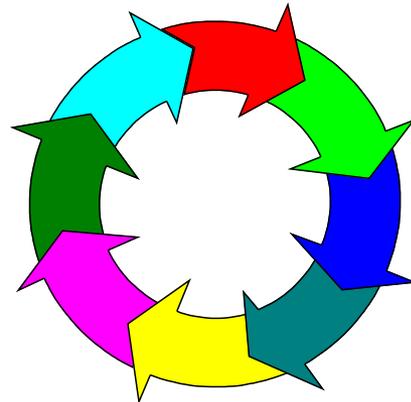


Nursing Assessment: A Systematic Approach

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Introduction



⌘ Health assessment of patients falls under the purview of both physicians and nurses.

General Health Assessment



- ⌘ The nursing health assessment is an incredibly valuable tool nurses have in their arsenal of skills.
- ⌘ A thorough and skilled assessment allows you, the nurse, to obtain descriptions about your patient's symptoms, how the symptoms developed, and a process to discover any associated physical findings that will aid in the development of differential diagnoses.

General Health Assessment



- ⌘ Assessment uses both **subjective** and **objective** data.
- ⌘ **Subjective assessment** factors are those that are reported by the patient.
- ⌘ **Objective assessment** data includes that which is **observable and measurable** (Jarvis, 2008).

General Health Assessment



- ⌘ During the assessment period, you are given an **opportunity to develop a rapport** with your patient and their family.

- ⌘ Your **interactions** with your patient gives the **patient and family lasting impressions** about you, other nurses, **the facility** you are **working** in, and **how care will be managed** (Jarvis, 2008).

Types of General Health Assessments



- ⌘ A **comprehensive or complete** health assessment
- ⌘ An **interval or abbreviated** assessment
- ⌘ A **problem-focused** assessment
- ⌘ An assessment for **special populations**

A comprehensive or complete health assessment

⌘ A comprehensive or complete health assessment usually begins with **obtaining a thorough**

☒ health history

☒ and physical exam.

⌘ This type of assessment is **usually performed** in **acute care settings** upon **admission**, once your patient is **stable**, or when a **new patient presents** to an **outpatient clinic**.

An interval or abbreviated assessment

- ⌘ If the patient **has been under your care for some time**, a complete health history is **usually not indicated**.
- ⌘ Nurses perform an **interval or abbreviated** assessment at this time.
- ⌘ These assessments are usually performed :
 - ☒ **subsequent visits in an outpatient setting**,
 - ☒ at **change of shift**,
 - ☒ when **returning from tests**,
 - ☒ or upon transfer to your unit from **another in-house unit**.

An interval or abbreviated assessment

- ⌘ This type of assessment is **not as detailed** as the **complete assessment** that occurs at admission.
- ⌘ The advantage of an abbreviated assessment is that it **allows you to thoroughly assess** your patient in a **shorter period of time** (Jarvis, 2008).

A problem-focused assessment

- ⌘ The problem-focused assessment is usually indicated after a comprehensive assessment has identified a potential health problem.
- ⌘ The problem-focused assessment is also indicated when an interval or abbreviated assessment shows a change in status from the most current previous assessment or report you received, when a new symptom emerges, or the patient develops any distress.
- ⌘ An advantage of the focused assessment is that it directs you to ask about symptoms and move quickly to conducting a focused physical exam (Jarvis, 2008; Scanlon, 2011).

An assessment for special populations



⌘ The fourth type of assessment is the assessment for special populations, including:

☑ Pregnant patients

☑ Infants

☑ Children

☑ The elderly

An assessment for special populations



- ⌘ If there is any indication to perform a problem-focused or special population assessment during the comprehensive assessment, the assessment should occur after obtaining a baseline comprehensive assessment.
- ⌘ Based upon the results of the problem-focused or special population assessment, you can decide how often to perform interval assessments to monitor your patient's identified problem (Jarvis, 2008; Scanlon, 2011).

Tool assessment

⌘ Whether you are performing a comprehensive assessment or a focused assessment, you will use at least one of the following four basic techniques during your physical exam:

☒ Inspection

☒ auscultation

☒ Percussion

☒ and palpation.

Assessment Techniques: Inspection

- ⌘ INSPECTION is the **most frequently** used assessment technique.
- ⌘ When you are using inspection, you are **looking for conditions** you can **observe** with your **eyes, ears, or nose**.
- ⌘ Examples of things you may inspect are **skin color, location of lesions, bruises or rash, symmetry, size** of body parts and **abnormal** findings.
- ⌘ Inspection can be **an important technique** as it **leads to further investigation of findings** (Jarvis, 2008).

Assessment Techniques: Auscultation

- ⌘ AUSCULTATION is usually performed following inspection, especially with abdominal assessment.
- ⌘ The abdomen should be auscultated before percussion or palpation to prevent production of false bowel sounds.
- ⌘ When auscultating, ensure the exam room is quiet and auscultate over bare skin, listening to one sound at a time.
- ⌘ The diaphragm is used to listen to high pitched sounds and the bell is best used to identify low pitched sounds (Jarvis, 2008; Edmunds, Ward & Barnes, 2010).

Assessment Techniques: Palpation

- ⌘ PALPATION is another commonly used physical exam technique, requires you to touch your patient with different parts of your hand using different strength pressures.
- ⌘ During light palpation, you press the skin about ½ inch to ¾ inch with the pads of your fingers.
- ⌘ When using deep palpation, use your finger pads and compress the skin approximately 1½ inches to 2 inches.
- ⌘ Light palpation allows you to assess for texture, tenderness, temperature, moisture, pulsations, and masses.
- ⌘ Deep palpation is performed to assess for masses and internal organs (Jarvis, 2008).

Assessment Techniques: Percussion

⌘ PERCUSSION is used to elicit tenderness or sounds that may provide clues to underlying problems.

These sounds may include:

- ☒ Tympani Resonance
- ☒ Hyper resonance Dullness
- ☒ Flatness

Assessment Techniques: Percussion

- ⌘ **Tympani** sounds like a **drum** and is heard over air pockets.
- ⌘ **Resonance** is a **hollow sound** heard over areas where there is a solid structure and some air (like the lungs).
- ⌘ **Hyper resonance** is a **booming sound** heard over air such as in emphysema.
- ⌘ **Dullness** is heard over solid organs or masses.
- ⌘ **Flatness** is heard over dense tissues including muscle and bone (Jarvis, 2008).

Health History



- ⌘ The **purpose** of obtaining a health history is to provide you with a **description** of your **patient's symptoms** and **how they developed**.
- ⌘ In addition to obtaining data about the patient's physical status, you will **obtain information about many other factors** that **impact your patient's physical status** including **spiritual needs, cultural idiosyncrasies**, and functional living status.

Health History



⌘ The basic components of the complete health history (other than biographical information) include:

- ☒ Chief complaint
- ☒ Present health status
- ☒ Past health history
- ☒ Current lifestyle
- ☒ Psychosocial status
- ☒ Family history
- ☒ Review of systems

Health History



- ⌘ **Communication** during the history and physical must be **respectful** and performed in a **culturally-sensitive manner**.
- ⌘ **Privacy** is vital, and the healthcare professional needs to be **aware of posture, body language, and tone of voice** while interviewing the patient (Jarvis, 2008; Caple, 2011)

Chief Complaint

- ⌘ In your **patient's own words**, document the chief complaint.
- ⌘ The chief complaint may be elicited by asking one of the following questions: **So, tell me why you have come here today?** Tell me what your **biggest complaint is right now?** If we could fix any of your health problems right now, what would it be? What is giving you the most problems right now?

Present Health Status

- ⌘ Obtaining information about a patient's present health status allows the nurse to investigate current complaints.
- ⌘ **Provocative or Palliative**: What makes the symptom(s) better or worse?
- ⌘ **Quality**: Describe the symptom(s).
- ⌘ **Region or Radiation**: Where in the body does the symptom occur? Is there radiation or extension of the symptom(s) to another area of the body?
- ⌘ **Severity**: On a scale of 1-10, (10 being the worst) how bad is the symptom(s)? Another visual scale may be appropriate for patients that are unable to identify with this scale.
- ⌘ **Timing**: Does it occur in association with something else (i.e. eating, exertion, movement)?

Past Health History



- ⌘ It is important to ask questions about your patient's past health history.
- ⌘ Childhood Illnesses:
- ⌘ Accidents or Traumatic Injuries:
- ⌘ Hospitalizations:
- ⌘ Surgeries
- ⌘ Psychiatric or Mental Illnesses
- ⌘ Allergies

Family History



- ⌘ Family history is important in identifying your **patient's risk for certain disease states.**
- ⌘ Applicable generations with whom to explore health status include **grandparents, parents, and the children of your patient.**
- ⌘ Chronic illnesses or known diseases with **genetic components**
- ⌘ Current Health Status: include details about your patient's **personal habits** such as **smoking or drinking, nutrition, cholesterol,** and if there is a history of **heart disease or hypertension.**
- ⌘ Medications:

Review of Systems and Physical Exam

- ⌘ A physical examination should include: **Complete set of vital signs** (blood pressure, heart rate, respiratory rate and temperature) Assess immediate pain level.
- ⌘ Can use acronym “**PQRST**” for quick pain assessment:
 - ☒ • **P=provoking factors** (what brought on the pain?)
 - ☒ • **Q=quality** (describe the pain- i.e. stabbing, throbbing, burning)
 - ☒ • **R=radiation** (does the pain radiate anywhere?)
 - ☒ • **S=severity/symptoms** (how bad is the pain-rate it; are there other symptoms with the pain?)
 - ☒ • **T=timing** (is it constant? What makes it better/worse?)

Skin Assessment

- ⌘ : Skin assessment can be performed throughout the physical examination. When assessing the skin, EXAMINE the following:
 - ⌘ **General pigmentation**
 - ⌘ **Systemic color changes** (pallor, erythematic, cyanosis, jaundice)
 - ⌘ **Freckles and moles** (symmetry, size, border, pigmentation)
 - ⌘ **Temperature** (hypothermia, hyperthermia)
 - ⌘ **Moisture and texture** (diaphoresis, dehydration, firm smooth texture)
 - ⌘ **Edema** (location and degree)

Skin Assessment



- ⌘ **Bruising** (location, pattern, consistent with history – especially in at risk populations)
- ⌘ **Lesions** (color, elevation, pattern or shape, size, location, exudates)
- ⌘ **Hair** (normal color, texture, distribution)
- ⌘ **Nails** (shape, contour, color)

Neurological Assessment

- ⌘ Any past **history of head injury**? (location, loss of consciousness)
- ⌘ Do you have **frequent or severe headaches**? (when, where, how often)
- ⌘ Any **dizziness or vertigo**? (frequency, precipitating factors, gradual or sudden)
- ⌘ Ever had/or do you have **seizures**? (when did they start, frequency, course and duration, motor activity associated with, associated signs, postictal phase, precipitating factors, medications, coping strategies)
- ⌘ Any difficulty swallowing? (solids or liquids, excessive saliva) Any difficulty speaking? (forming words or actually saying what you intended)
- ⌘ Do you have any **coordination problems**? (describe)
- ⌘ Do you have any **numbness or tingling**? (describe)
- ⌘ Any significant past neurologic history? (cerebral vascular accident, spinal cord injuries, neurologic infections, congenital disorders)
- ⌘ **Environmental or occupational hazards**? (insecticides, lead, organic solvents, illicit drugs, alcohol) (Jarvis, 2008)

Head, Face & Throat Assessment



When assessing the head, face and throat, focus on assessment of suspected deficits as indicated by the history, **patient complaints**, or disease process the patient is exhibiting. Some of the following points fall outside of the general scope of nursing practice but may be observed by the nurse, or practiced in advanced nursing roles. A complete exam of the **head, face and throat is not warranted in** every patient.

Assessment of the Eyes

Eyes Any **vision changes or difficulty**? Any **eye pain**? Do you have **double vision**? Any **redness, swelling or discharge**? Do you have a history of glaucoma? Do you wear glasses or contacts (Jarvis, 2008)? Look for: Visual acuity Visual fields (confrontation test) Extra ocular muscle function (nystagmus, abnormal corneal light reflex) **Conjunctiva and sclera** (redness, irritation) Pupil (shape, symmetry, light reflexes, accommodation) **Ocular fundus** (red reflex, optic disc, retinal vessels, macula) (Jarvis, 2008)

Assessment of the Ears

Ears Have you had many ear infections? Do you have any discharge from your ears? Do you have any hearing difficulty? Do you have any environmental or occupational exposure to loud noises? Any ringing in your ears (**tinnitus**)? Any **dizziness** (**vertigo**) (Jarvis, 2008)? Look for: **Size, shape, skin condition, and tenderness** External canal (redness, swelling, discharge) **Tympanic membrane** [color & characteristics (redness), air/fluid levels] Hearing acuity (also examined as you collect the patient's history)

Assessment of the Nose



Nose Any nasal discharge? Do you get frequent colds? Do you have **sinus pain**? Do you get nose bleeds? Do you have allergies? Have you had a change in sense of smell (Jarvis, 2008)? Look for: **Nasal cavity** (discharge, **rhinorrhea**, **swollen**, mucosa) Sinuses (tenderness) (Jarvis, 2008)

Assessment of the Mouth & Throat

Mouth and Throat **Skin integrity** (lesions or blisters)

Teeth (discoloration, bleeding or swollen gums)

Tongue (color, surface characteristics, moisture, lesions) **Buccal mucosa** (discoloration, leukoplakia)

Uvula (midline) Throat (tonsils, Cranial Nerve XII by sticking out tongue) (Jarvis, 2008) Look For: Do you have any sores or lesions in your mouth or throat? Do you have a sore throat and hoarseness? Do you have a toothache or get bleeding gums? Any difficulty swallowing? Do things taste differently than usual? Do you smoke, drink or chew tobacco (Jarvis, 2008)?

Cardiovascular Assessment

Any **chest pain**? (use PQRST mnemonic) Do you ever get **short of breath**? (associated with what) How many pillows do **you sleep on at night**? (**orthopnea**) Do you have a cough? (describe, frequency, timing, severity, sputum production) Are you frequently fatigued? (morning or night) Do you have any swelling or skin color changes? (**edema, cyanosis, pallor**) How often do you get up at night to urinate? (**nocturia**) Do you have a past history of **cardiac or cardiovascular events** or disorders? Do you have a family history of **cardiovascular disease**? Assess cardiac risk factors? (Jarvis, 2008; Edmunds, Ward & Barnes, 2010)

Pulmonary Assessment



Do you have a cough? (use PQRST mnemonic) Do you **frequently get short of breath**? (position, associated night sweats, related to any triggering event) **Pain with breathing**? (constant or periodic, describe the quality, treatment) Any past history of **breathing trouble or lung disease**? (frequency and severity of colds, allergies, asthma family history, smoking, environmental or occupational risk factors)

Assessing the Abdomen/Gastrointestinal System

: Any change in appetite? Any difficulty **swallowing**? (dysphagia) Any **abdominal pain**? (use PQRST mnemonic) Any nausea or vomiting? (color, odor, presence of blood, food intake in past 24 hours) Any change in bowel habits? (**constipation, diarrhea, blood in stool, or dark, tarry stools**) Do you have any hemorrhoids? (**bleeding, treatment**) Any past history of abdominal problems? (**gall bladder, liver, pancreas, digestion, elimination**)

Musculoskeletal System



: Any joint **pain or problems**? (Use PQRST mnemonic.) Any **stiffness in your joints**? Any swelling, heat or **redness in your joints**? Any limitation of movement in your joints? Which activities are difficult? (Assess functional ability.) Any muscle problems (**pain, cramping, aches, weakness, atrophy**)? Any bone problems (bone pain, deformity, history of broken bones)? (Jarvis, 2008)

Male Reproductive System



Do you urinate more than usual? (frequency, urgency, nocturia) Any pain or burning upon urination? Any difficulty starting or maintaining the stream of urine? Any difficulty controlling your urine? Any blood in your urine? Any problems with your penis? (pain, lesions, discharge) Any problems with your scrotum? (lumps, tenderness, swelling) Are you in a sexually active relationship and if so any difficulties in this relationship related to the physical act of intercourse? Do you use contraceptives? (what type, questions or concerns) Any sexual contact with a partner whom may have had a sexually transmitted disease? Do you perform self-testicular examinations monthly? (Jarvis, 2008)

Female Reproductive System

Do you urinate more than usual? (frequency, urgency, nocturia); Any pain or burning upon urination? Any difficulty starting or maintaining the stream of urine? Any blood in your urine? Any difficulty controlling you urine? Any unusual vaginal discharge? Are you sexually active? Any difficulties related to the physical act of intercourse? Do you use contraceptives? (what type, questions or concerns) Any sexual contact with a partner whom may have had a sexually transmitted disease? Tell me about your menstrual history (onset, length, amount of flow, cramps, bloating, PMS, age of first period, age of menopause).

Nutritional Assessment

Biographical data Age Height Weight Lab Data

Albumin Hemoglobin Hematocrit Total
lymphocytes Other abnormal labs?

Signs of Malnutrition

Lab Values Associated with Malnutrition Abnormal

laboratory values consistent with malnutrition

include: Hemoglobin < 12 g/dl in adult females & <
14 g/dl in adult males Hematocrit < 36-46% in adult
females and < 37-49% in adult males Total

lymphocyte count of < 1800 cell/mm³ Serum

Albumin < 3.5 g/dl Serum Transferrin < 170 mg/dl
(Jarvis, 2008)

Nursing Assessment form

✂ Assessmen.pdf جنرال

TULANE UNIVERSITY MEDICAL CENTER

Date: _____ PEDIATRIC FLOW SHEET

NURSE'S NOTES

NURSE'S NOTES (Continued)

LEGEND

Resp. Quality RG-regular G-grunting R-retracting P-periodic A-apneic S-shallow L-labored F-nasal flaring	Cough NP- non productive PC-productive cough Edema N-none D-dependent G-generalized O-periorbital P-pitting T/P-tibial/pedal	Sputum C-clear T-tenacious P-purulent G-green Y-yellow B-bloody W-white Nail bed Color P-pink W-pale C-cyanotic D-dusky	Breath Sounds C-Clear A-Absent W-Wheezes CS-Coarse CR-Crackles D-Decreased Pulses 3+-bounding 2+-normal 1+-weak 0 -absent	O₂ Route RA-Room air M-Mask N-Nasal Cannula T-Tent Tr-Trach Tube LOC A-awake/alert L-lethargic F-flaccid S-sedated R-respond to pain C-coma Stool N-Soft/formed W-watery S-seedy F-frothy B-bloody T-tarry H-hard
Heart Sounds RG-regular M-murmur I-irregular	Fontanel S-soft FL-flat Sn-sunken B-bulging F-full T-tense	Bowel Sounds P-present A-absent I-decreased II-hyperactive	Abdomen S-soft F-flat D-distended H-hard	Skin Discoloration N-none W-pale D-dusky C-cyanotic J-jaundice M-mottled
Pupils R-reactive NR-non-reactive	Oral Mucosa P-pink W-pale D-dusky C-cyanotic M-moist DR-dry	Turgor G-good F-fair P-poor T-tenting		
Urine Color C-clear Y-yellow L-cloudy B-bloody	Strength N-normal P-paretic D-decerebrate DC-decorticate F-flaccid W-weak	Turn/Position Sf-self L-left R-right P-prone S-supine	Attendant A-absent P-present	I.V. Site N-Dry & intact I-infiltrated P-Phlebotic E-Edematous



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