-musical, short & crackling primarily on Inspiration
  - Produced by bubbling of air through secretions in small airways in lung bases
  - May not clear with cough
- Friction Rub
  - Creaking, grating sound created by rubbing of inflamed pleural spaces
- Wheeze
- High-pitched, musical, squeaky sounds
- Best heard on expiration
- Not typically cleared by coughing
- Heard over all lung fields
- Rhonchi (gurgles)
- Loud, low-pitched, coarse, harsh gurgling, moaning sounds
- Best heard on expiration, but can be both I and E
- Clear with cough
- Over all lung fields but most prevalent over trachea and bronchi

COVID-19 patient’s lung sounds

MUSCULOSKELETAL SYSTEM

- **ROS**:
  - Muscle strength, pain, cramping?
  - Onset, location, character, associated phenomena?
  - Swelling or redness of joints?
  - Limitations of movement or activity or full Range of Motion (ROM)
  - Sport or other injuries? Loss of functions?
  - Arthritis, Muscle diseases?
  - Back pain, scoliosis?

- Surgical history, fractures
- Tremors?

- **PA (Inspection & Palpation)**
  - Alignment
  - Symmetry & muscle mass
  - Muscle tone, size, strength, contractions, tremors
  - Range of Motion (ROM) of joints
  - **Passive ROM** move joints through full range of movement, not past a point of pain or resistance.
  - **Active ROM-**ask to repeat movements demonstrated by nurse
  - Ambulation / gait
  - Involuntary movements
  - Signs of inflammation
  - Redness, swelling, warmth, tenderness, loss of function
  - Inspect joints
  - Swelling, tenderness, crepitation
  - Palpate bones

  - Range of Motion of Joints
    - Flexion-decrease angle
    - Extension-extend angle
    - Hyperextension-extreme extension
    - Supination-ventral surface up
    - Pronation-ventral surface down
    - Abduction-move away
    - Adduction-move toward
    - Dorsiflexion-top wrist or foot
    - Plantar flexion-move toward
    - Eversion-away midline
    - Inversion-toward midline

Muscle strength is graded on 0-5 scale

- 0 no muscular contraction detected
- 1 barely detectable flicker/trace contraction
- 2 active movement of body part with gravity eliminated
- 3 active movement against gravity
- 4 active movement against gravity & some resistance
- 5 active movement against full resistance without evidence of fatigue. (Normal muscle strength)

NEUROLOGICAL SYSTEM

- **ROS:**
  - General mood, behavior, depression, anger?
  - Concussion, Pain or Headaches?
  - Loss of consciousness, Dizziness? Memory lapses, Mood swings? Uncontrolled muscle movement? Numbness, tingling? Seizures?
  - Diseases (MS, Parkinson's, Epilepsy)
  - Stroke, deficits- Aphasia, paralysis,weak?
  - Increased or decreased sensation?
  - Strange thoughts/actions?
  - Difficulty learning?

- Assess mental status to determine general cerebral function
- Language
    - Express or understand
        - Aphasia
- Orientation
    - Person, place, time, situation (AxOx4)
- Memory
    - Immediate (few seconds)
    - Recent(earlier in day)
    - Remote(years ago, birthday/place)
- Attention span
    - Mental task focus (count backward)
- Level of Consciousness
    - Anywhere along a continuum from alert to comatose
    - Glasgow coma scale used to assess LOC
        - Eye, motor, verbal response
- Basic LOC
    - Alert –awake & responsive
    - Lethargic-sleepy, but arousable
    - Obtunded-needs to be shaken
    - Stuporous-arouses with difficulty, painful stimuli
    - Comatose-not arousable
- Reflex
    - Automatic response to stimulus
- Babinski-normal negative
- Motor Function
    - Proprioceptors-sensory nerve terminals in muscles, tendons, joints
    - Movement & body position
- Sensory Function
    - Touch, pain, temp, position, tactile discrimination
- Cranial Nerves
    - Many cranial nerve functions are assessed with visual & hearing assessments
    - Usually only selected nerve functions are evaluated

VALIDATING DATA

- Info. must be complete, factual, & accurate
- *Validation is "double-checking" data*
- Ensure subjective & related objective data agree
- Validate data when discrepancy between interview and Physical Exam
- Differentiate between cues & inferences
- Validate assumptions based on physical or emotional behavior
- Clarify ambiguous or vague statements

DOCUMENTING YOUR ASSESSMENT

- Client's record, or chart, is a formal legal document of care provided
- Must be timely, complete, accurate, confidential, and patient-specific (JCAHO requirement)

- After completion of ROS & PA, need to chart findings
- Increase accuracy by recording subjective data in the client's own words
    - Can provide insight into their understanding of their condition
- Always use black pen
- Correct any errors by drawing a single line through and writing correction -Never use white-out
-

RP for Assessment unit
Day 1:

- A client has come in for a routine health assessment without having a specific health concern.
- Identify open ended questions that the nurse could ask to encourage the client to talk further about her health.
- **Was there a specific reason you wanted a physical exam done at this time?**
- **What made you decide to come in for your physical exam?**
- **What concerns do you have about your health?**
- Which of the following is an effective technique to use when interviewing a client?
    - A. Start the interview with "nonthreatening" topics.
    - B. Use only nondirective questions
    - C. Have the client fill out a printed nursing history form.
    - D. Ask the questions word for word from the history form
- **Correct answer is A**
- **Starting the interview with nonthreatening topics will facilitate establishment of rapport and trust between the client and the nurse.**
- Using **nondirective questions may make the client feel comfortable**, but may allow the client to **avoid discussing important details**
- Having the client **fill out a history form and asking questions word for word** may discourage the establishment of a therapeutic relationship with the client.

The history of present illness is

- A. information about family members with the same health problem
- B. Extensive information about a body system

- C. The primary care provider's report of the client.
- D. A chronological description of the client's chief concern.

- **Answer is D**
- The HPI (chief complaint) is a **chronological description of the client's chief concern starting from the farthest point in time to the present.**
- **Family member info** is **part of the family history** Ask them
- Info about **body systems is part of the ROS.**
- The **primary care providers report is more inclusive** than the HPI

Which of the following is true regarding inspection?

- A. Very little information is provided
- B. Adequate time should be allowed.
- C. It must be done quickly to avoid making the client uncomfortable
- D. It can be eliminated if the client is too modest.

- Correct Answer B
- Inspection reveals a great deal of information and the nurse should devote adequate time during the physical exam for inspection.
- It is a necessary component of the physical exam.

DAY 2

Assessment of an older adult reveals significant tenting of the skin over the forearm. Which of the following best explains this finding?

- A. Loss of adipose tissue and elasticity
- B. Parchment like skin
- C. Significant flaking and dryness
- D. Skin tags

- Answer is A
- Tenting is loss of adipose tissue and elasticity of the skin.
- Parchment like skin , dryness, skin tags do not cause tenting.
- When auscultating breath sounds, the nurse should
  - A. listen to the top of the anterior chest & then the top of the posterior chest
  - B. compare side to side proceeding from top to bottom
  - C. Listen only to the posterior chest
  - D. Complete one side of the chest before proceeding to the other side
- **Correct answer B**

- Comparing side to side breath sounds is the correct technique to use. This allows comparison between right and left lungs in a systematic way.
- The correct order for performing assessment techniques for the abdomen is
    - A. inspection palpation percussion auscultation
    - B. Inspection auscultation palpation percussion
    - C. Auscultation inspection percussion palpation
    - D. Auscultation palpation percussion inspection
- Why is this important?
- Correct answer is B
- Inspection auscultation palpation percussion
- If you do palpation or percussion you may change the exam results as bowel sounds may increase etc. from stimulation or if patient has pain you may not be able to go further with the exam.
- A client expresses concern over the confidentiality of the information she is providing during a health history. The nurse should respond by telling the client
    - A. Exactly with whom the information will be shared
    - B. That it is required for her to give any information when requested
    - C. A confidential piece of information about herself.
    - D. Not to worry about anything.
- **Correct answer is A**
- **The client has the right to confidentiality and the right to know with whom her information will be shared.**
- *The client has the right to refuse to reveal information if she chooses.*
- *The nurse telling the client confidential information about herself is not professional.*
- *Telling the client not to worry discounts their concerns.*