

Nursing Assessment

Patient info, physical, cardiovascular, HEENT, integumentary, respiratory, breasts, GI, GU, musculoskeletal & neurologic systems including post-assessment

INTRODUCTION

Performing an **accurate physical assessment** and being able to differentiate **normal from abnormal findings** is one of the most important roles for today's health-care practitioner. If an accurate physical assessment cannot be performed, whether for **baseline data** or when the client's **condition changes**, then the client is **NOT** receiving the level of **competent care** he/she deserves.

Assessment

This is the process by which a nurse investigates the body of a client for **signs of disease or disorders**. It generally follows the taking of the **history**—an account of the **symptoms** as experienced by the client. Using critical thinking and professional knowledge, the nurse analyzes the **person-specific history** and **physical assessment** in order to determine the client's nursing care needs and to design appropriate nursing responses. This data then becomes part of the client's **health record**.

- Nursing assessment is the **first stage** of the nursing process
- It includes the **gathering of information** about a client's physiological, psychological, sociological and spiritual status
- The purpose of assessment is to **identify** the client's nursing **problems** and nursing care needs

Collection of Symptoms & Signs

- **Symptoms:** A subjective experience by the client
- **Signs:** An objective finding by the examiner/practitioner

Nurses use assessment to:

- Obtain baseline data and expand the database from which subsequent phases of the nursing process can evolve
- Identify and manage a variety of client problems
- Evaluate the effectiveness of nursing care
- Provide data for planning interventions
- Enhance the nurse/client relationship
- Make clinical judgments

Assessment Preparation

Before you begin: Being prepared and helping the client establish a trusting relationship is important to conducting a comprehensive and accurate assessment.

Review the Chart

- Note the client's name, age, address, race, occupation and religion
- The chart provides a starting point for coming to know the client as a person
- Information on the chart gives you an idea of the client's lifestyle
- Chart data may identify risk factors

Establish Rapport

- Greet the client in a friendly, non-threatening manner
- Explain your role in client care—your first impression can earn the client's trust and confidence
- Share with the client the purpose of the assessment: "the assessment will provide a baseline picture of your health status"

Control Environment

- Give privacy by drawing the curtain, closing the door
- Excuse family members so the client can talk candidly with you

PHYSICAL EXAMINATION

This is the process by which a health-care provider investigates the body of a client for **signs of disease**.

Physical Examination Techniques

Four assessment techniques are used in a physical examination: **inspection, palpation, percussion and auscultation**.

Inspection

This is the close, careful and unaided visualization of the client as a whole and also of each body system.

- It involves **critical observation** that:
 - requires good lighting, to visually inspect the body without distortion or shadows
 - looks at the color, shape, symmetry and position of body parts

Palpation

This is the purposeful and careful feeling with the hands during a physical examination. The health-care provider touches and feels the client's body to examine the **size, consistency, texture, location and tenderness** of an organ or body part.

- Palm of hand or fingertips assess:
 - consistency of tissue
 - alignment and intactness of structures
 - symmetry of body parts or movements
 - transmission of sound and fine vibrations
- Back of the hand assesses skin temperature

Position Client

- Drape client in a loose-fitting gown, providing easy access for inspection and palpation of body
- **Respect personal space:** Stay three feet away from the client to avoid invading personal space; for some portions of the examination closer proximity is needed, but personal space needs to be respected
- Ask permission when touching the person, especially private or sensitive areas of the body

Techniques of Assessment

Observation

Critical scrutiny using the senses is called observation.

• Looking

- overall appearance, signs of distress or discomfort
- color of skin, nails and hair
- skeletal deformities or use of assistive aids

• Listening

- interactions with provider and others
- congruence of verbal and non-verbal actions

• Smelling

- the presence of any peculiar odors from the body
- the presence of odors from substances ingested or applied to the body

Interview

The use of therapeutic communication to obtain subjective data is called an interview.

- Identifies strengths, actual or potential health problems, support systems, teaching needs and referral needs from the **client's perspective**

Nursing History

A structured interview prior to the physical examination is known as a nursing history.

- A comprehensive nursing history is obtained at the first visit
- History is updated at subsequent visits

• Elements of the history include:

- reason for seeking care/**health status**
- course of present illness, including **symptoms**
- current management of illness
- **past medical history**
- family history
- social history
- perception of illness
- review of systems:
 - a series of questions about current and past health, including health-promoting practices
 - ask about **signs and symptoms**, as well as **diseases** related to each body system
- functional assessment activities of **daily living**
- perception of health

THE NURSE KNOWS

Collecting a nursing history requires careful listening and use of therapeutic questions to help the client's concerns

Analysis of a Symptom

Crowbars: What makes symptoms better or worse?

Quality: What does it feel like?

Radiation: Where is the symptom and where does it go?

Severity: How bad does it feel on a scale of 1 to 10?

Time: When does it occur, how often, and how long does it last?

- Ulnar surface of fingers assesses texture, moisture, masses, organ position and area of tenderness

Percussion

This is a method of tapping on a surface to assess the underlying structure's **location, size or density**. The sound changes as the practitioner moves from one area to the next.

- Done with the middle finger of the right hand tapping on the middle finger of the left hand, while the left palm is on the body

• There are two types of percussion:

- direct, which uses only one or two fingers
- indirect, which uses the middle/flexor finger

• There are four types of percussion sounds:

- tympanic
- resonant
- flat
- dull

- A **flat/dull sound** indicates the presence of a solid mass under the surface
- A **tympanic/resonant sound** indicates hollow, air-containing structures



THE NURSE KNOWS

Auscultation is a skill that requires substantial clinical experience, a fine stethoscope and good listening skills. High pitched tones are best heard with the diaphragm of the stethoscope. Low pitched tones are best heard with the bell of the stethoscope.

Whats Up Assessment Guide For Nursing

Jiyuan Zhang



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