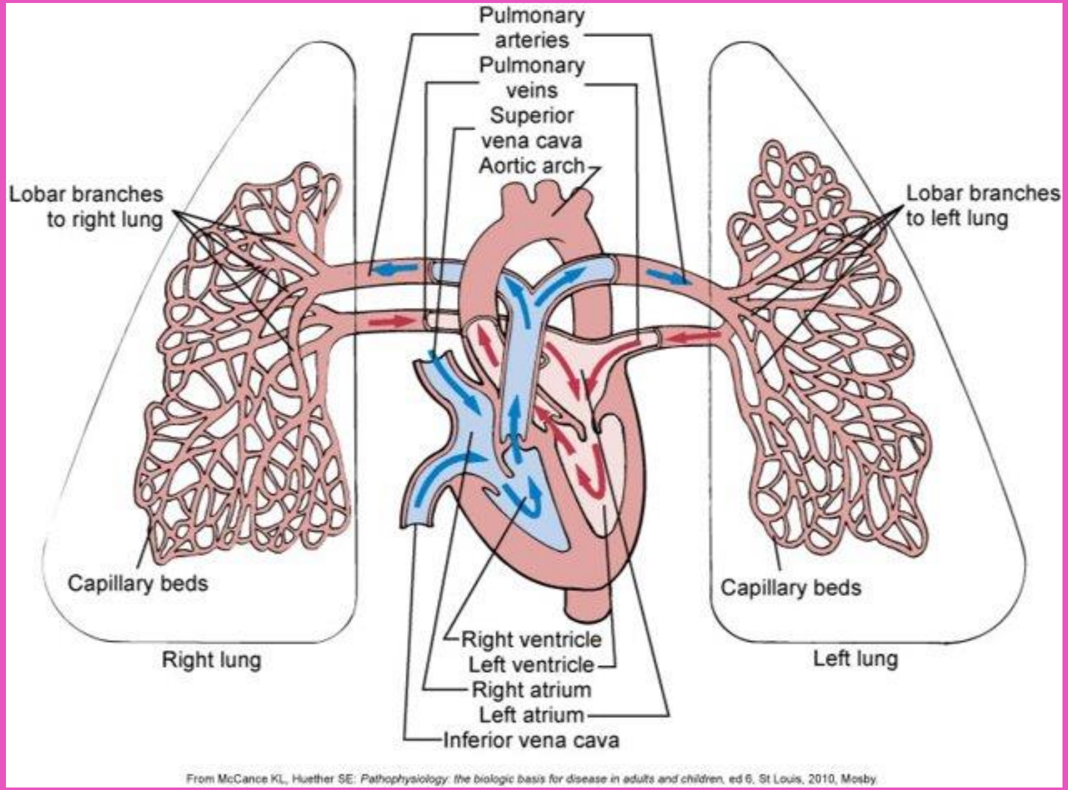
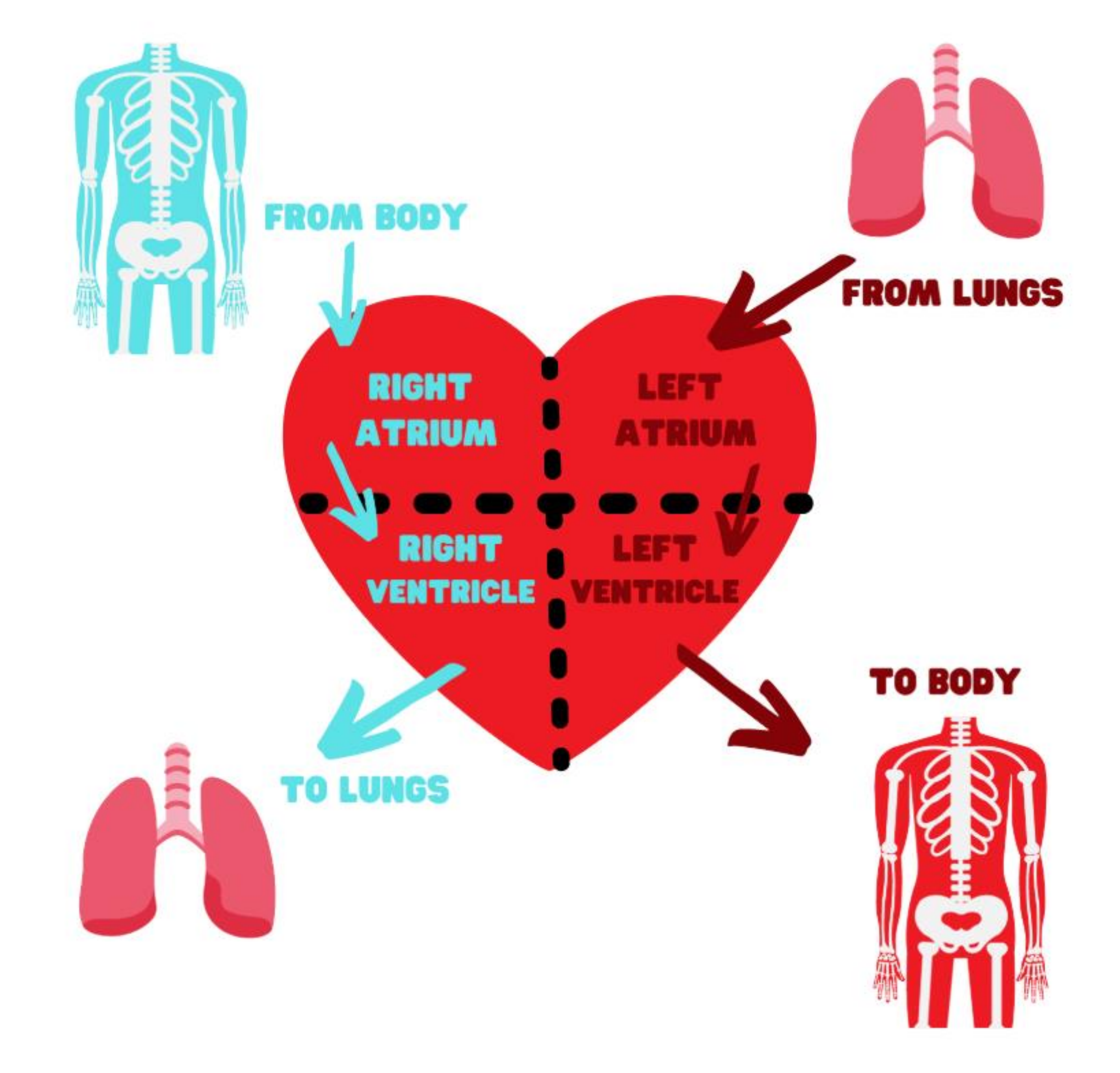
BASIC ANATOMY REVIEW

IM1 – SPRING 26

CARDIAC REVIEW

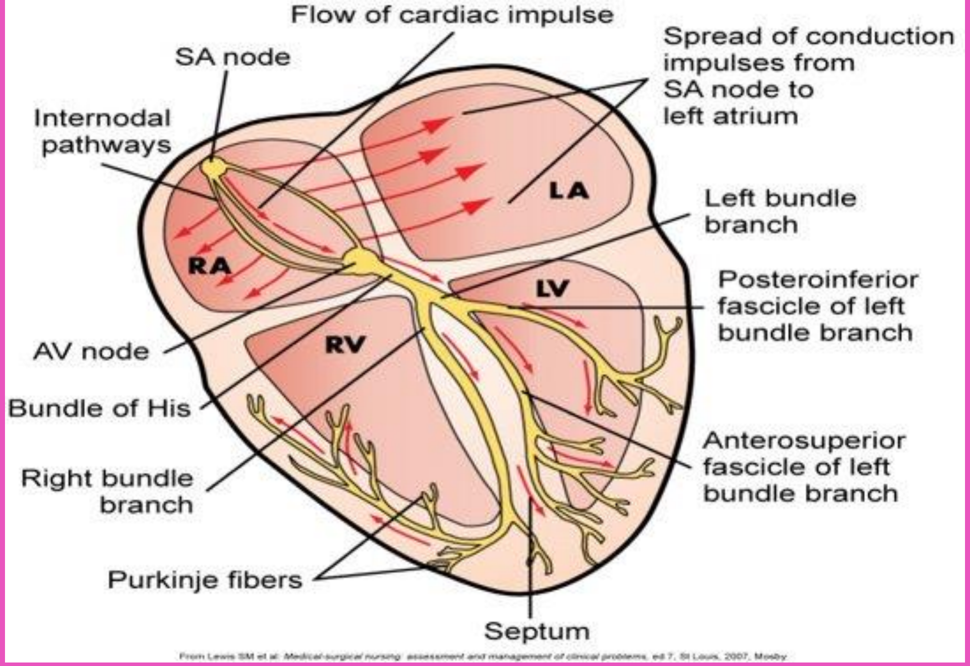
Pathophysiology of blood flow

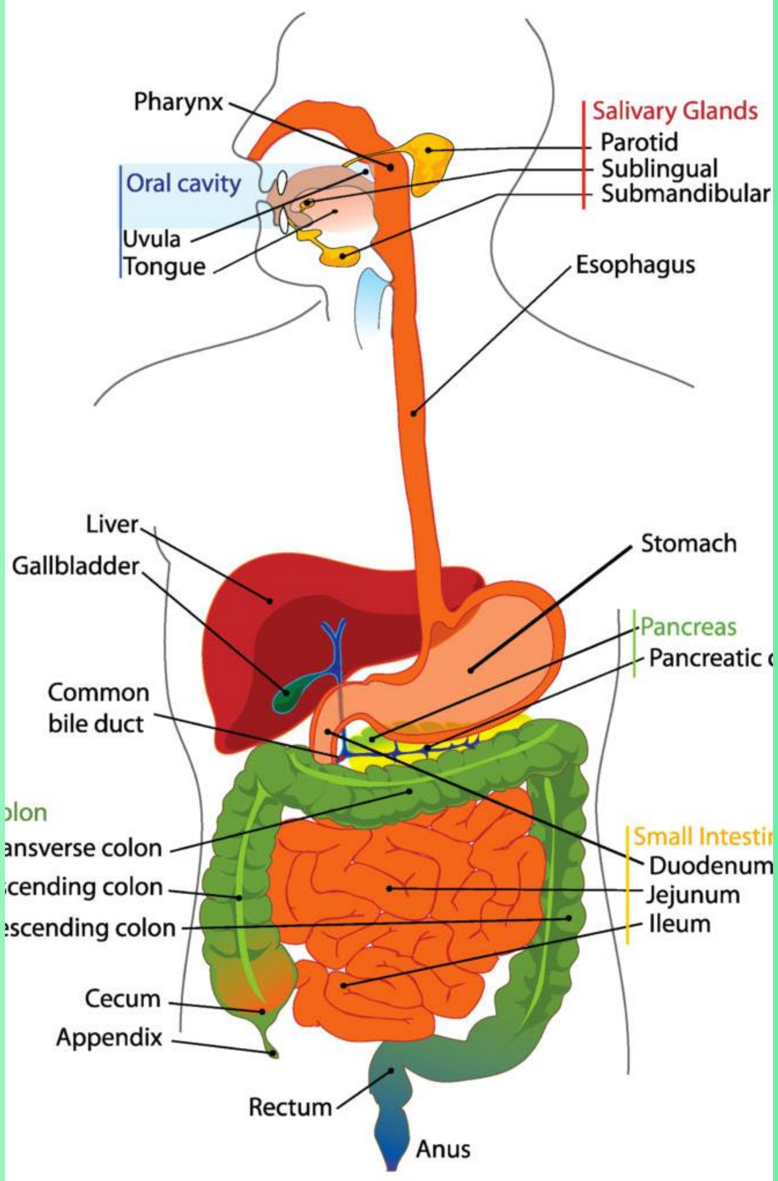



FROM BODY
FROM LUNGS
RIGHT ATRIUM
LEFT ATRIUM
RIGHT VENTRICLE
LEFT VENTRICLE
TO BODY
TO LUNGS

CARDIAC REVIEW

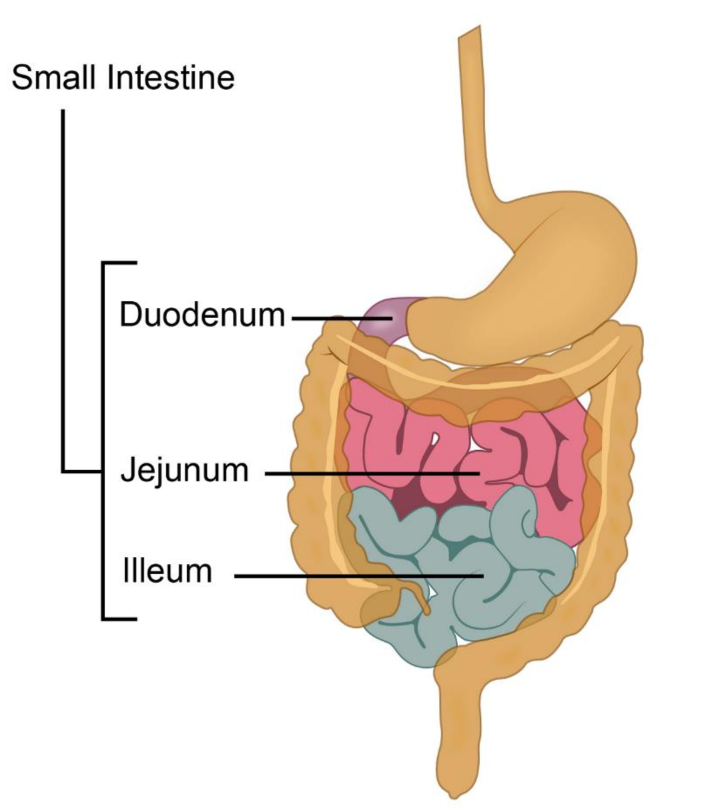
Conduction of the heart





GASTROINTESTINAL REVIEW

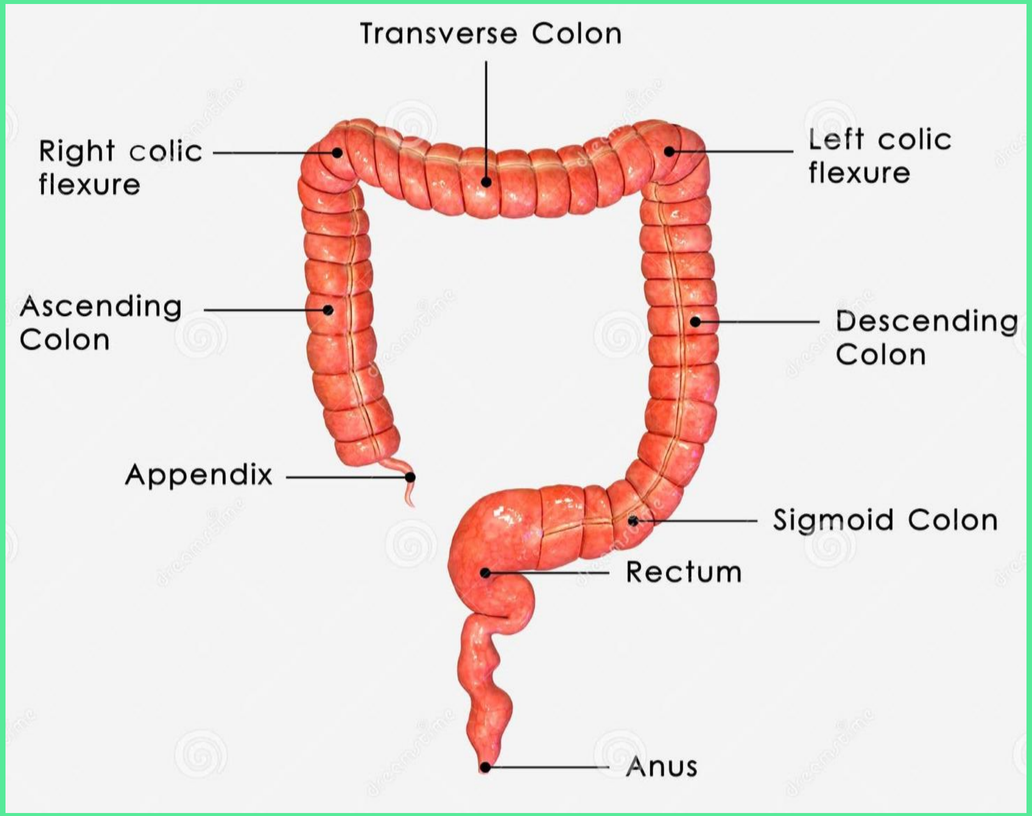
SMALL INTESTINE



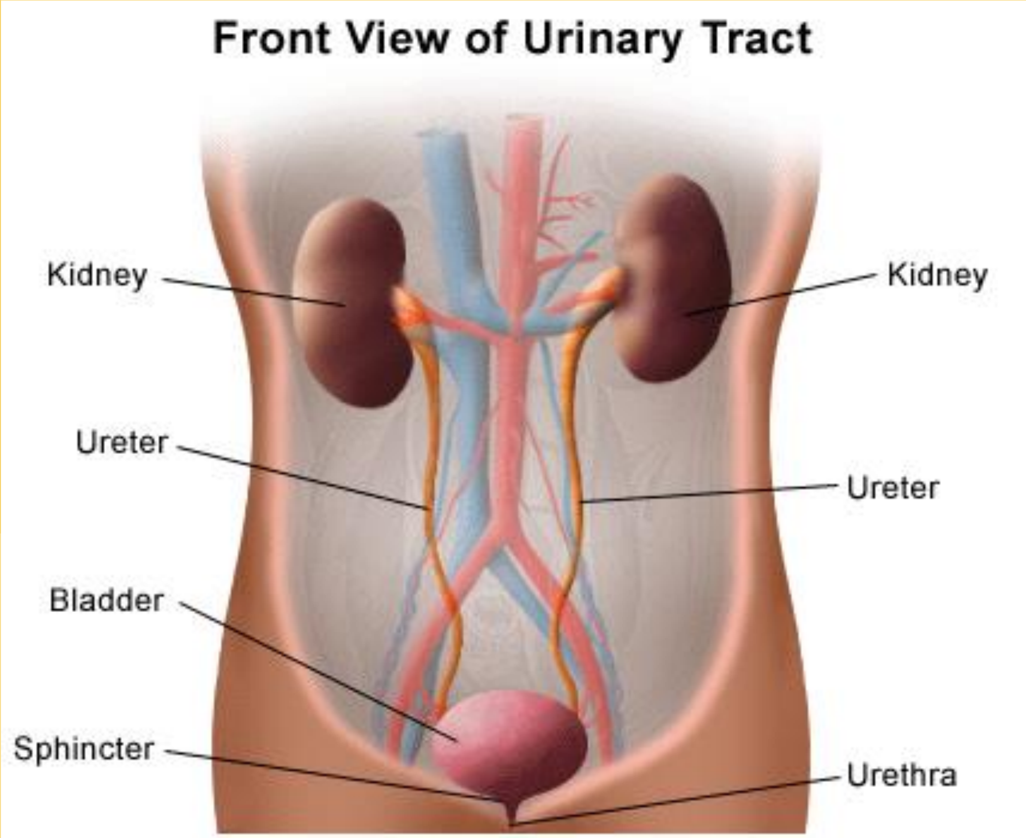
- Folded, twisted and coiled tube from stomach to large intestine
- 1" in diameter and 20' long
- Most digestion and absorption happens here
- Chyme travels via peristalsis
- Three segments:
  - Duodenum
  - Jejunum
  - Ileum

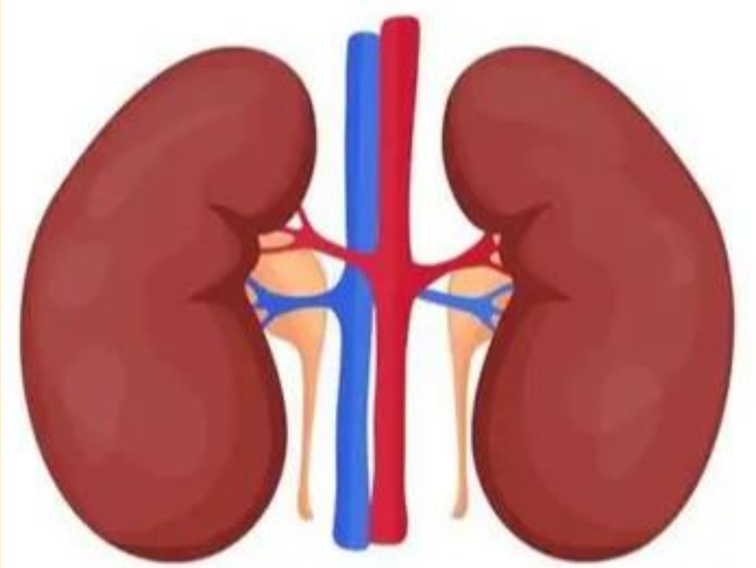
LARGE INTESTINE

- Colon
- 2.5' in diameter and 5-6' long
- Seven Segments:
    - Cecum
    - Ascending colon
    - Transverse colon
    - Descending colon
    - Sigmoid colon
    - Rectum
    - Anus



GENITOURINARY REVIEW





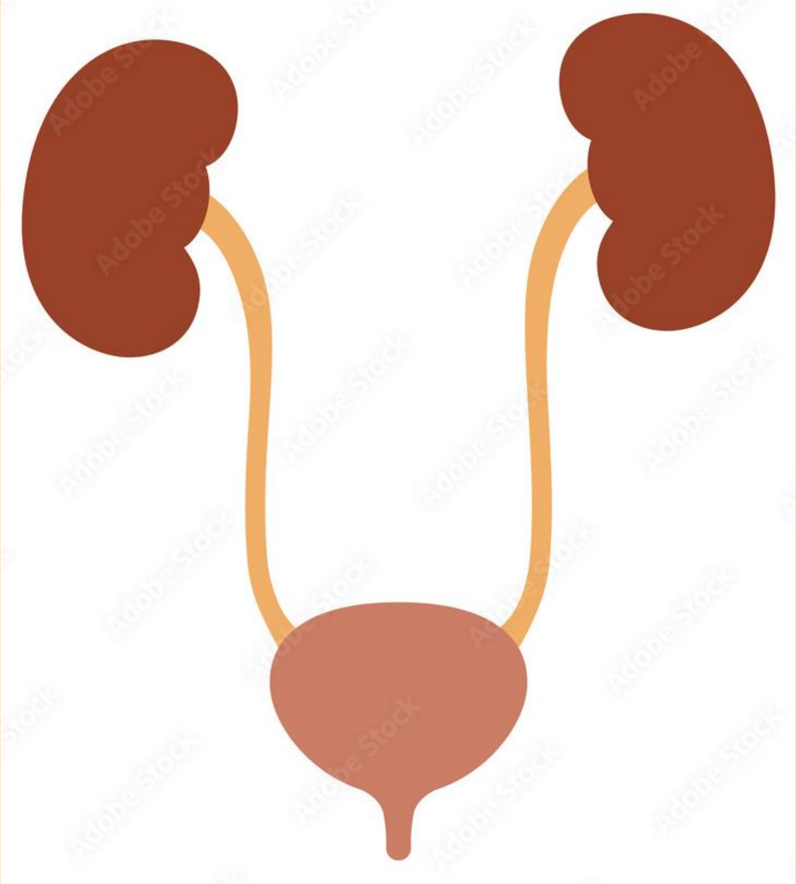
KIDNEYS

Functions:

- Filter and regulate
- Remove waste from blood to form urine
- Primary regulator of fluid and acid-base balance

Characteristics:

- Bilateral, posterior flanks
- Size of fists



URETERS

Functions:

- Transport urine from kidneys to bladder

Characteristics:

- Bilateral tubular structures
- Urine is sterile travelling through
- Enter bladder obliquely and posteriorly to prevent reflux
- Obstructions cause peristaltic waves
    - Severe pain often referred to as renal colic

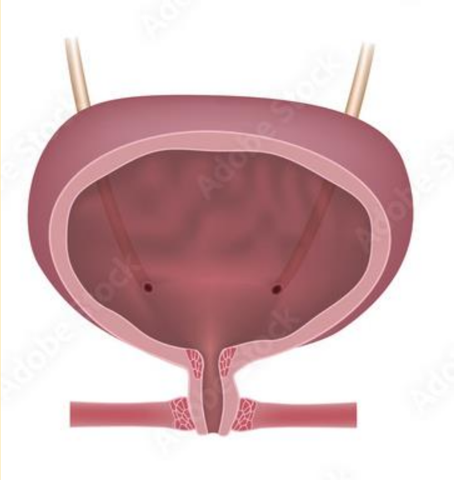
BLADDER

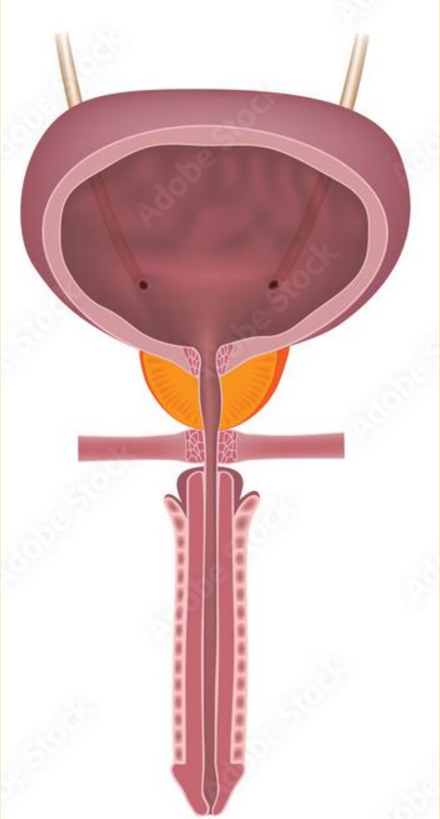
Functions:

- Reservoir for urine until urge develops

Characteristics:

- Hollow, distensible, muscular organ
- Bladder lies against anterior wall of rectum (MEN)
- Bladder rest against anterior wall of uterus and vagina (WOMEN)
- When full, extends above pubic symphysis
- Holds approximately 500 ml and can extend to 1000 mL





URETHRA

Functions:

- Urine travels from bladder and exits through urethral meatus

Characteristics

- Descends through pelvic floor muscles
- Contraction of pelvic floor muscles can prevent urine flow
- Women: 1.5 to 2.5 inches
  - Leads to prevalence of infection
- Men: 8 inches
  - Serves in both GU and reproductive system
  - Prostatic, membranous and penile

PHYSICAL ASSESSMENT

LEARNING OUTCOMES

- Describe how to actively utilize the Nursing Process when providing patient care
- Identify the types of physical assessment formats and at what times they care utilized during patient care
- Compare and contrast methods of data collection when obtaining a health history and the potential sources of data
- Identify the components of a General Survey
- Describe the techniques used during a physical assessment
- Perform a comprehensive and focused physical assessment on a patient

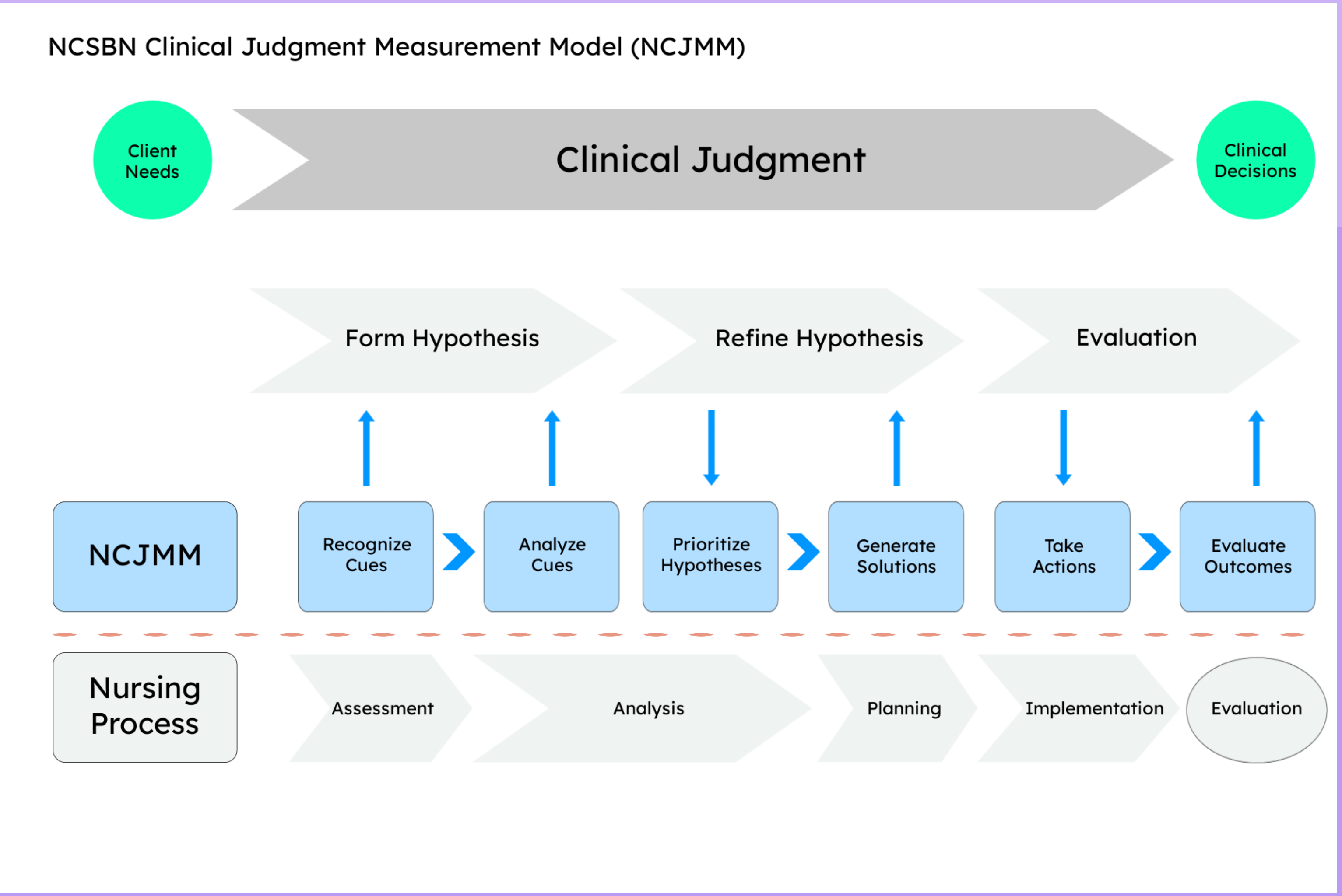
PURPOSE OF PHYSICAL ASSESSMENT

- Gather baseline data about a patient's health status
- Supplement, confirm, or refute subjective data obtained
- Identify and confirm nursing diagnosis
- Make clinical decisions about a patient's changing health status and management
- Evaluate the outcomes of care

NURSING PROCESS AND PHYSICAL ASSESSMENT

- Assessment
- Analysis
- Planning
- Implementation
- Evaluation

NCSBN CLINICAL JUDGEMENT MODEL



ELEMENTS OF ASSESSMENT

History

- Baseline
- Problem based

Examination

- Vital signs
- Inspection
- Auscultation
- Palpation

METHODS OF DATA COLLECTION

Interview

Health History

Physical Examination

Diagnostic and Laboratory Results

INTERVIEW

- Complete PIOR to exam
- Primary and secondary data
- Subjective and objective data

HEALTH HISTORY

- Past medical history
- Recent illnesses
- Social history
- Medication list

TECHNIQUES USED DURING ASSESSMENT

- Inspection
- Auscultation
- Percussion
- Palpation

GENERAL SURVEY

What do you see, hear, smell and observe?

- Gender/race
- Age
- Signs of distress
- Body type
- Gait, body movements, posture
- Hygiene, grooming, body odor
- Dress
- Affect/mood
- Speech
- Substance abuse or signs of

INSPECTION

- Use adequate lighting and pen light when needed
- Inspect each area (bilaterally) for size, shape, color, symmetry, position and abnormality
- Position/expose body parts as needed so that all surfaces can be viewed

AUSCULTATION: CHARACTERISTICS OF SOUND

Frequency:

- Number of sound wave cycles per second generated by a vibrating object

Loudness:

- Amplitude of sound waves

Quality:

- Terms describe the quality of sound

Duration:

- Length of time the sound last

AUSCULTATION: STETHOSCOPE

ALWAYS PLACE DIRECTLY ON THE SKIN

- **Bell:**
  - Best for low pitched sounds
  - Heart and Vascular Sounds
- **Diaphragm:**
  - Best for high pitched sounds
  - Lung and bowel sounds

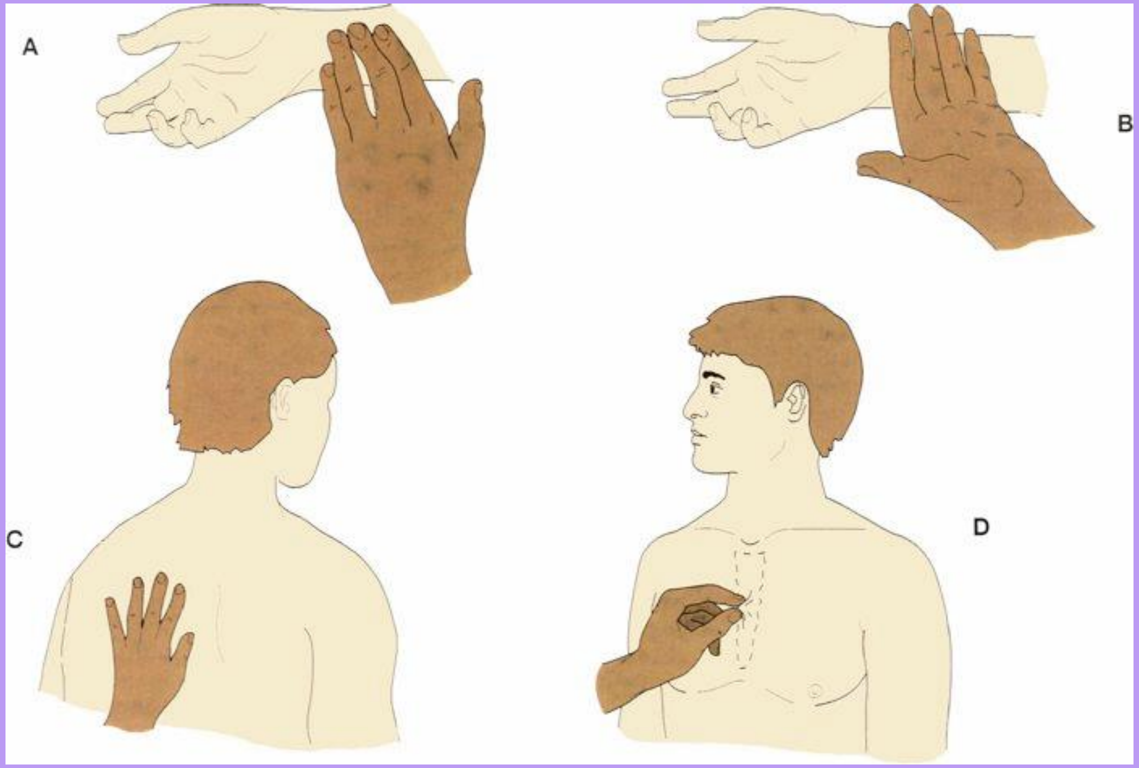
PALPATION

- Manual/bimanual technique
- Dorsal surface of hand
- Palmar surface and finger/finger pads
- Light palpation: 1 cm (1/2 in) depth
- Deep palpation: 4 cm (2 in) depth

Palpate to Assess:

- Texture and thickness
- Resistance/resilience
- Mobility
- Temperature and moisture
- Shape

PERFORMING PALPATION



OLFACTION

Helps detect abnormalities

- Alcohol on breath
- Foul smelling odor from wound
- Sweet smelling odor from mouth

PHYSICAL ASSESSMENT CONSIDERATIONS

- Cultural sensitivity
- Infection control
- Environment
- Equipment

SPECIAL CONSIDERATIONS FOR OLDER PATIENTS

Recognize physical and sensory limitations

- May need to adjust position
- May need to allow more time
- May need to allow more space

Recognize normal changes of aging vs abnormal

Common Physiological Changes with Aging at a Glance

System	Common Changes
Integumentary	Loss of skin elasticity with fat loss in extremities; pigmentation changes; glandular atrophy (oil, moisture, sweat glands); thinning hair, with hair turning gray-white (facial hair: decreased in men, increased in women); slower nail growth; atrophy of epidermal arterioles
Respiratory	Decreased cough reflex and ciliary activity; increased anterior-posterior chest diameter; increased chest wall rigidity; fewer alveoli, increased airway resistance
Cardiovascular	Thickening of blood vessel walls, narrowing of vessel lumen, loss of vessel elasticity, lower cardiac output, decreased number of heart muscle fibers, decreased elasticity and calcification of heart valves, decreased baroreceptor sensitivity, decreased efficiency of venous valves, increased pulmonary vascular tension, increased systolic blood pressure, decreased peripheral circulation
Gastrointestinal	Periodontal disease; decrease in saliva, gastric secretions, and pancreatic enzymes; smooth-muscle changes with decreased peristalsis and small intestinal motility; gastric atrophy; decreased production of intrinsic factor; increased stomach pH; loss of smooth muscle in the stomach; hemorrhoids; rectal prolapse; impaired rectal sensation

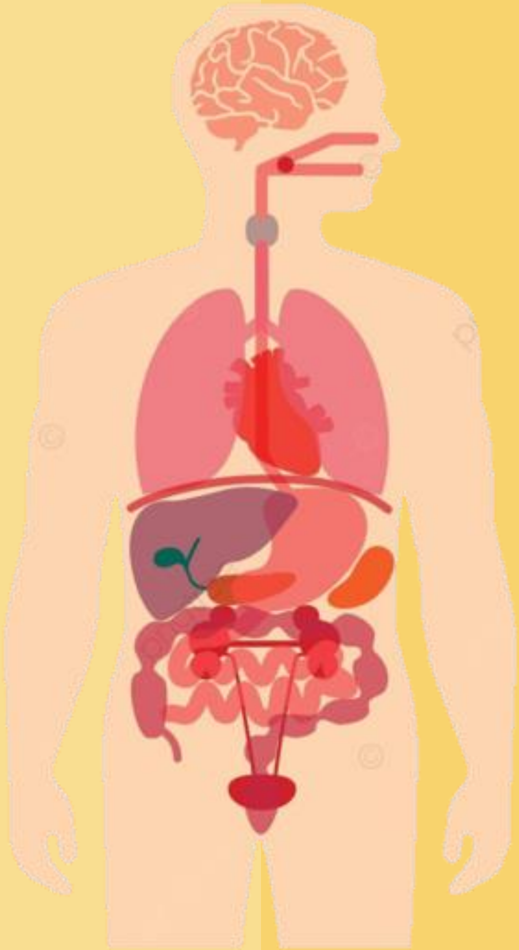
Potter and Perry, Fundamentals of Nursing, Table 14.1

Musculoskeletal	Decreased muscle mass and strength, decalcification of bones, degenerative joint changes, dehydration of intervertebral disks, fat tissue increases
Neurological	Degeneration of nerve cells, decrease in neurotransmitters, decrease in rate of conduction of impulses
Sensory	
Eyes	Decreased accommodation to near/far vision (presbyopia), difficulty adjusting to changes from light to dark, yellowing of the lens, altered color perception, increased sensitivity to glare, smaller pupils
Ears	Loss of acuity for high-frequency tones (presbycusis), thickening of tympanic membrane, sclerosis of inner ear, buildup of earwax (cerumen)
Taste	Often diminished, often fewer taste buds
Smell	Often diminished
Touch	Decreased skin receptors

Potter and Perry, Fundamentals of Nursing, Table 14.1

Proprioception	Decreased awareness of body positioning in space
Genitourinary	Fewer nephrons, 50% decrease in renal blood flow by age 80, decreased bladder capacity Male—enlargement of prostate Female—reduced sphincter tone
Reproductive	Male—sperm count diminished, smaller testes, erections less firm and slow to develop Female—decreased estrogen production; degeneration of ovaries; atrophy of vagina, uterus, and breasts; dryness of vaginal mucosa
Endocrine	General—alterations in hormone production with decreased ability to respond to stress Thyroid—diminished secretions Cortisol, glucocorticoids—increased anti-inflammatory hormone Pancreas—increased fibrosis, decreased secretion of enzymes and hormones, decreased sensitivity to insulin
Immune	Thymus decreases in size and volume T-cell function decreases Core temperature elevation is lowered

Potter and Perry, Fundamentals of Nursing, Table 14.1



HEAD TO TOE PHYSICAL ASSESSMENT

PREPARING FOR THE ASSESSMENT

- Gather all necessary equipment
- AIDET
- Hand hygiene before and after ANY contact with patient
- Don PPE if necessary
- Clean equipment between patients
- Make patient comfortable; allow for privacy and confidentiality

BEFORE YOU BEGIN

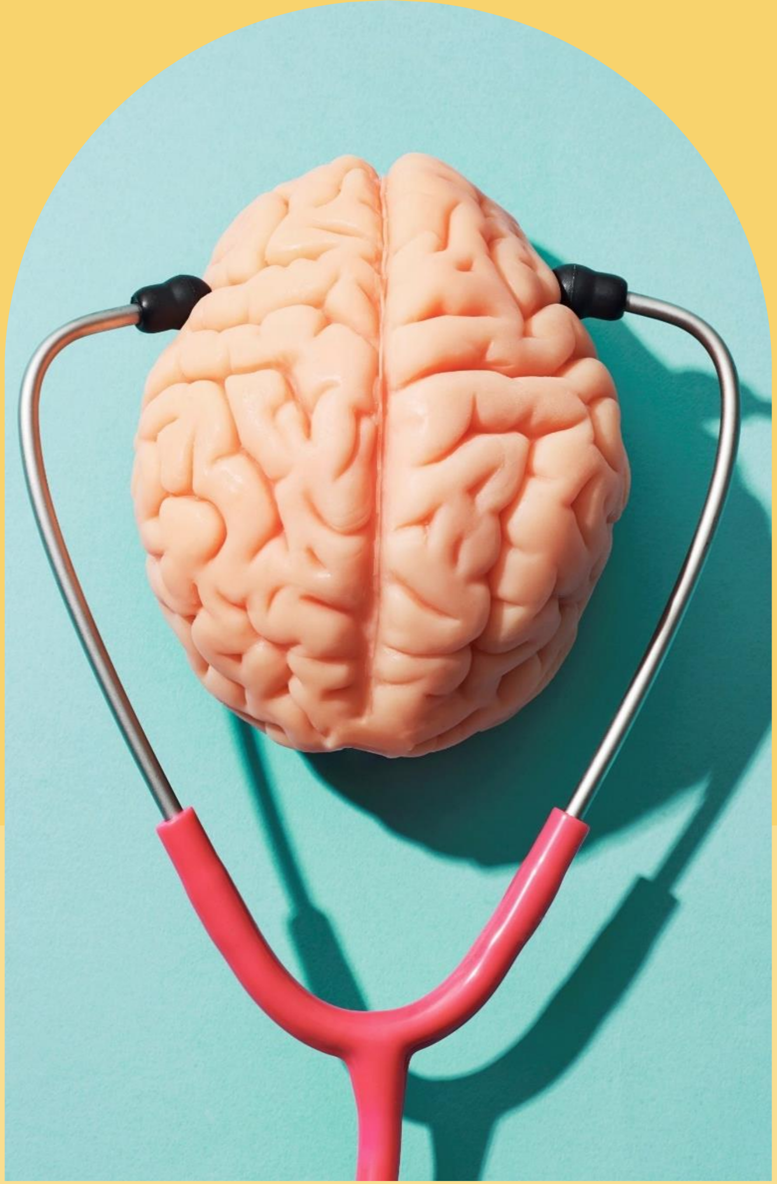
Obtain vital signs

- Are they within normal limits (WNL)?
- If not, report it to TPCN or CN

Height and Weight

- Height in inches
- Weight in kilograms (1 kg = 2.2 lbs)

NEUROLOGICAL ASSESSMENT



LEVEL OF CONSCIOUSNESS (LOC)

Alert: attentive, follows commands, if asleep – wakes promptly and remains attentive

Lethargic: drowsy but awakens, slow to respond

Obtunded: difficult to arouse, needs constant stimulation

Stuporous/Semi-comatose: arouses only to vigorous/noxious stimuli, may only withdraw from pain

Comatose: no response to verbal or noxious stimuli, no movement except deep tendon reflexes

COGNITIVE AWARENESS

Is the patient oriented to person, place, time and event?

Also known as mentation (using mind to think)

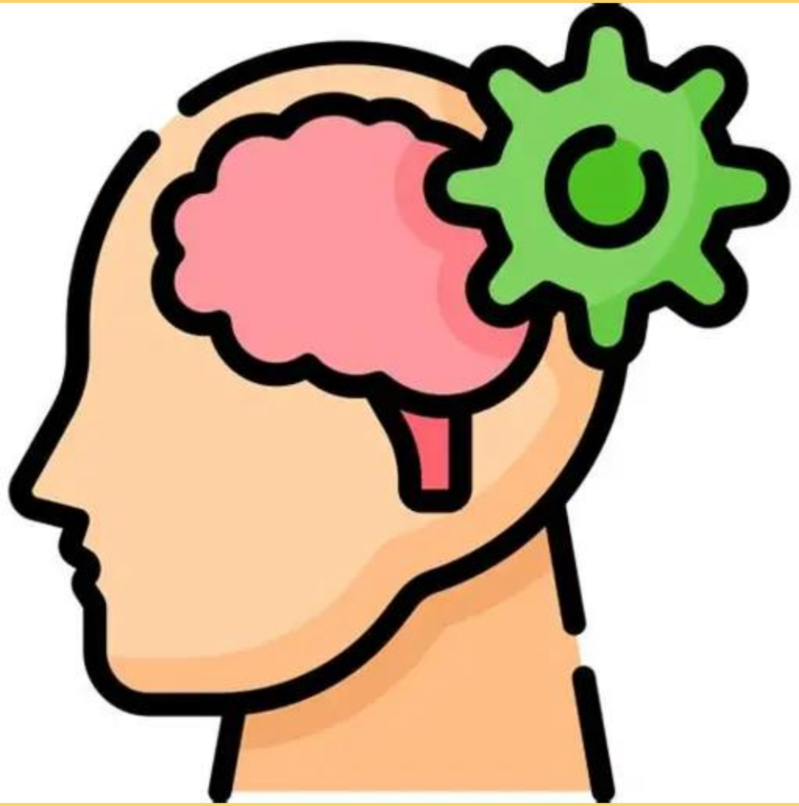
TESTING COGNITIVE AWARENESS

What is your name and date of birth?

Where are you right now?

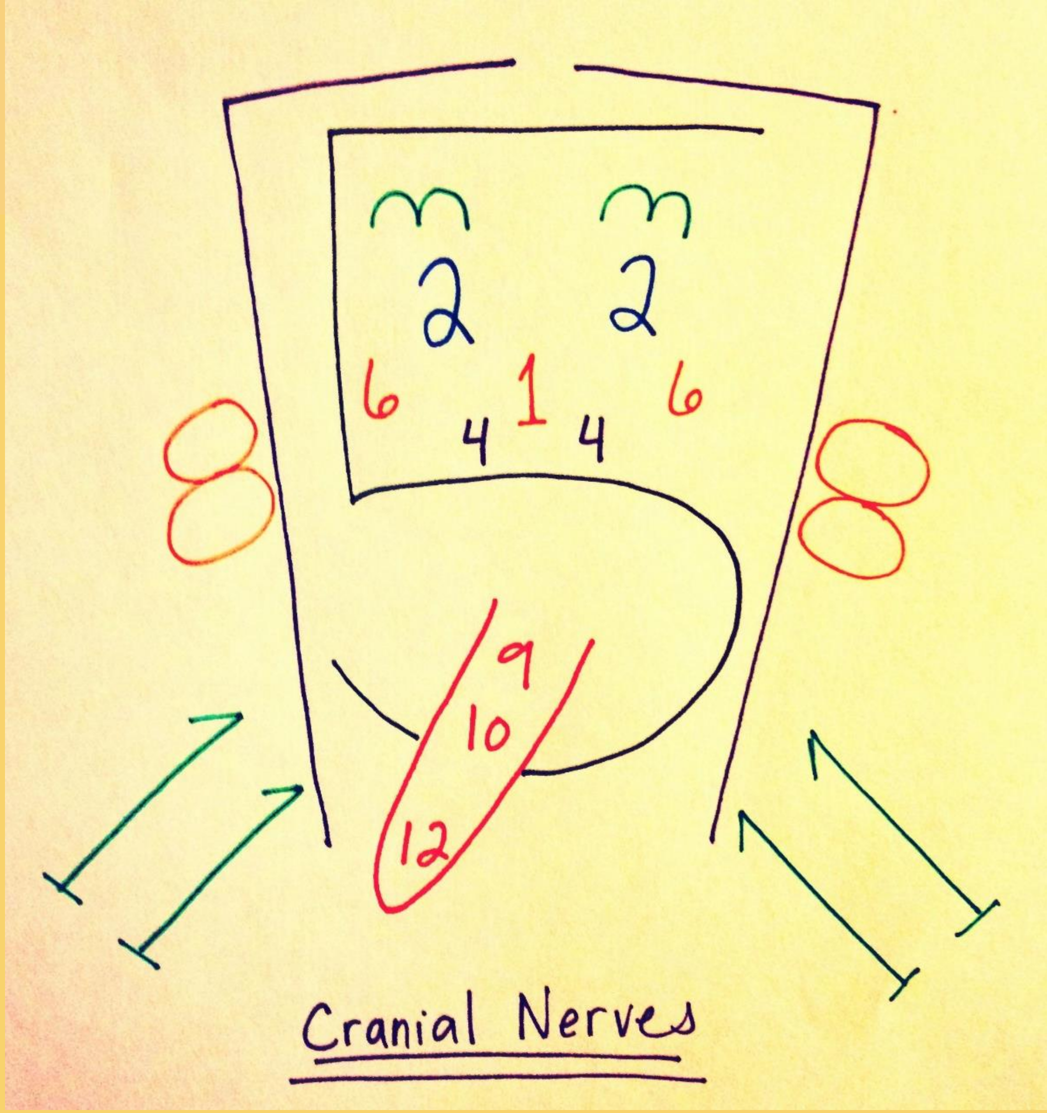
What year or day is it?

What brought you to the hospital?



CRANIAL NERVES

- 12 pairs
- Sensory, motor, or both
- Not all cranial nerves are always tested
- Listed in order of testing



CRANIAL NERVES

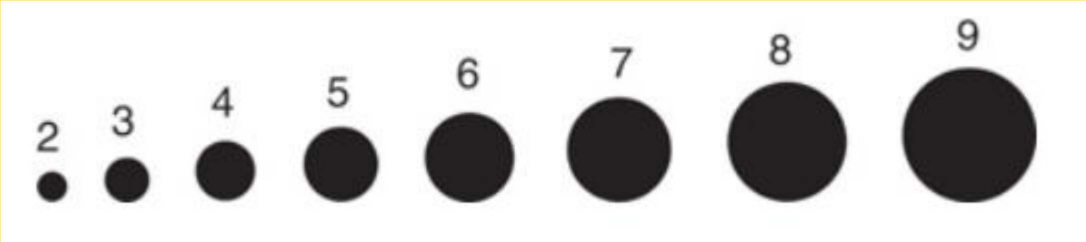
I. Olfactory
II. Optic
III. Oculomotor
IV. Trochlear
V. Trigeminal
VI. Abducens
VII. Facial
VIII. Auditory
IX. Glossopharyngeal
X. Vagus
XI. Spinal accessory
XII. Hypoglossal

TESTING CRANIAL NERVES III, IV & VI

Pupil Response

- Examine size and shape, compare to scale
- Start at ear with penlight and move in toward nose
- Note change in size and speed of reaction
- With penlight off, move penlight close to and away from pupils

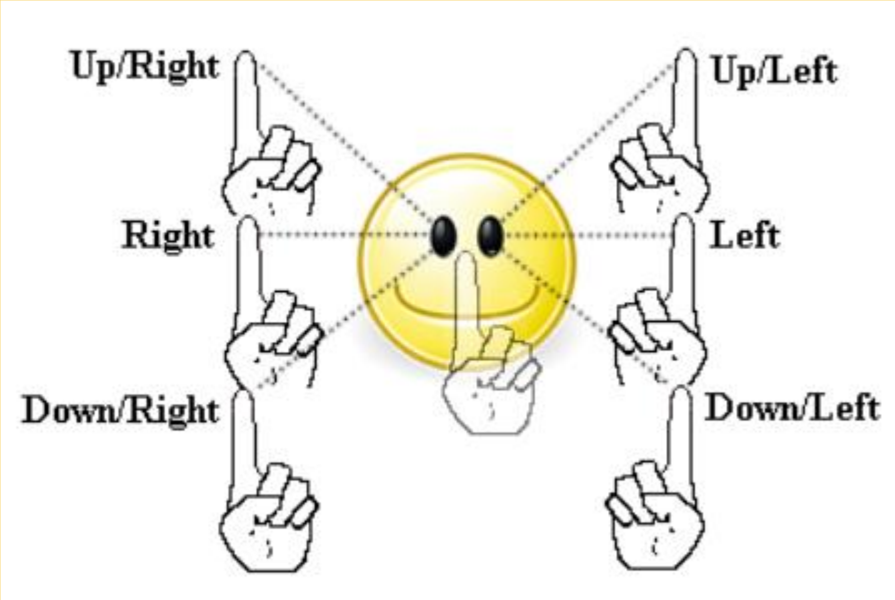
Pupils
Equal
Round
React to
Light and
Accommodation



CARDINAL GAZE

Testing Cranial Nerves III, IV and VI

- Use tip of penlight
- Have patient follow with eyes only
- About 9-12' from face, move the end of penlight in an "H" motion



TESTING CRANIAL NERVE VII

Ask patient to smile and show teeth

Ask patient to wrinkle forehead or raise eyebrows

TESTING CRANIAL NERVE XI

Place hands lightly on patient shoulders

Ask patient to shrug shoulders

TESTING CRANIAL NERVE XII

Ask patient to touch the roof of mouth with tongue

Protrude tongue out of mouth

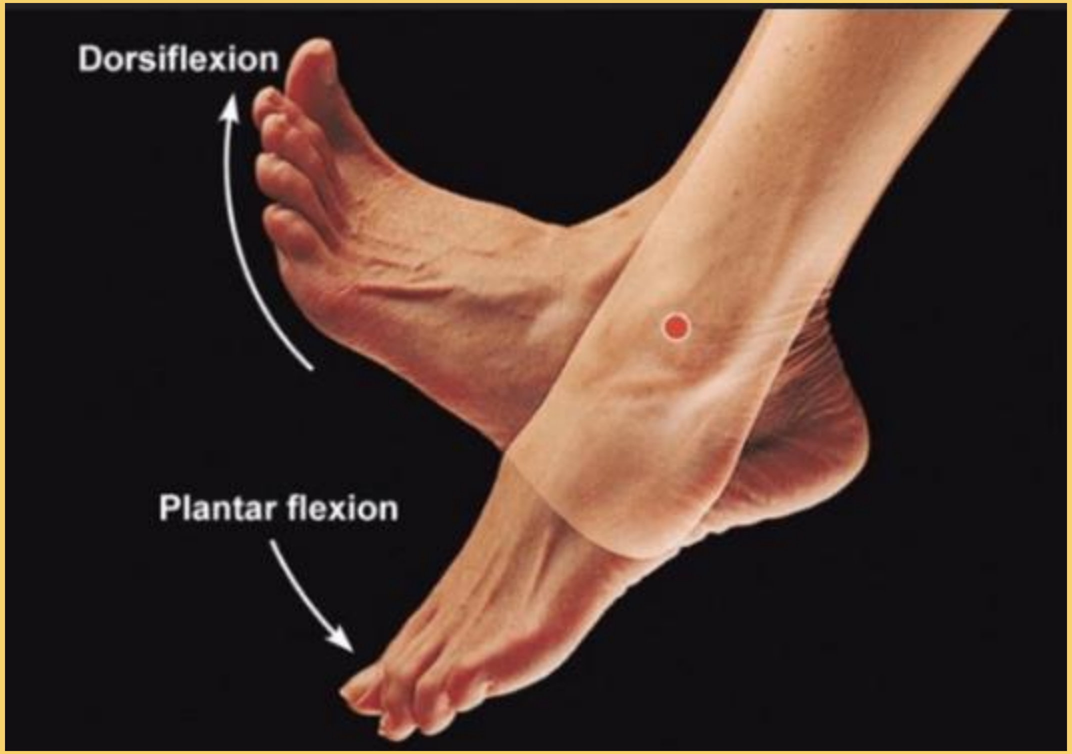
Move tongue side to side

TESTING MOTOR FUNCTION

Will complete as part of neuro and musculoskeletal assessments

Done bilaterally on BUE and BLE

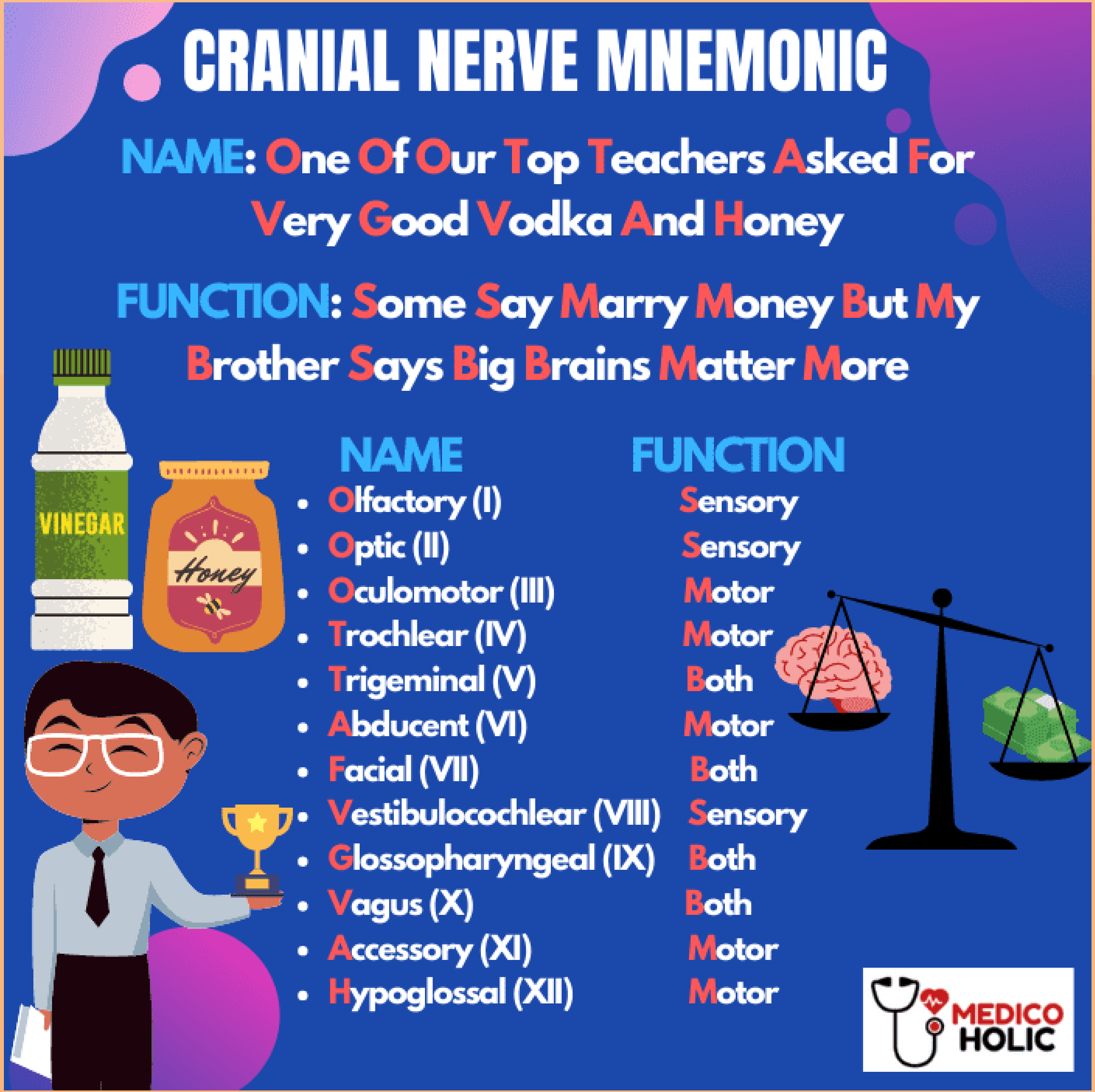
- Hand grasp and toe wiggle (HGTW)
- Flexion and extension with resistance



NEURO ASSESSMENT SUMMARY

- LOC and orientation
- Pupil response and cardinal gaze
- Smile and show teeth, raise eyebrows
- Tongue to roof of mouth, out and side to side
- Shoulder strength with resistance
- HGTW
- Flexion/extension BUE and BLE

Number	Name	Type	Function	Method
I	Olfactory	Sensory	Sense of smell	Ask patient to identify different nonirritating aromas, such as coffee and vanilla.
II	Optic	Sensory	Visual acuity	Use Snellen chart or ask patient to read printed material while wearing glasses.
III	Oculomotor	Motor	Extraocular eye movements: inward, up and inward, up and outward, down and outward	Assess six directions of gaze.
			Pupil constriction and dilation	Measure pupillary reaction to light reflex and accommodation.
			Opening the eye	
IV	Trochlear	Motor	Downward, inward eye movements	Assess six directions of gaze.
V	Trigeminal	Sensory and motor	Sensory nerve to skin of face	Lightly touch cornea with wisp of cotton. Assess corneal reflex. Measure sensation of light pain and touch across skin of face.
			Motor nerve to muscles of jaw	Palpate temples as patient clenches teeth.
VI	Abducens	Motor	Lateral movement of eyeballs	Assess six directions of gaze.
VII	Facial	Sensory and motor	Facial expression	As patient smiles, frowns, puffs out cheeks, and raises and lowers eyebrows, look for asymmetry.
			Taste	Have patient identify salty or sweet taste on front of tongue.
VIII	Auditory	Sensory	Hearing	Assess ability to hear spoken word.
IX	Glossopharyngeal	Sensory and motor	Taste	Ask patient to identify sour or sweet taste on back of tongue.
			Ability to swallow	Use tongue blade to elicit gag reflex.
X	Vagus	Sensory and motor	Sensation of pharynx	Ask patient to say “ah.” Observe movement of palate and pharynx.
			Movement of vocal cords	Assess speech for hoarseness.
			Parasympathetic innervation to glands of mucous membranes of the pharynx, larynx, organs in the neck, thorax (heart and lungs), and abdomen	Assess heart rate, presence of peristalsis.
XI	Spinal accessory	Motor	Movement of head and shoulders	Ask patient to shrug shoulders and turn head against passive resistance.
XII	Hypoglossal	Motor	Position of tongue	Ask patient to stick out tongue to midline and move it from side to side.

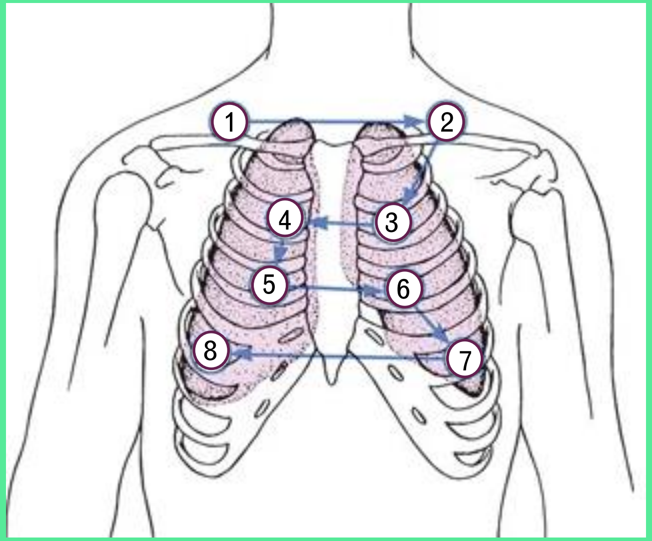

CRANIAL NERVE MNEMONIC
NAME: One Of Our Top Teachers Asked For Very Good Vodka And Honey
FUNCTION: Some Say Marry Money But My Brother Says Big Brains Matter More
NAME
FUNCTION
Olfactory (I) Sensory
Optic (II) Sensory
Oculomotor (III) Motor
Trochlear (IV) Motor
Trigeminal (V) Both
Abducent (VI) Motor
Facial (VII) Both
Vestibulocochlear (VIII) Sensory
Glossopharyngeal (IX) Both
Vagus (X) Both
Accessory (XI) Motor
Hypoglossal (XII) Motor
VINEGAR
Honey
MEDICO HOLIC

RESPIRATORY ASSESSMENT

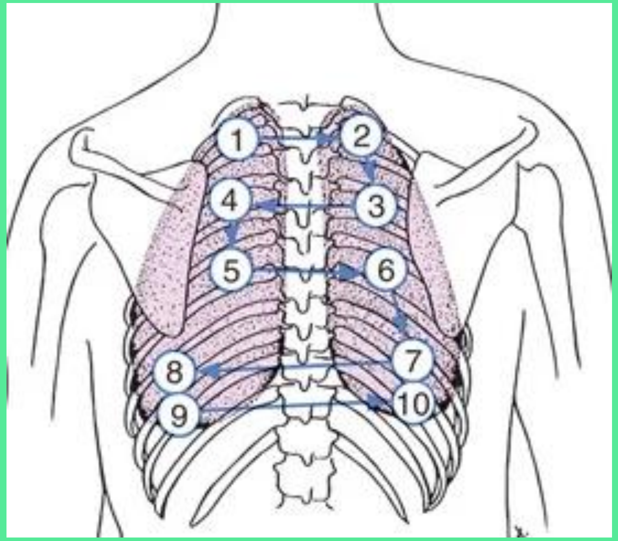
PATTERN OF AUSCULTATION

Listen to entire inspiration and expirations at each position of the stethoscope

How should **normal** breath sounds sound?

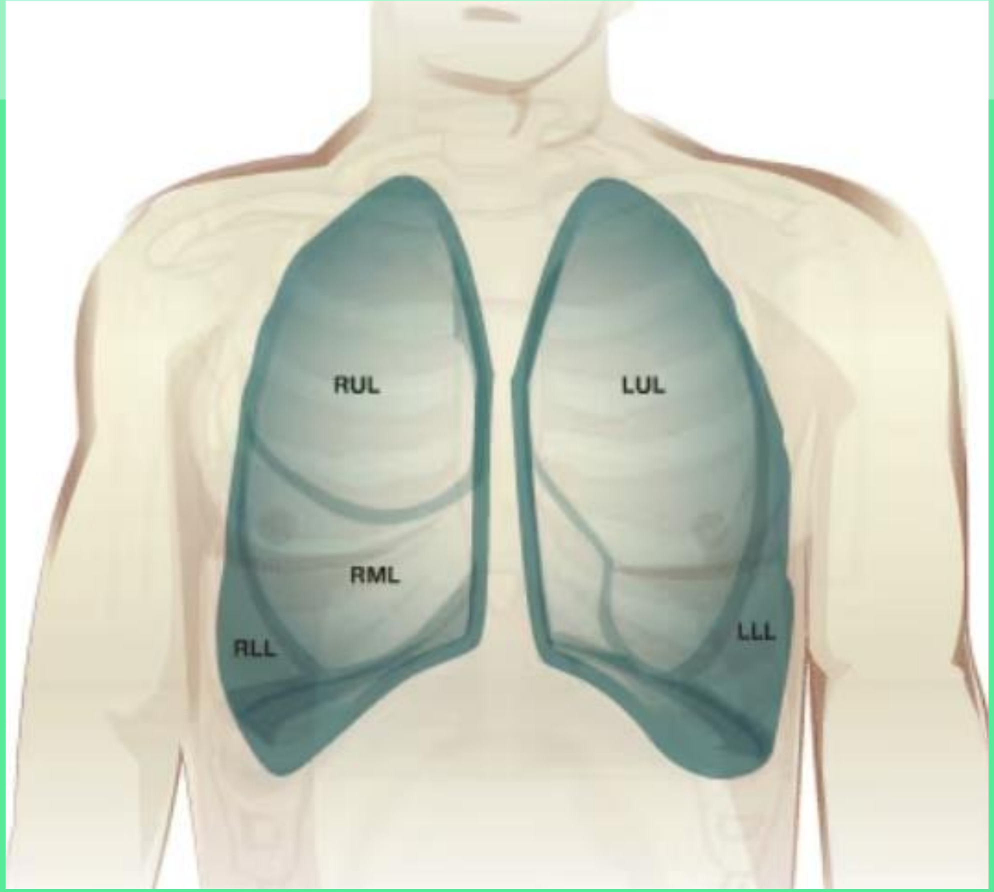


Anterior

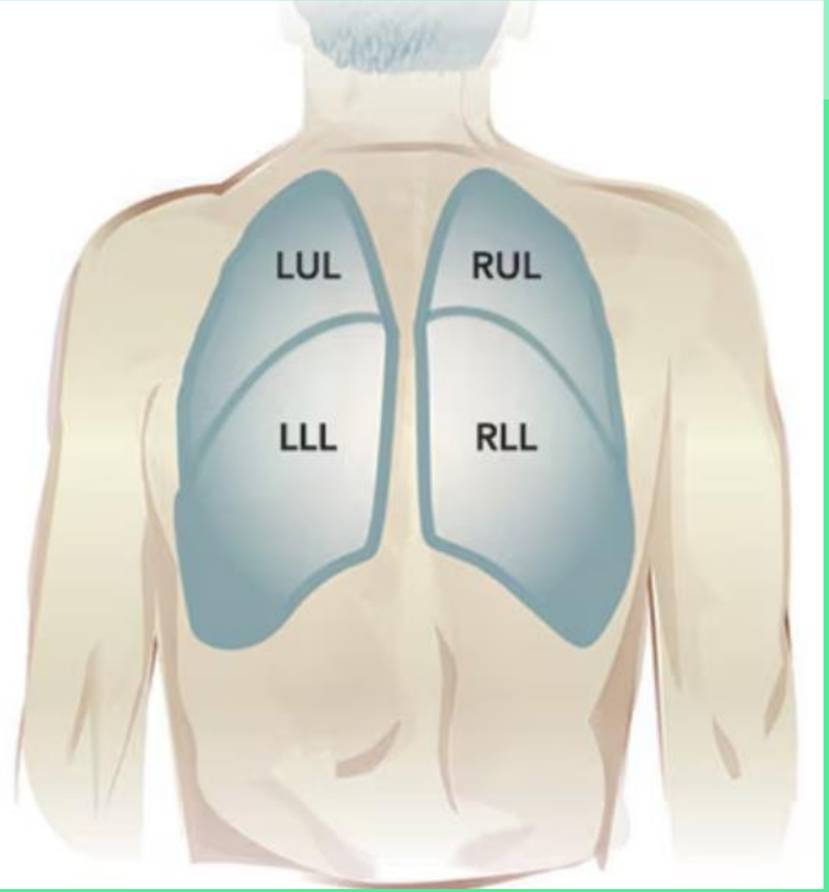


Posterior

Anterior



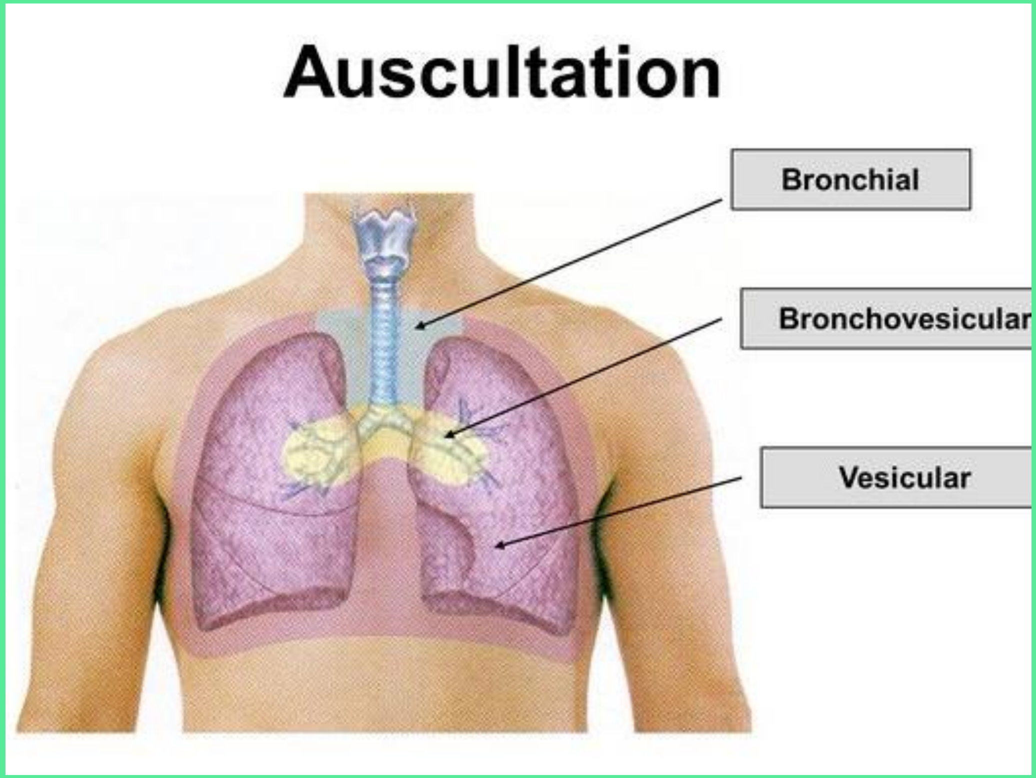
Posterior



AUSCULTATION OF THE LUNGS

Normal Sounds

- **Vesicular:** periphery of the lungs
- **Bronchovesicular:** closer to the sternum
- **Bronchial:** over trachea



ABNORMAL OR ADVENTITIOUS SOUNDS

Crackles

Wheezes

Rhonchi

Pleural Friction Rub

CRACKLES

Heard in the bilateral lung bases

Cause:

- Random, sudden reinflation of groups of alveoli
- Disruptive passage of air through small airways
- Can result from pneumonia, heart failure, chronic lung disease

Character:

- **Fine crackles:** high pitched, short, interrupted crackling sounds heard during end of inspiration
- **Medium crackles:** low pitched, moister sounds heard during middle of inspiration
- **Coarse crackles:** loud, bubbly sounds hears during inspiration

RHONCHI

Primarily heard over trachea and bronchi
If loud enough, can hear over most lung fields

Cause:

- Muscular spasm, fluid, or mucus in larger airways
- New growth
- External pressure causing turbulence

Character:

- Loud, low pitched, rumbling
- Heard in either inspiration or expiration
- Sometimes cleared by coughing

WHEEZES

Heard over all lung fields

Cause:

- High-velocity airflow through severely narrowed/obstructed airway
- Common in asthma and bronchitis

Character:

- High-pitched, continuous musical sounds like a squeak
- Heard continuously during inspiration/expiration
- Louder on expiration

PLEURAL FRICTION RUB

Heard over anterior lateral lung field
Patient must be sitting up right

Cause:

- Inflamed pleura
- Parietal pleura rubbing against visceral pleura
- Common in viral infection

Character:

- Dry, rubbing, or grating quality
- Heard during inspiration or expiration
- Loudest over lower lateral anterior surface

ABNORMAL RESPIRATORY PATTERNS

Eupnea: normal respirations

Bradypnea: respirations < 12 bpm

Tachypnea: respirations > 20 bpm

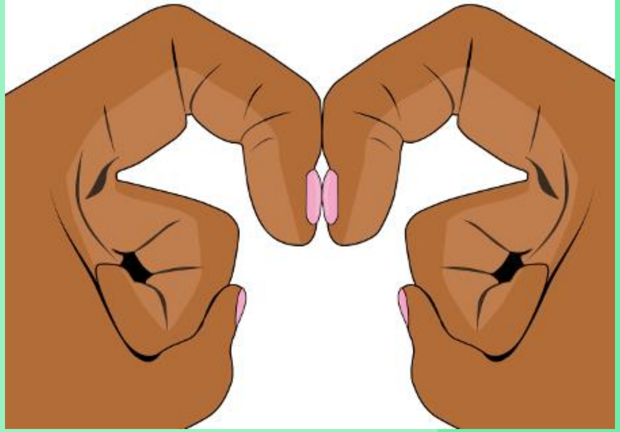
Apnea: absence of respirations

Hyperpnea: respirations deeper and faster or labored

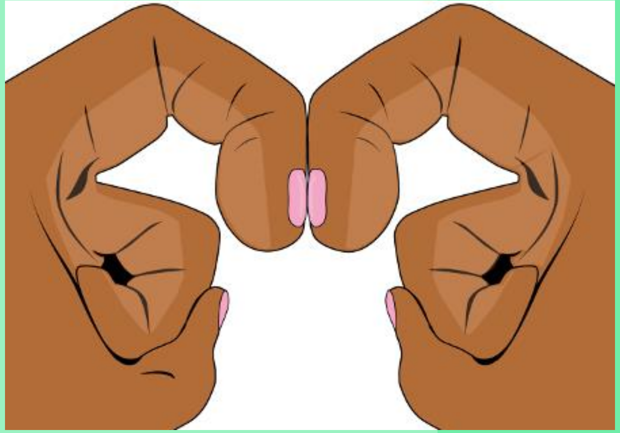
Kussmaul: fast, deep, labored respirations without pause

Cheyne-Stokes: fast, deep respirations punctuated by periods of apnea lasting 20 to 60 seconds

CLUBBING



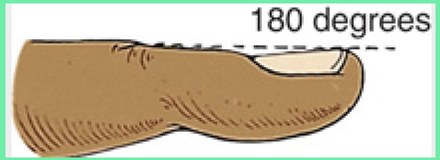
Schamroth's Sign =
NO clubbing

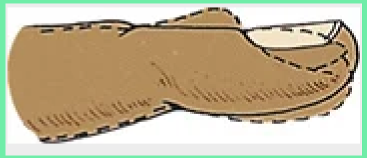


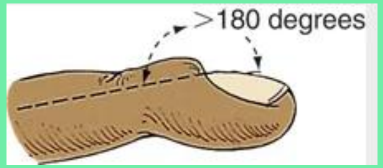
No Schamroth's Sign =
clubbing

- Bulging of the tissues at the nail base
- Results from chronic low blood-oxygen levels related to chronic medical issues
  - Emphysema, congenital heart disease
- Usually chronic, bilateral and painless

Examine shape of bilateral distal ends of fingers and toes







RESPIRATORY ASSESSMENT SUMMARY

- Anterior and posterior lung sounds
- Clubbing

CARDIAC ASSESSMENT

HEART SOUNDS

LUB: systole or S1

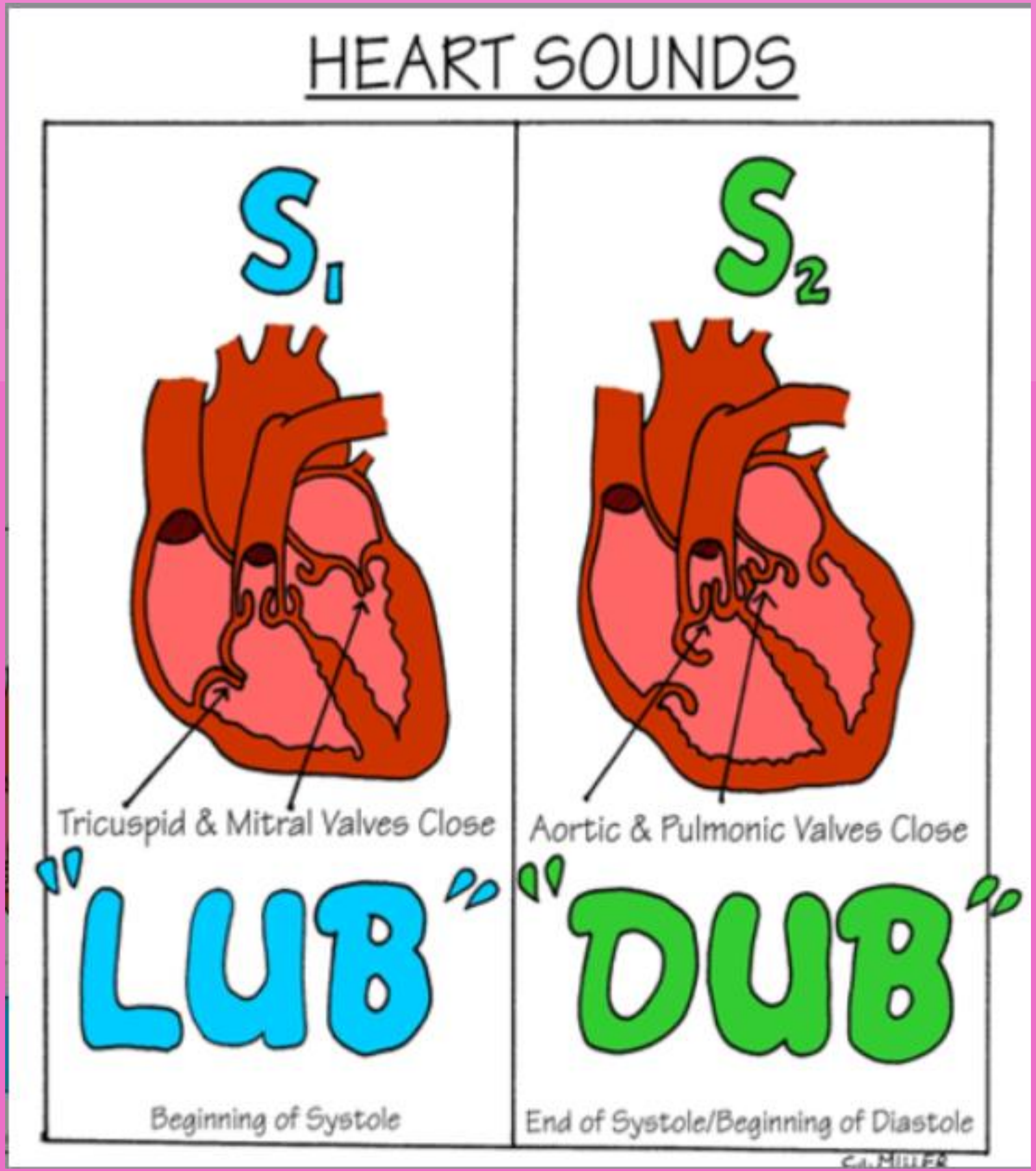
- Associated with closing of mitral and tricuspid valves

DUB: diastole or S2

- Associated with closing of the aortic and pulmonic valves

There are natural pauses between S1 and S2 as well as between S2 and S1

There should be a longer pause between S2 and S1


HEART SOUNDS
S1
S2
Tricuspid & Mitral Valves Close
Aortic & Pulmonic Valves Close
"LUB"
"DUB"
Beginning of Systole
End of Systole/Beginning of Diastole

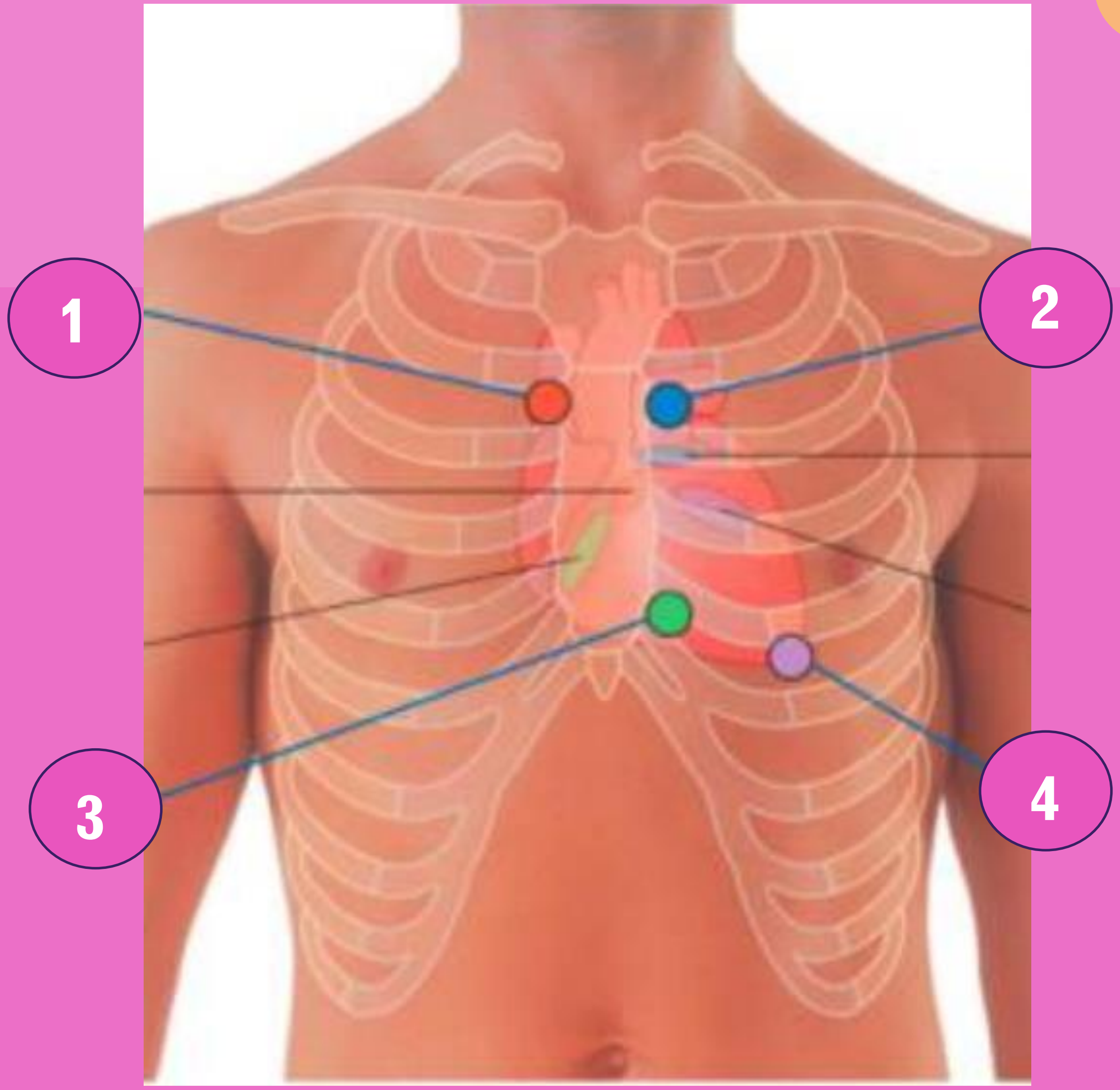
HEART VALVES

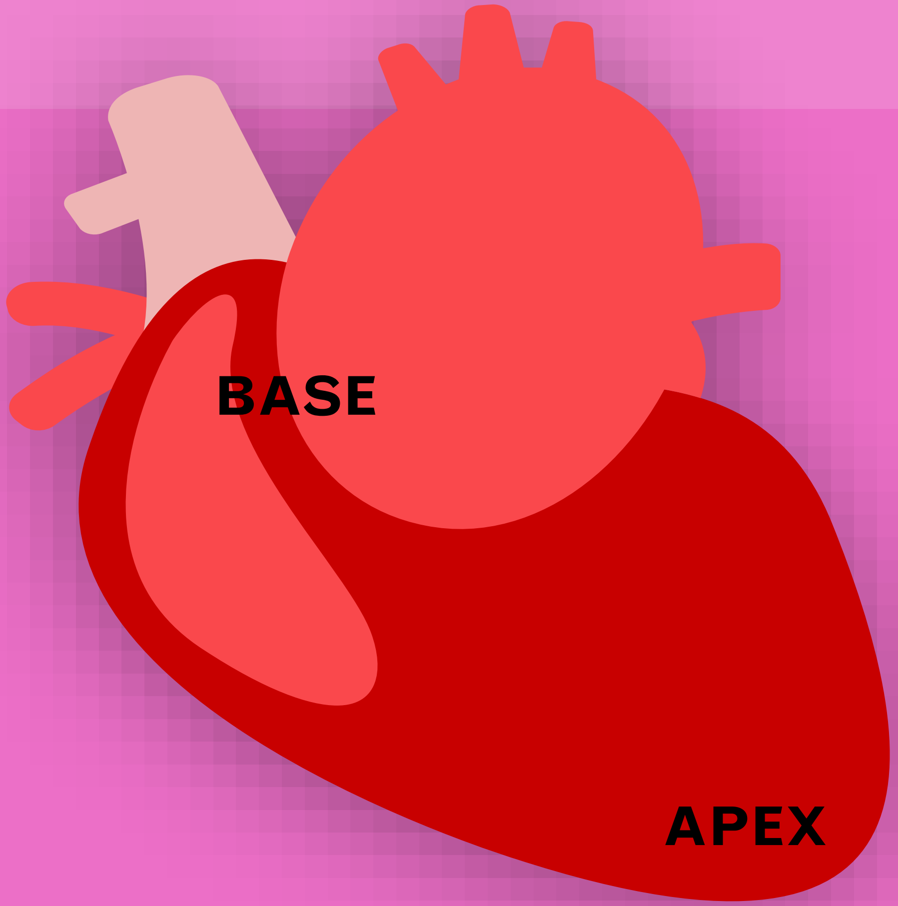
Aortic

Pulmonic

Tricuspid

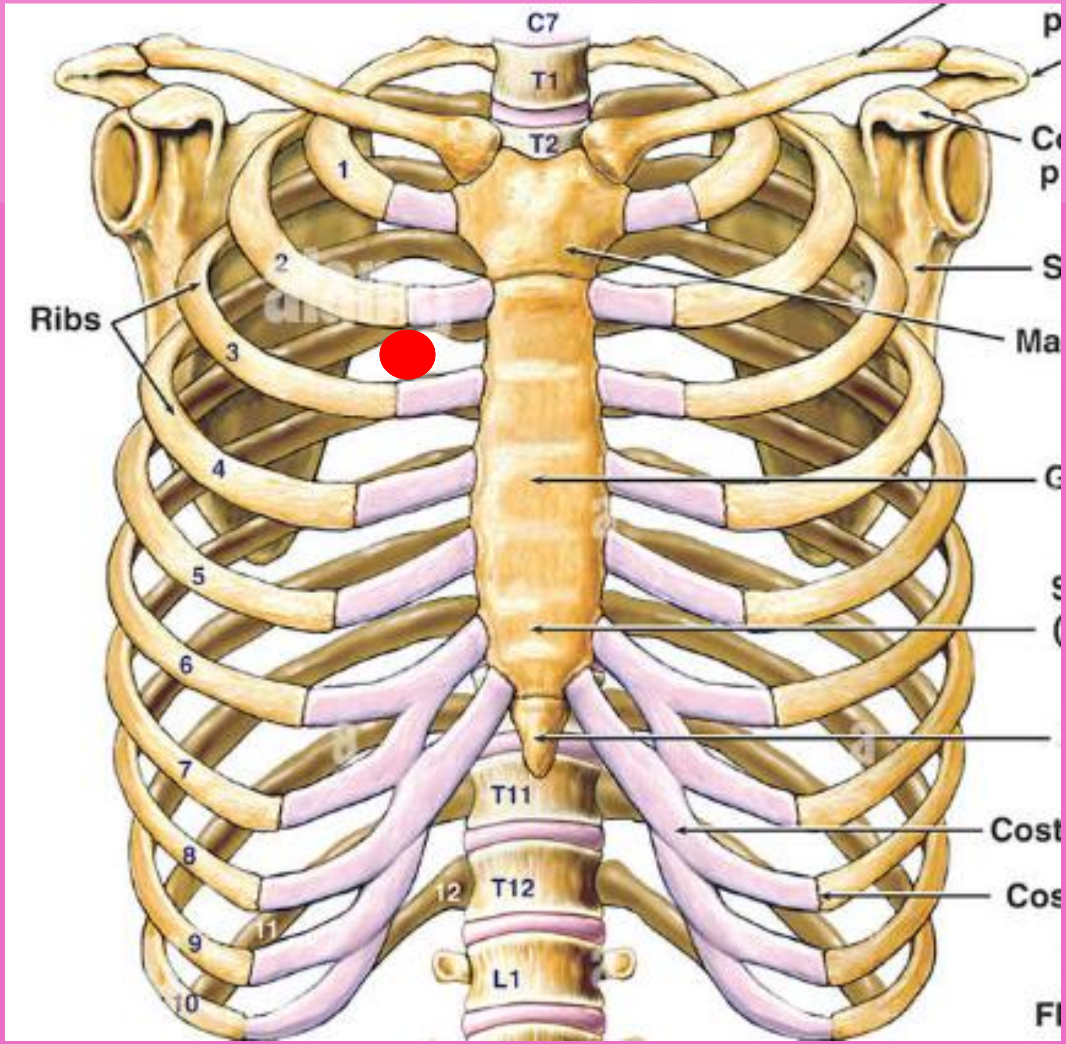
Mitral




BASE
APEX

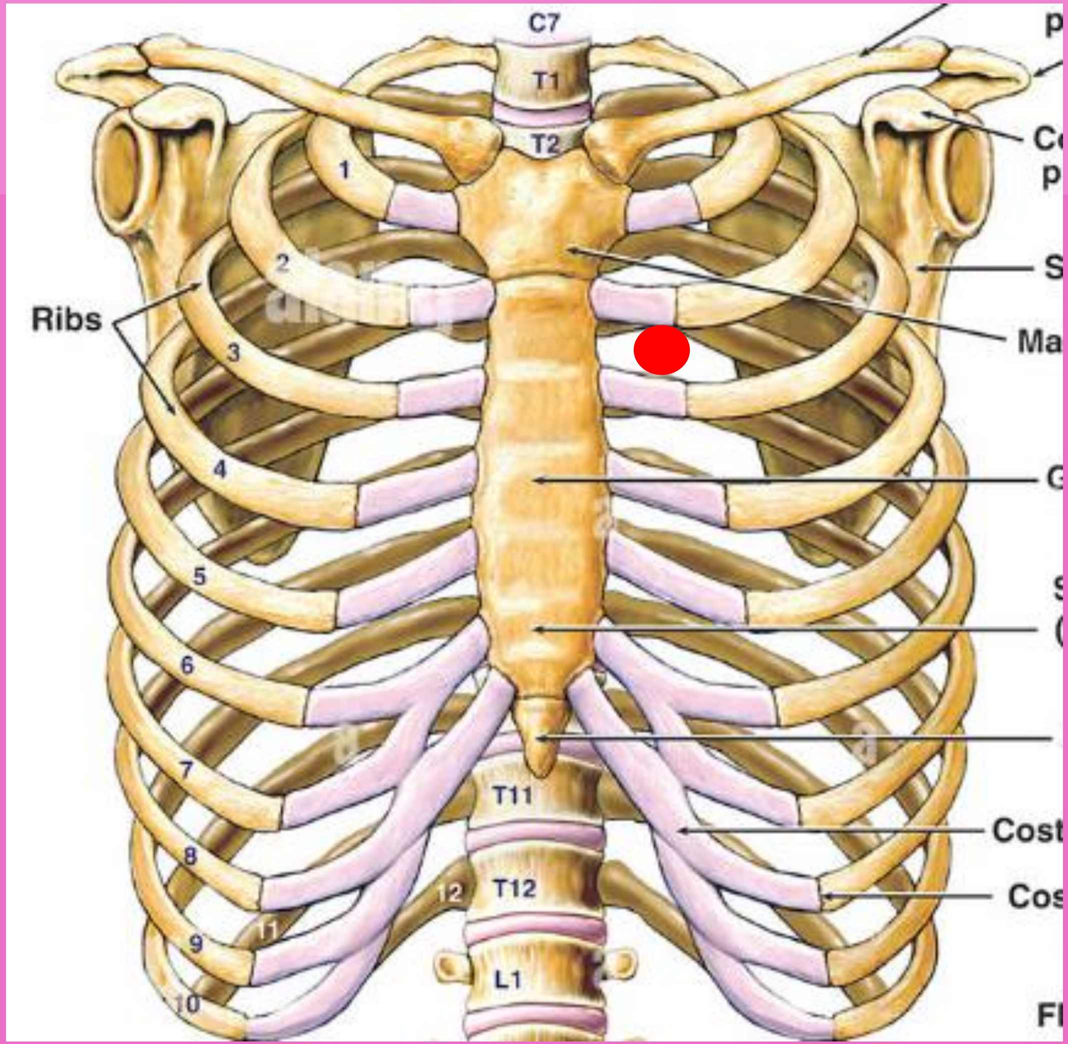
AORTIC VALVE

- Right base
- Second intercostal space to the **right** of the sternum



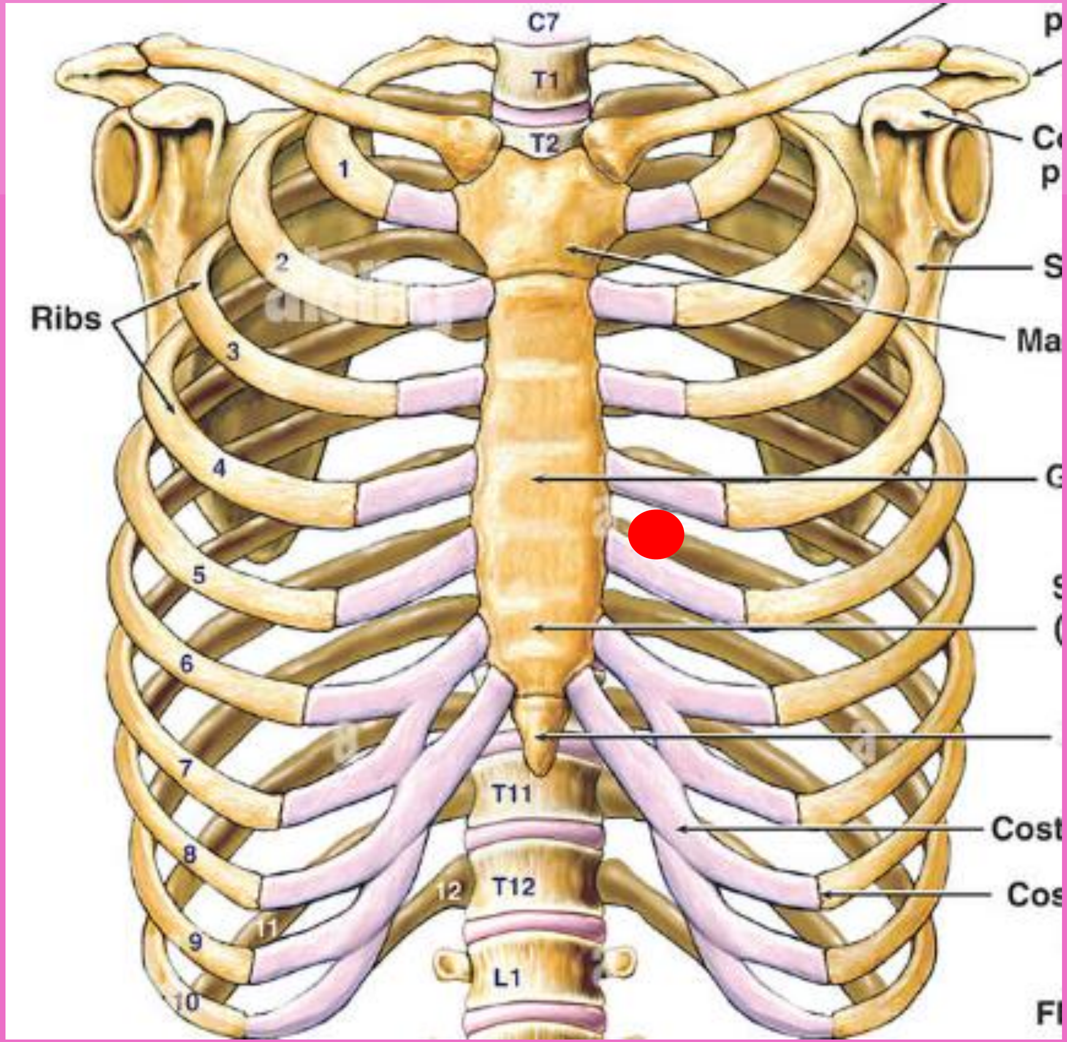
PULMONIC VALVE

- Left base
- Second intercostal space to the **left** of the sternum



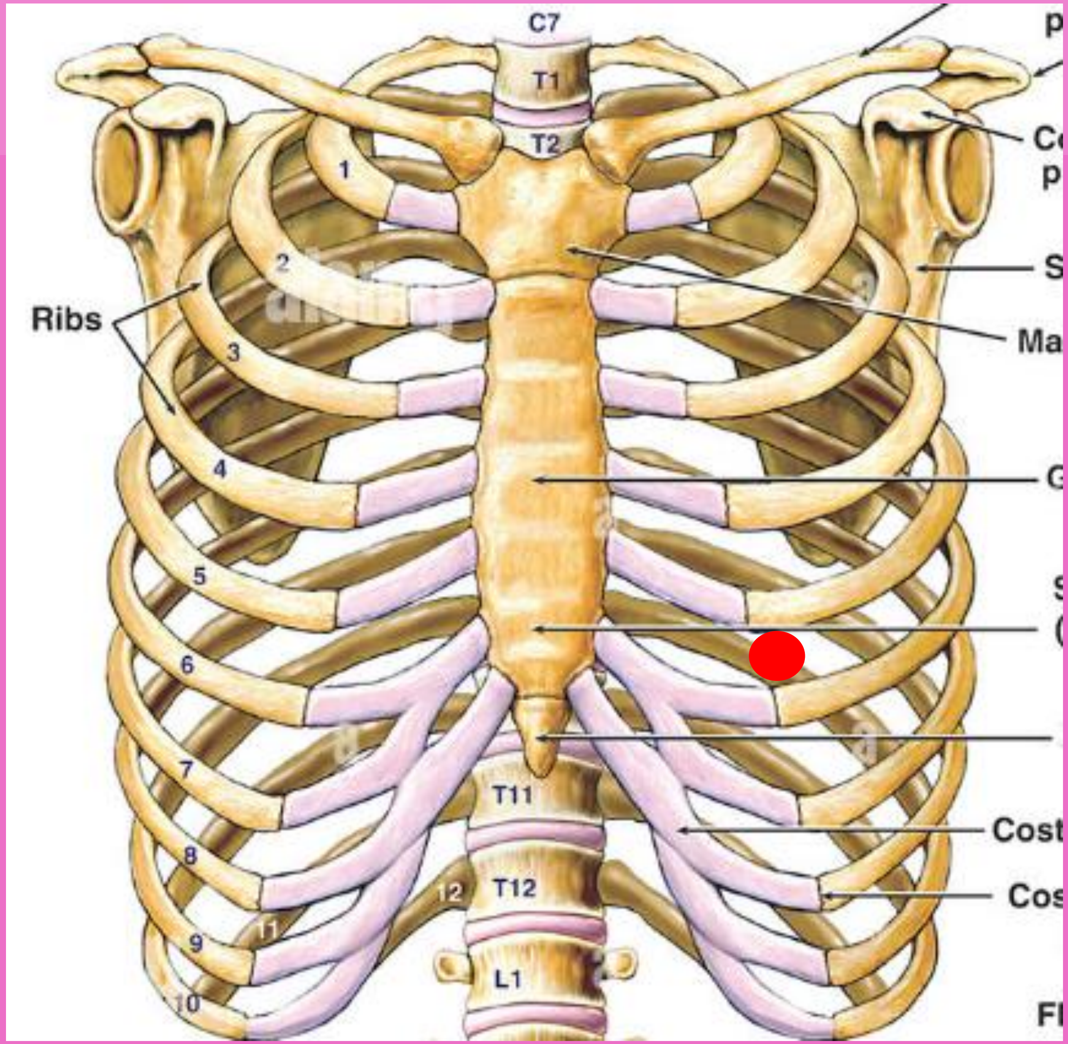
TRICUSPID VALVE

- Left apex
- Fourth or fifth intercostal space to the **left** of the sternum



MITRAL VALVE

- Left apex
- Fourth or fifth intercostal space to the **left** of the sternum at the **midclavicular line**

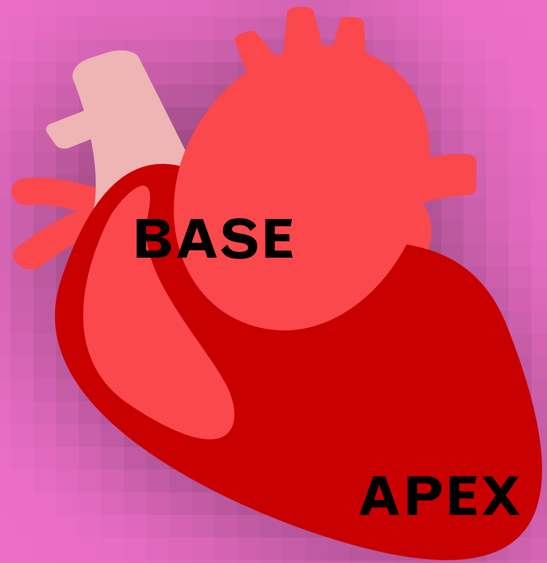


STETHOSCOPE PLACEMENT

Inspect chest

Auscultate:

- **Aortic:** 2nd intercostal space to the right of the sternum
- **Pulmonic:** 2nd intercostal space to the left of the sternum
- **Tricuspid:** 4th or 5th intercostal space to the left of the sternum
- **Mitral:** 5th intercostal space to the left of the sternum at the midclavicular line



PULSES

Carotid*

Brachial

Radial*

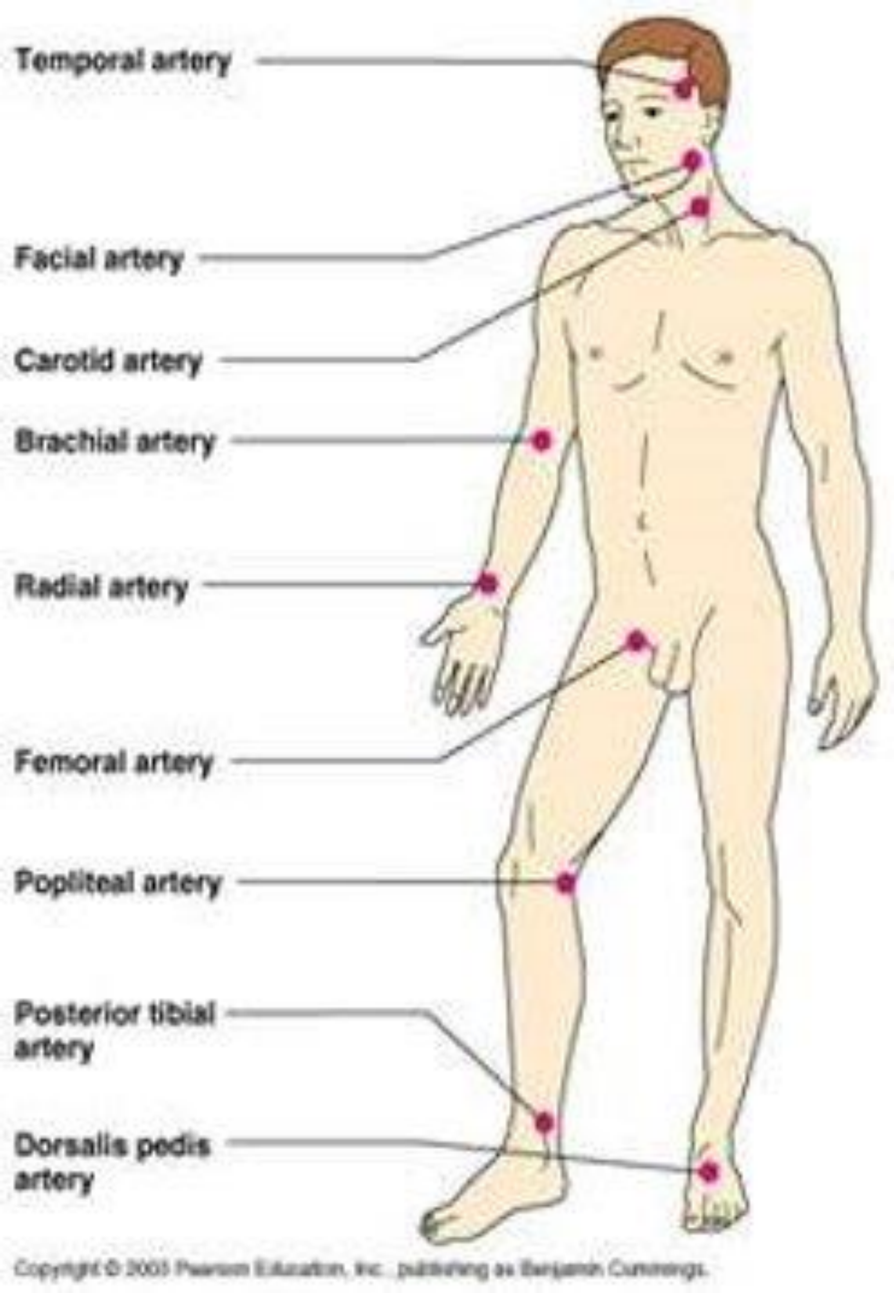
Ulnar

Apical*

Femoral

Popliteal

Dorsalis pedis*



ASSESSMENT OF PULSES

- **Carotid:** assess bilaterally but **one** at a time
- **Radial:** bilaterally at the **same** time
- **Apical:** auscultate for 2 cycles
  - Auscultate for 1 minute is your assessing apical pulse
- **Dorsalis Pedis:** bilaterally at the **same** time

Pulse Quality

- 0 – absent, non-palpable
- 1+ - diminished, weak but palpable
- 2+ - strong, normal
- 3+ - full, increased
- 4+ - bounding

ASSESSMENT VIA DOPPLER

Handheld device

Most often used for pedal pulses

ASSESSMENT OF EXTREMITIES

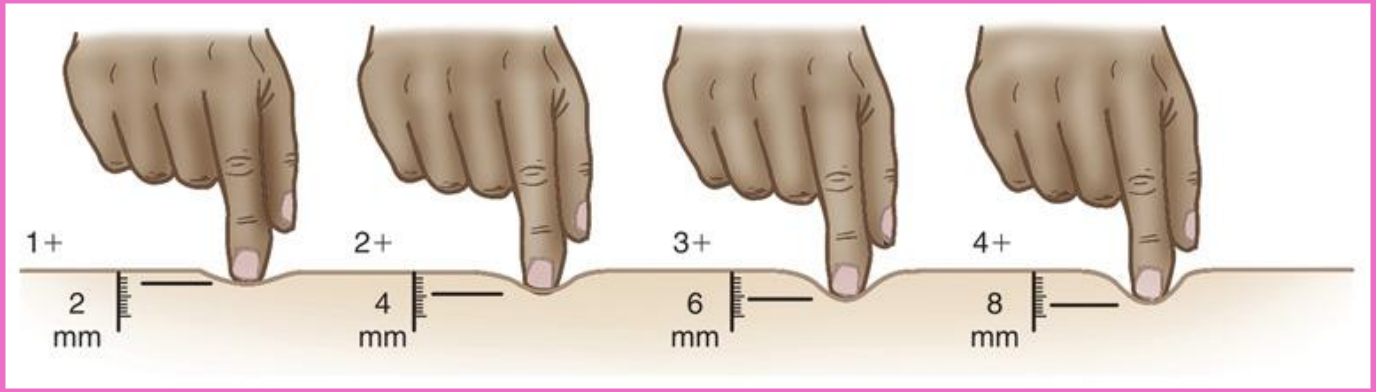
Capillary Refill:

- Press skin of nail bed to produce blanching, release pressure and observe time taken for color return (BUE and BLE)
- Should be less than 2-3 seconds

Edema:

- **Dependent edema:** results from gravity pulling blood down
- **Pitting edema:** indentions in the tissue

CAPILLARY REFILL & PITTING EDEMA

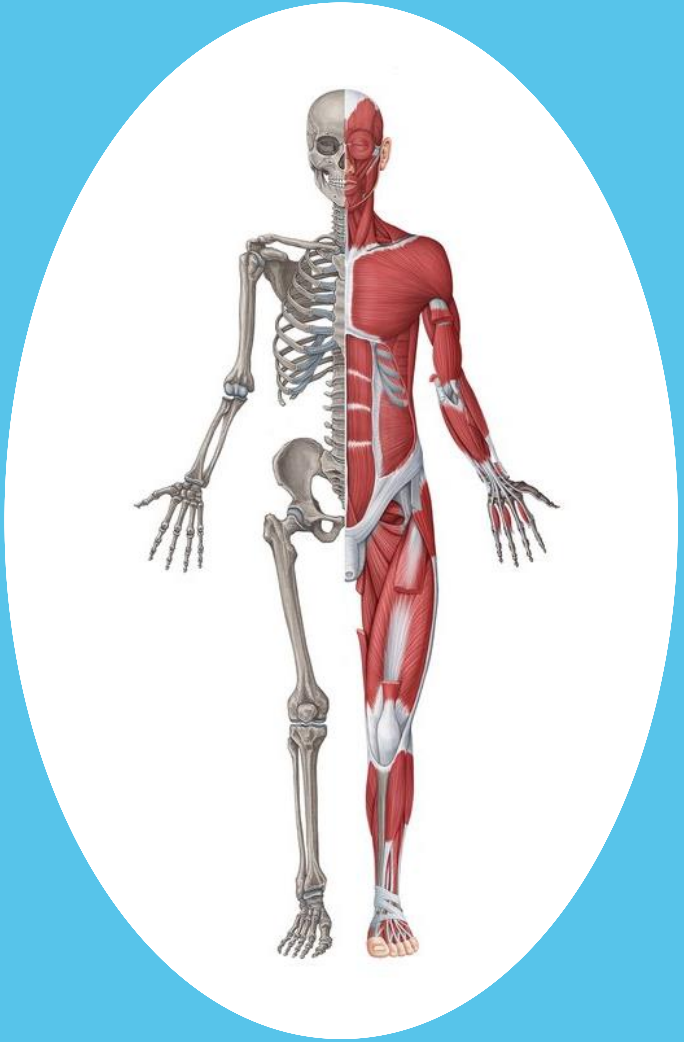


Rapid response 10-18 seconds 1-2 minutes 2-5 minutes

CARDIAC ASSESSMENT SUMMARY

- Heart sounds
- Carotid pulses
- Radial pulses
- Pedal pulses
- Capillary refill
- Assess for edema

MUSCULOSKELETAL ASSESSMENT



RANGE OF MOTION(ROM)

- Neck
- Shoulders, upper arms and elbows
- Wrists
- Hips
- Knees
- Ankles

NECK ROM

- Move neck side to side
- Chin to chest
- Extension back

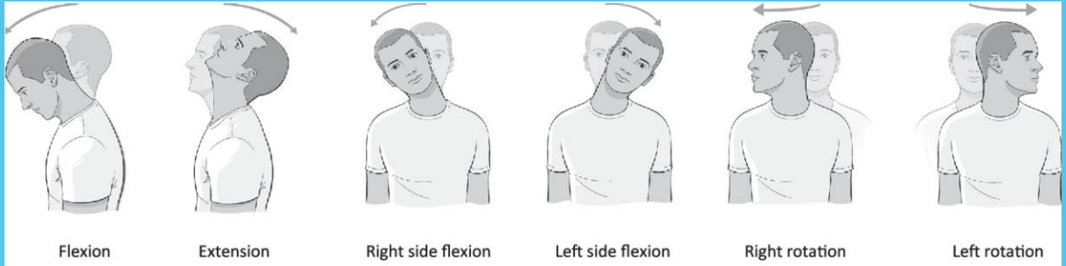
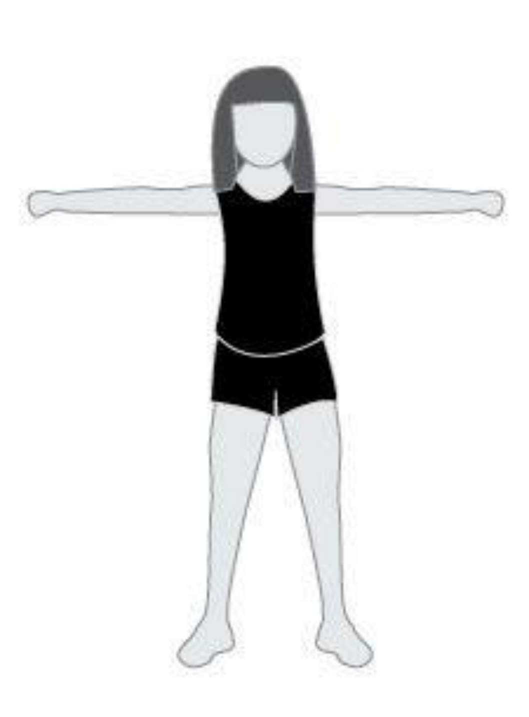
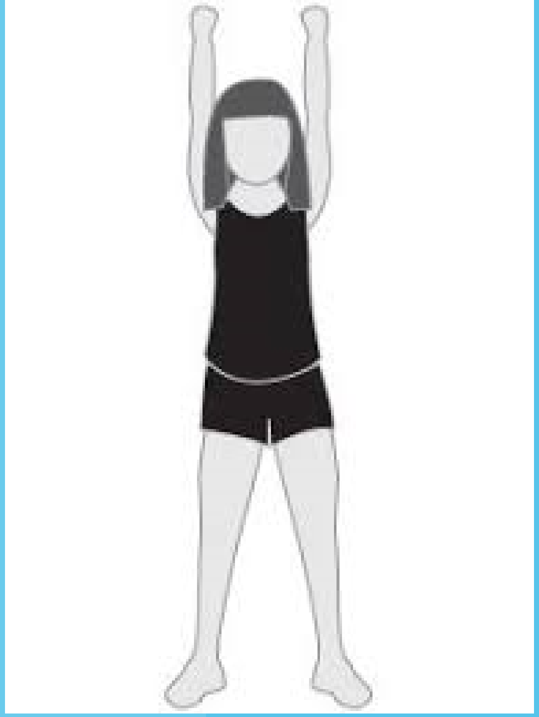


Fig. 2. Neck movements tested.

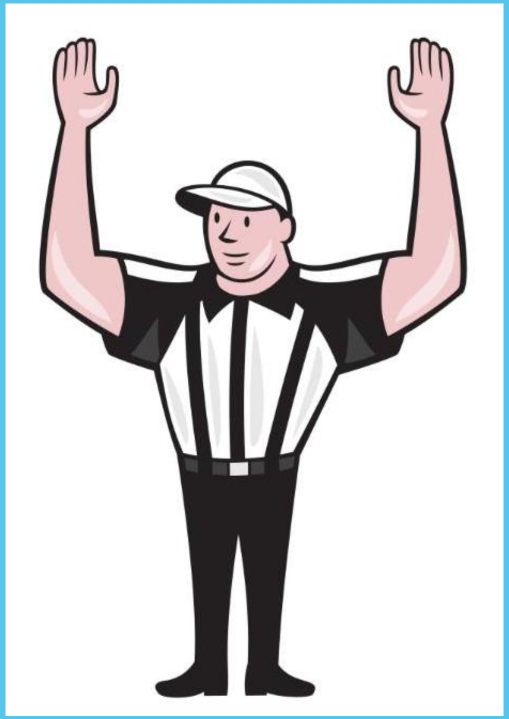
SHOULDERS, UPPER ARMS & ELBOWS



Arms out to side



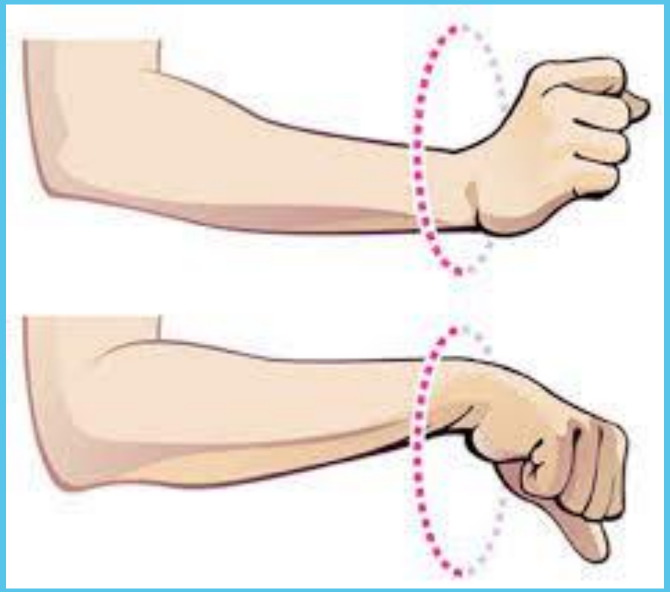
Arms straight up

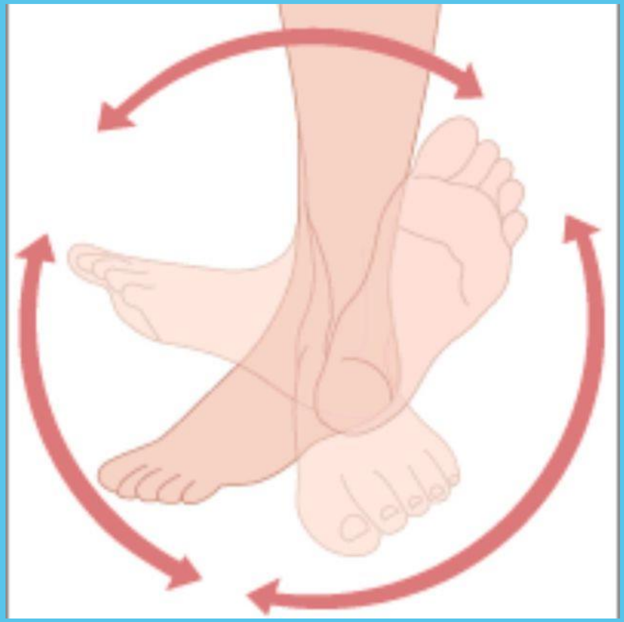


Touchdown

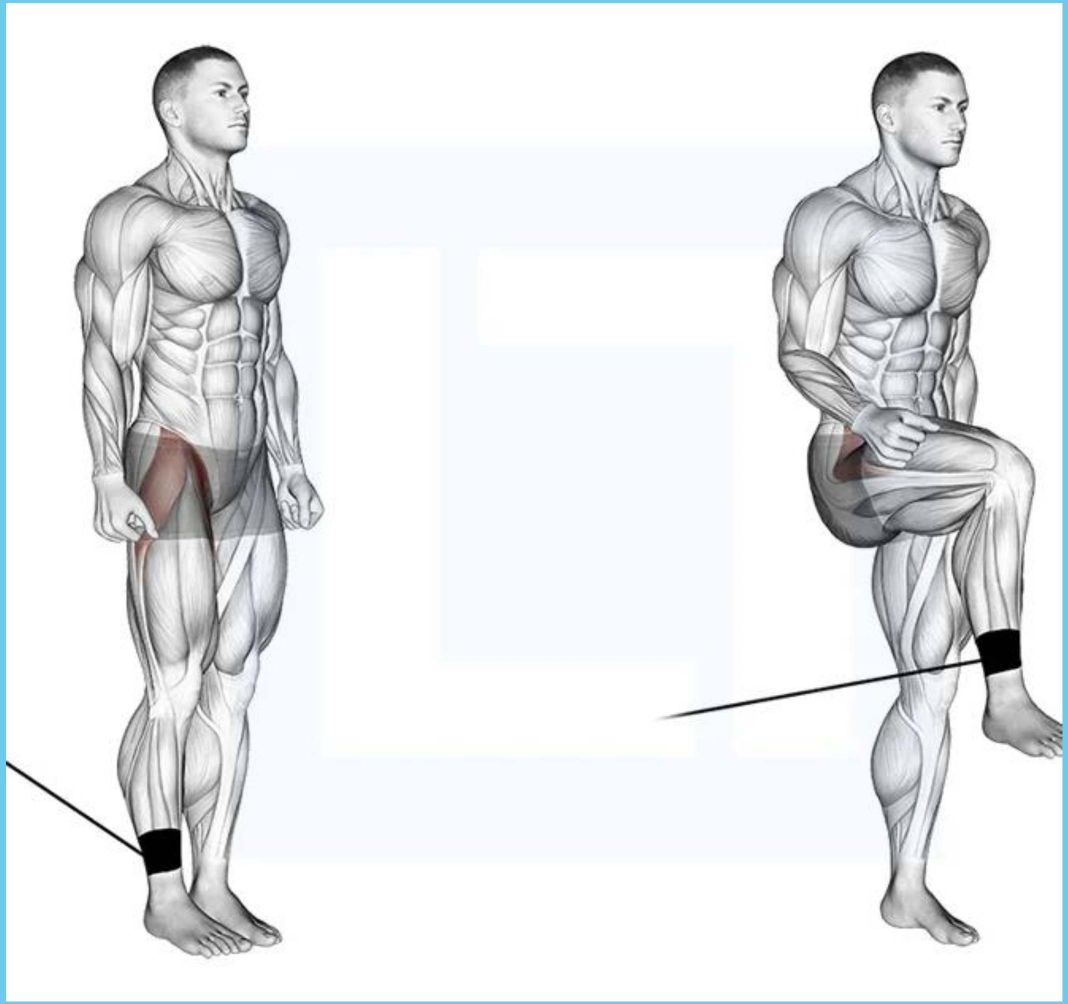
WRISTS & ANKLE ROM

- Wrist circles
- Ankle circles





BILATERAL HIP FLEXION OUT & BEND KNEE



STRENGTH

Hand grasp and toe wiggle

Flexion and extension of BUE/BLE

MUSCULOSKELETAL ASSESSMENT SUMMARY

- Neck ROM
- BUE ROM
- BLE ROM
- HGTW (hand grasp, toe wiggle)
- Flexion and extension of hands and feet

INTEGUMENTARY ASSESSMENT

ASSESSMENT OF SKIN

Inspect Head to Toe

- Color
- Moisture
- Temperature
- Texture
- Turgor
- Vascularity
- Edema
- Lesions

SKIN COLOR ASSESSMENT

- **Pallor:** paleness
- **Erythema:** redness related to vasodilation
- **Jaundice:** yellow, impaired liver
- **Cyanosis:** bluish, decreased circulation or oxygenation of blood

SKIN CHARACTERISTICS

Skin offers clue to health status

- **Moisture:** normally dry to touch
- **Temperature:** normally warm, consistent with room
- **Texture:** normally smooth, soft, even, flexible
  - Dry and course
  - Shiny with no hair
- **Turgor:** refers to elasticity of skin
  - Normally skin lifts easily and falls immediately
  - Failure indicates dehydration
  - Test on back of forearm or sternal area

ASSESSING SKIN TURGOR

FACTORS AFFECTING THE SKIN

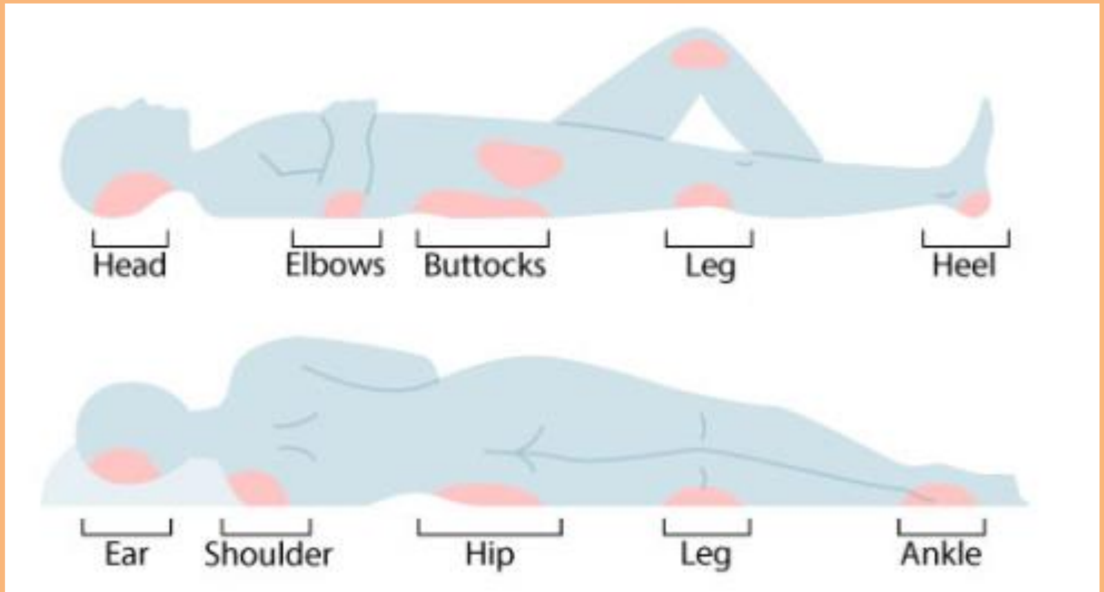
- Dampness
- Dehydration
- Nutrition
- Circulation
- Disease
- Jaundice
- Lifestyle

NORMAL SKIN CHANGES IN OLDER ADULTS

- **Epidermis:** thinner, paler and translucent, slower healing
- **Subcutaneous:** thinner, fragile, decreased protection
- **Collagen and Elastin Fibers:** less elasticity, back of hands, wrinkles on face
- **Hormones:** lack of lead to dryness and thinning of hair
- **Vascularity:** decreases and leads to cool skin
- **Hair follicles:** diminish in number and activity, grows slower
- **Melanocytes:** decreases, hair turns gray, skin pigment becomes uneven
- **Nails:** thicker, softer, slower growing, tear easily
- **Skin growths:** warts, liver spots caused by aging and sun exposure

ASSESSMENT OF BONY PROMINENCES

- Hips, heels, coccyx and shoulders
- Assess for skin integrity
- Blanching



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HAIR ASSESSMENT

Color

Distribution

Quantity

Texture

Lice or parasites

Terminal hair:

- Course, long, thick
- Scalp, axillae, pubic and beard

Vellus hair:

- Soft, fine hairs covering body

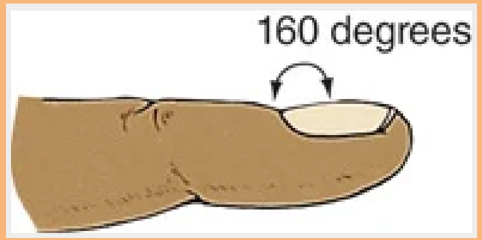
NAIL ASSESSMENT

Observe for:

- Shape
- Contour
- Cleanliness
- Neatly manicured/trimmed

Should be:

- Transparent
- Smooth
- Rounded
- Convex
- Clean and neat



INTEGUMENTARY ASSESSMENT SUMMARY

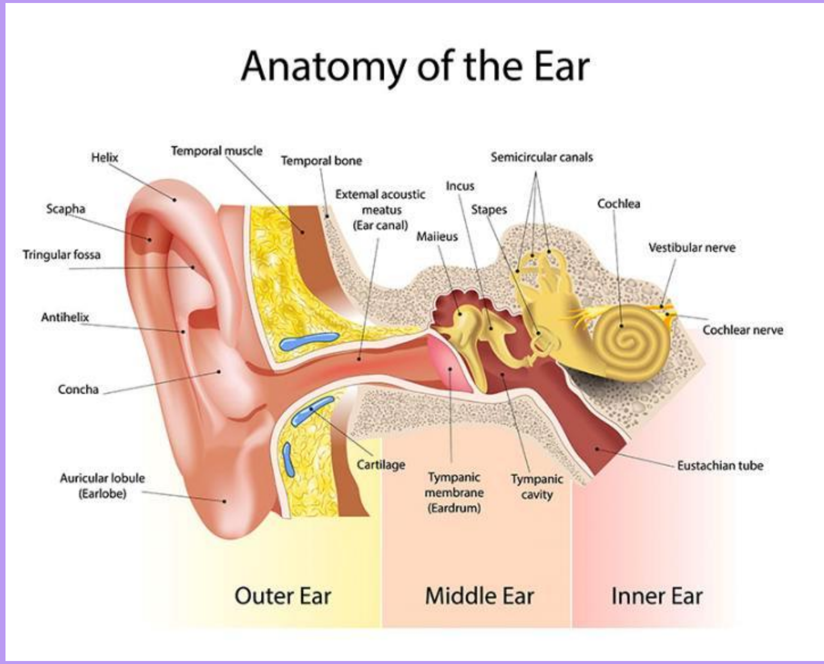
- Assess skin including back, bony prominences, BUE and BLE
- Inspect scalp and hair
- Inspect nails

HEAD & NECK ASSESSMENT

EAR ASSESSMENT

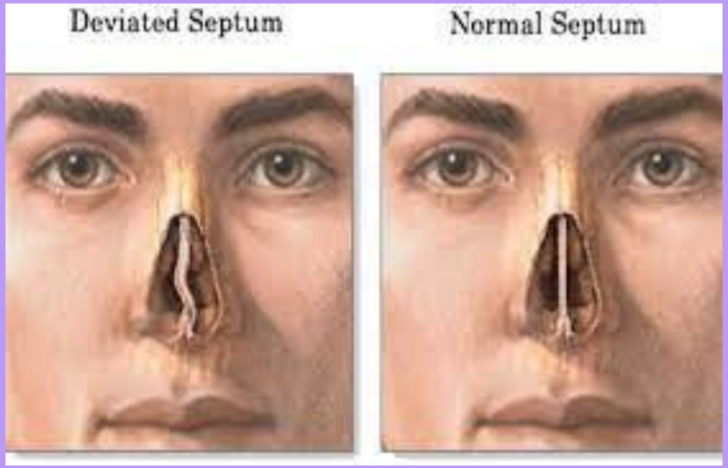
Inspect ears for:

- Symmetry
- Drainage
- Shape
- Hearing defects
- Lesions
- Redness
- Tenderness
- Odor



NOSE ASSESSMENT

- Shape and size
- Skin color
- Deformities
- Inflammation
- Patency, discharge
- Flaring
- Sinus tenderness



MOUTH &PHARYNX ASSESSMENT

Inspect oral cavity:

- Lips
- Oral mucosa
- Teeth/gums
- Tongue and palate
- Pharynx
- Breath odor

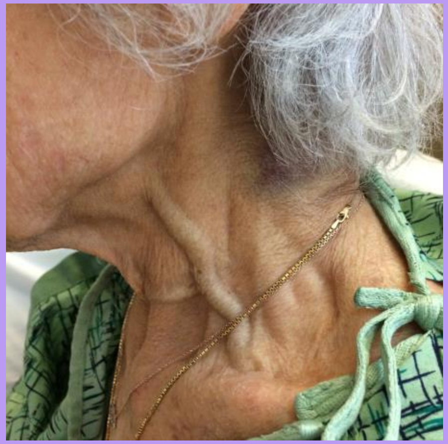
Inspect throat for:

- Lumps
- Ulcers
- Edema
- White spots/redness
- Swallowing

NECK ASSESSMENT

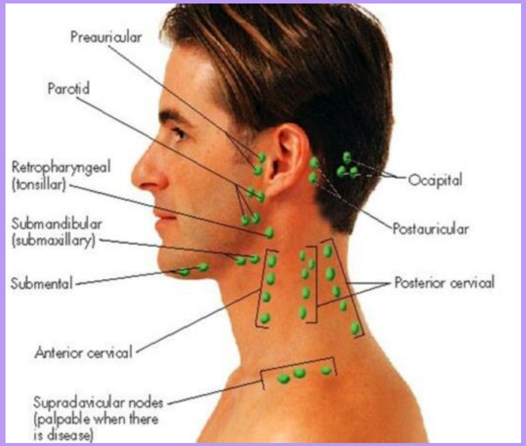
Inspect for:

- Contour and symmetry
- Midline trachea
- Jugular vein distention (JVD)



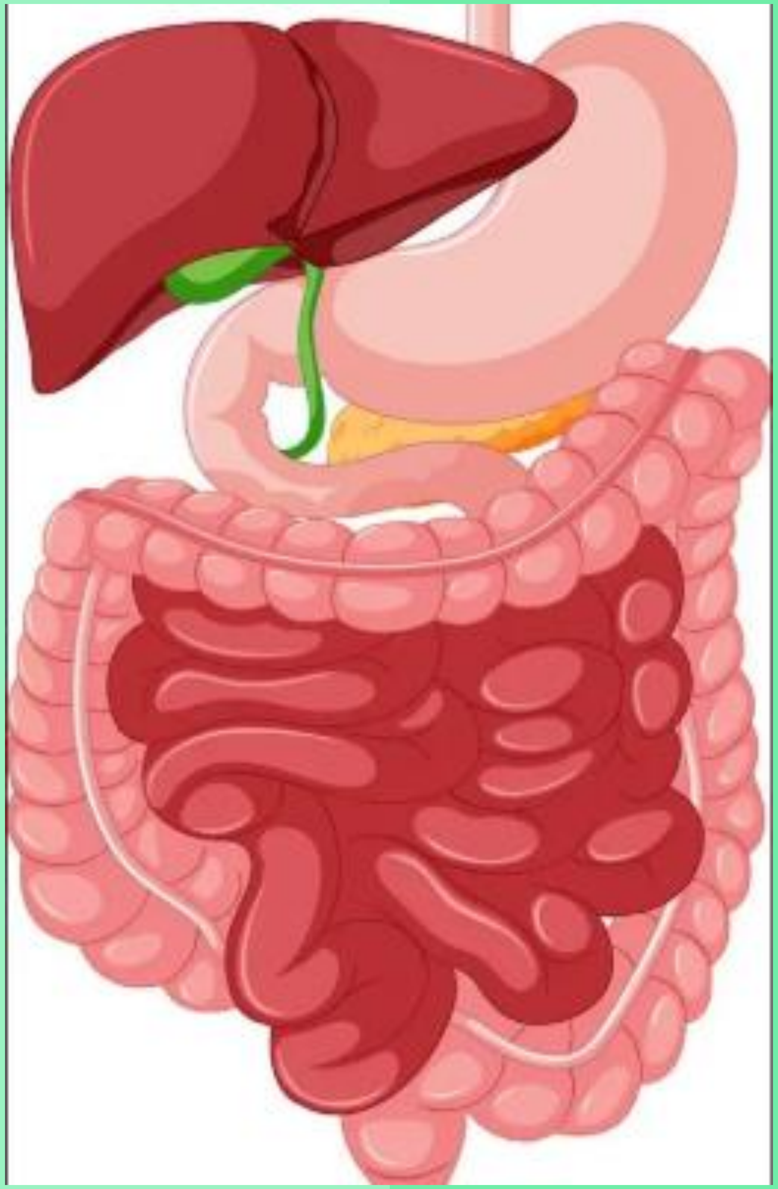
Palpate neck for:

- Inflamed or enlarged lymph nodes



HEAD & NECK ASSESSMENT SUMMARY

- Inspect ears
- Inspect nose
- Inspect mouth and pharynx
- Inspect and palpate neck



GASTROINTESTINAL ASSESSMENT

ABDOMEN ASSESSMENT

Examine in this order:

1. **Inspection:** observe size, shape, contour, and skin integrity
2. **Auscultation:** bowel sounds in four quadrants and epigastric area
3. **Palpation:** palpate for tenderness, pain and masses

Ask:

- About bowel elimination habits

LOOK, LISTEN, FEEL

Look:

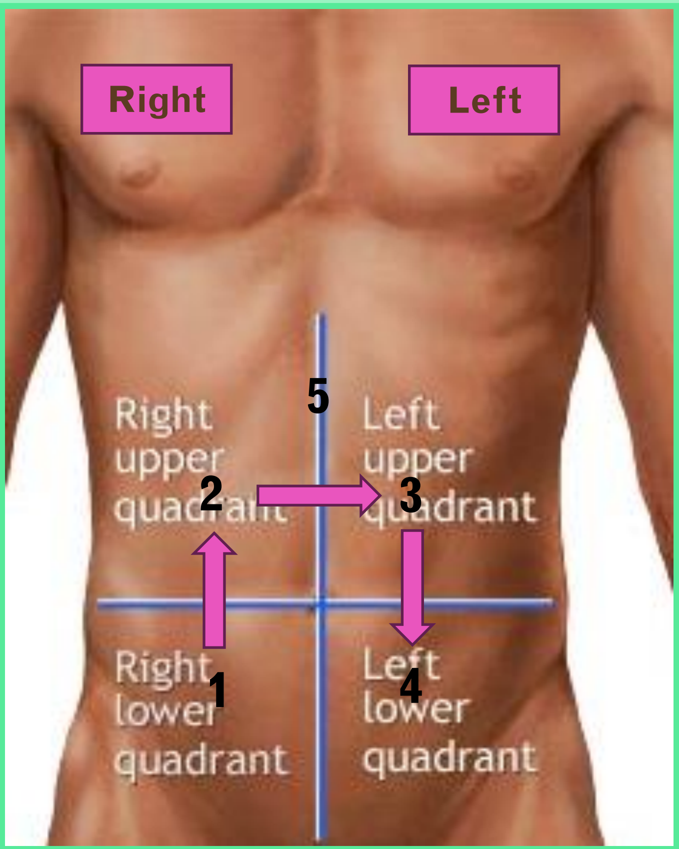
- Visually inspect abdomen

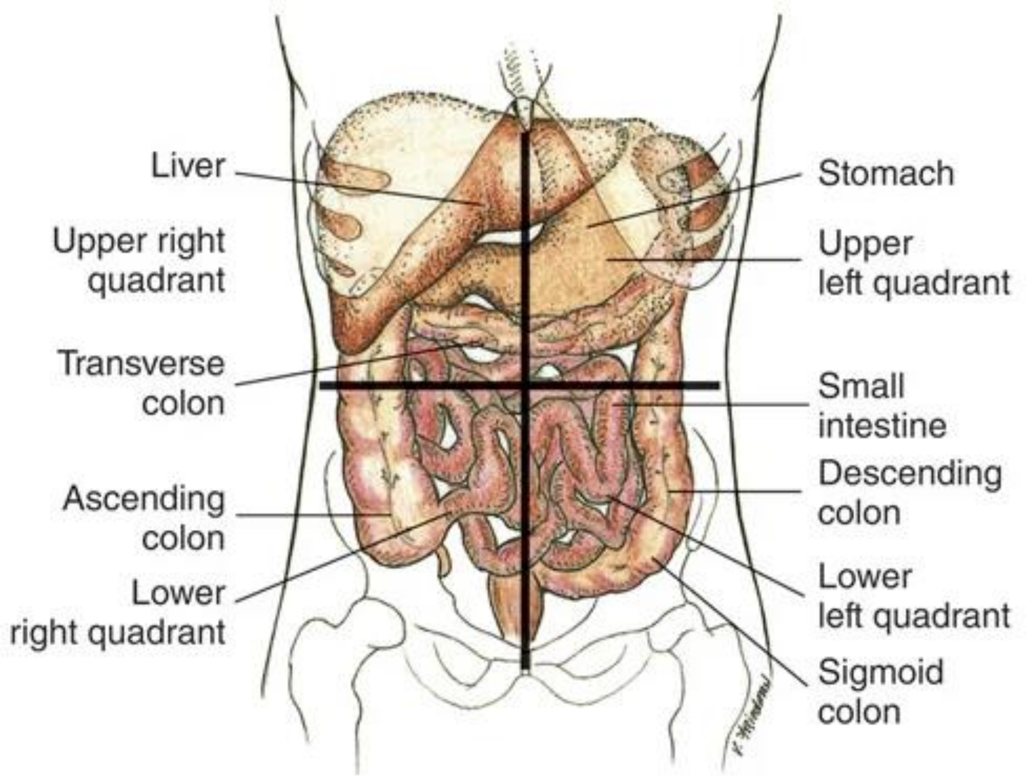
Listen:

- RLQ → RUQ→ LUQ → LLQ→ Epigastric

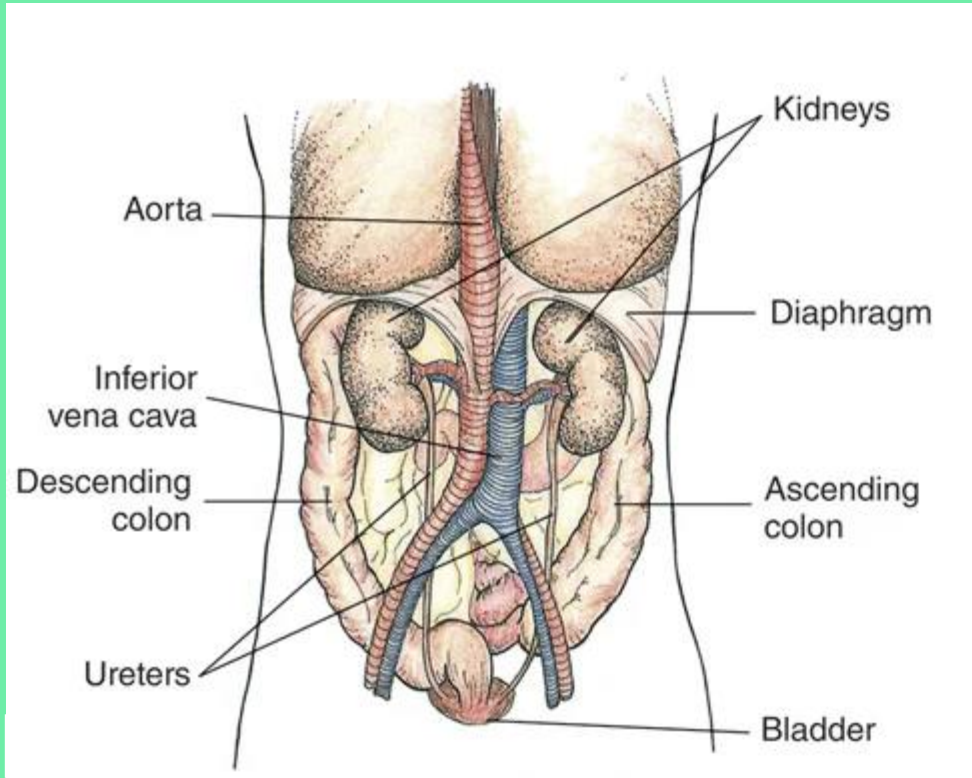
Feel:

- RLQ → RUQ→ LUQ → LLQ→ Epigastric





Anterior



Posterior

BOWEL ELIMINATION DEFINITIONS

Elimination: excretion of waste products from kidneys and intestines

Defecation: process of elimination of waste

Feces: semisolid mass of fiber, undigested food and inorganic matter

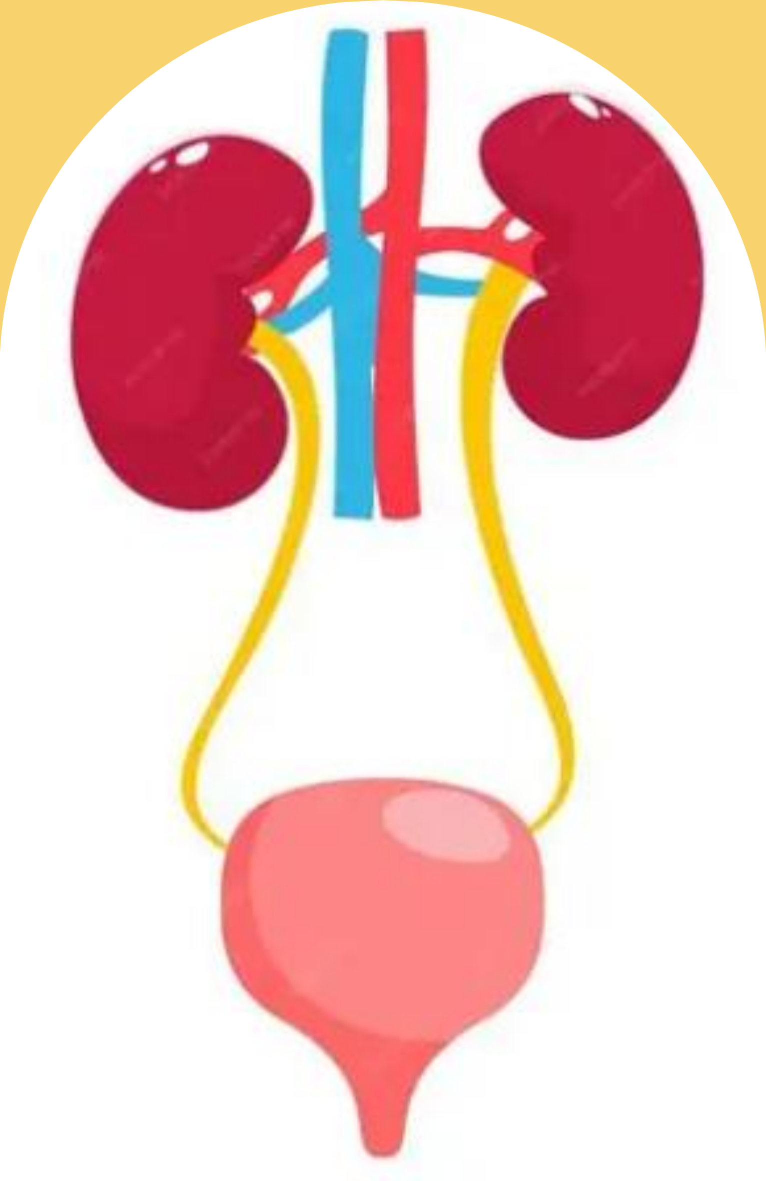
GASTROINTESTINAL ASSESSMENT SUMMARY

Examination of abdomen

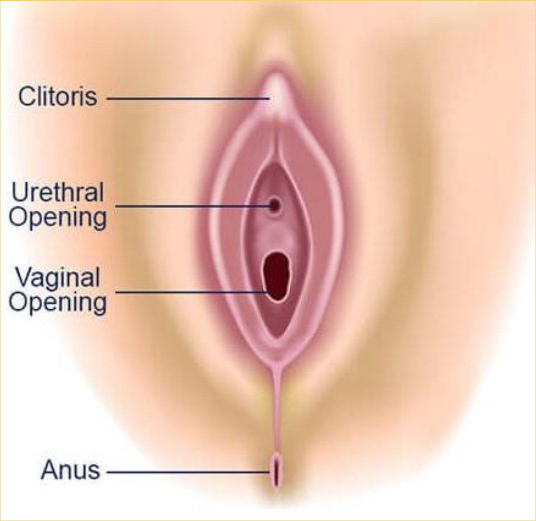
- Look, listen and feel

Ask about bowel elimination habits

GENITOURINARY ASSESSMENT



URETHRAL MEATUS AND PERINEAL AREA ASSESSMENT



Inspect urethral orifice for erythema, discharge, swelling, or odor

Signs of infection, inflammation or trauma

Perineal area: color, condition, presence of urine or stool

URINARY ELIMINATION DEFINITIONS

Incontinence: inability to control urine or feces

Void: to urinate

Micturate: to urinate

Dysuria: painful or difficult urination

Hematuria: blood in the urine

Nocturia: frequent night urination

Polyuria: large amounts of urine

Nocturnal enuresis: bedwetting at night

DEFINITIONS CONTINUED

Urinary frequency: voiding at frequent intervals

Urinary urgency: the need to void all at once

Proteinuria: presence of large protein in urine

Dribbling: leakage of urine despite voluntary control of urination

Retention: accumulation of urine in the bladder without the ability to completely empty

Residual: urine remaining post void, >100 mL

GENITOURINARY ASSESSMENT SUMMARY

- Examination of urethral meatus and perineal area
- Ask about urination habits

THROUGHOUT ASSESSMENT: OBSERVE FOR SIGNS OF ABUSE

- Inconsistency between injury and statement
- Bruises, lacerations, burns and bites
- X-ray shows fractures in various stages of healing
- Behavior issues: insomnia, anxiety and isolation

FOCUSED ASSESSMENTS

FOCUSED NEUROLOGICAL ASSESSMENT

Assess LOC:

- Eye opening
- Verbal response
- Orientation

Assess motor function: bilaterally

- HGTW
- Flexion and extension

Assess Sensation:

- Pain
- Temperature
- Touch
- Pressure

FOCUSED CARDIAC ASSESSMENT

Inspect Chest:

- Scars, bruising, or abnormalities

Auscultate cardiac valves: two complete cycles

- Aortic
- Pulmonic
- Tricuspid
- Mitral

Auscultate apical pulse: one full minute

FOCUSED RESPIRATORY ASSESSMENT

Obtain respiratory rate and O2 sat

Inspect upper airway:

- Purse lip breathing, circumoral pallor, cyanosis of lips/oral mucosa or fingertips
- Trachea position
- Assess cough

Inspect chest:

- Size, shape, symmetry
- Scars, wounds, dressings, IV sites and drains

Auscultate chest: one full breath

- Anteriorly 8 locations
- Posteriorly 10 locations

FOCUSED ABDOMINAL ASSESSMENT

Inspect abdomen:

- Size, shape, symmetry
- Scars, wounds, dressings and drains

Auscultate abdomen:

- Start in RLQ and move clockwise
- Listen for 5-20 seconds in each quadrant
- Listen at the xyphoid process
- Absent sounds are defined by no sound in 3-5 mins

Palpate abdomen:

- Start in RLQ and move clockwise

FOCUSED PERIPHERAL NEUROVASCULAR ASSESSMENT

Assess the six P’s:

- Assess for **pain**
- Assess for **pallor**
- Assess peripheral **pulses**
- Assess for **paresthesia**
- Assess for **paralysis**
- Assess for **poikilothermia**