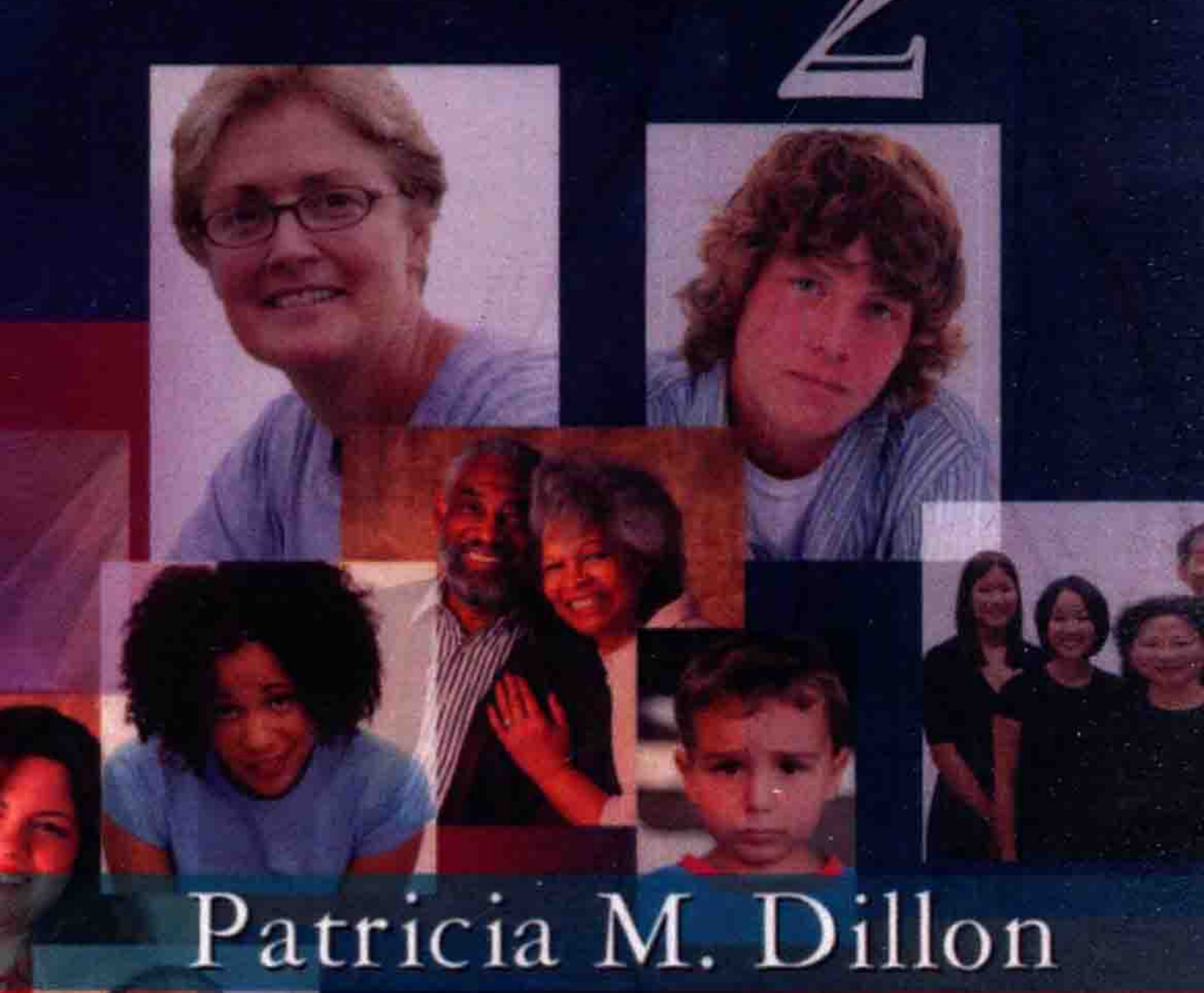
Nursing Health Assessment

CLINICAL POCKET GUIDE

EDITION 2



Patricia M. Dillon

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CLINICAL POCKET GUIDE

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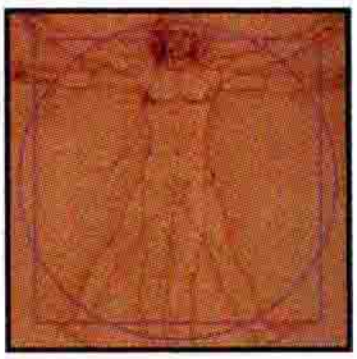

Dedication

To my patients and students

Acknowledgments

I would like to acknowledge the staff of F.A. Davis, especially Lisa Deitch, Darlene Pedersen, William Welsh, and Ilysa Richman, for their support and expertise throughout this project.

Preface

Dear Students,

Now that you have learned the theory behind assessment in class, you need to apply that theory when assessing your patients. *Nursing Health Assessment: Clinical Pocket Guide,* second edition, will help you to bridge the gap from the classroom to the clinical area.

The *Clinical Pocket Guide* contains:

- Primary function of every system
- Developmental and cultural considerations
- Key history questions with specific symptoms
- Integration with other systems
- The physical assessment, which includes:
  - Anatomical landmarks
  - Approach
  - Position for exam
  - Tools needed for exam
  - Assessment procedure and normal and abnormal findings with helpful hints identified by this symbol  and alerts identified by this symbol  .

Think of this pocket guide as another valuable assessment tool that will help you to assess your patients. Take this guide with you wherever you are practicing nursing: the hospital, the home, the community, schools, and long-term care facilities. Use the Clinical Pocket Guide to help you:

- Perfect your assessment skills
- Differentiate normal from abnormal findings
- Validate your assessment findings

Never forget that you learn much from your patients, so view your encounters with them as a means to learn assessment and develop your skills. And practice, practice, practice!

PATRICIA DILLON, DNSC, RN

Contents

CHAPTER 1

The Complete Health Assessment

A complete health assessment includes a comprehensive history and a complete physical assessment.

Complete Health History

Biographical Data

Includes name, address, phone number, contact person, age, birth date, place of birth, gender, race/ethnicity/nationality, religion, marital status, number of dependents, educational level, occupation, social security number/health insurance, source of history/reliability, referral, advance directive.

Current Health Status

Includes symptom analysis for chief complaint and current medications. (At primary level of health-care when the patient does not have an acute problem, current health status should include: usual state of health, any major health problems, usual patterns of health care and any health concerns.)

Past Health History

Includes childhood illnesses, surgeries, hospitalizations, serious injuries, medical problems, medications, allergies, immunizations, and recent travel or military service.

Family History

Includes patient, spouse, children, siblings, parents, aunts, uncles, and grandparents' health status, or, if deceased, age and cause of death.

Review of Systems

Includes questions specific to each body system and analysis of any positive symptoms.

Psychosocial Profile

Includes health practices and beliefs, typical day, nutritional patterns, activity/exercise patterns, recreation, pets/hobbies, sleep/rest patterns, personal habits, occupational health patterns, socioeconomic status, environmental health patterns, roles/relationships, sexuality patterns, social supports, and stress/coping patterns.

Complete Physical Assessment

Approach

Two methods are used for completing a total physical assessment: a systems approach and a head-to-toe approach.

- A systems approach allows for a thorough assessment of each system, doing all assessments related to one system before moving on to the next. Better for a focused assessment.
- A head-to-toe assessment includes the same examinations as a systems assessment, but you assess each region of the body before moving on to the next. Better for a complete assessment.

No matter which approach you use, be systematic and consistent.

All four assessment techniques—inspection, percussion, palpation, and auscultation—are used to perform a complete assessment. Remember:

- Inspect for abnormalities and normal variations of visible body parts.
- Palpate to identify surface characteristics, areas of pain

or tenderness, organs, and abnormalities, including masses and fremitus.
- Percuss to determine the density of underlying tissues and to detect abnormalities in underlying organs.
- Auscultate for sounds made by body organs, including the heart, lungs, intestines, and vascular structures.

Assessment data are usually charted by systems (e.g., respiratory or neurological) and by regions to a limited extent (e.g., head/neck). Your documentation can focus only on positive findings or on both positive and negative findings. No matter which format you use, always be brief and to the point and avoid generalizations.

Toolbox

You will need all of the tools of assessment identified in the other chapters of this book.

Performing a Head-to-Toe Physical Assessment

Here are some helpful hints to keep in mind as you conduct the assessment:

- Wash your hands before you begin.
- Listen to your patient.
- Provide a warm environment.
- If your patient has a problem, start at that point.
- Work from head to toe.
- Compare side to side.
- Let your patient know your findings.
- Use your time not only to assess but also to teach your patient.
- Leave sensitive or painful areas until the end of the examination.

General Survey

Get anthropometric data and vital signs, and evaluate patient's clothing, hygiene, state of well-being, nutritional status, emotional status, speech patterns, level of consciousness, affect, posture, gait, coordination and balance, and gross deformities.

Skin/Hair/Nails

- Inspect and palpate patient's visible skin for color, lesions, texture, and warmth. Continue observation throughout the examination.

Percussion produces sounds that vary according to the tissue being percussed. This chart shows important percussion sounds along with their characteristics and typical locations.

SOUND	INTENSITY	PITCH	DURATION	QUALITY	SOURCE
Resonance	Loud	Low	Long	Hollow	Normal lung
Tympany	Moderate to loud	Medium	Moderate	Drumlike	Gastric air bubble; intestinal air
Dullness	Soft to moderate	High	Moderate	Thudlike	Liver; full bladder; pregnant uterus
Hyperresonance	Very loud	Very low	Long	Booming	Hyperinflated lung (as in emphysema)
Flatness	Soft	Very high	Short	Flat	Muscle

The Effect of Age on Vital Signs

Normal vital sign ranges vary with age, as this chart shows.

AGE	TEMPERATURE		PULSE RATE	RESPIRATORY RATE	BLOOD PRESSURE
	°Fahrenheit	°Celsius			
Newborn	98.6–99.8	37–37.7	120–160	30–80	Systolic: 50–52; diastolic: 25–30; mean: 35–40
3 Yr	98.5–99.5	36.9–37.5	80–125	20–30	Systolic: 78–114; diastolic: 46–78
10 Yr	97.5–98.6	36.3–37	70–110	16–22	Systolic: 90–132; diastolic: 56–86
16 Yr	97.6–98.8	36.4–37.1	55–100	15–20	Systolic: 104–108; diastolic: 60–92
Adult	96.8–99.5	36–37.5	60–100	15–20	Systolic: <120; diastolic: <80
Older Adult	96.5–97.5	35.9–36.3	60–100	15–25	Systolic: <120; diastolic: <80

- Note hair color, texture, and distribution over body.
- Observe hands and nails for clubbing or other abnormalities.

Head/Face

- Note head size, shape, and position.
- Note scalp tenderness, lesions, or masses.
- Observe for facial symmetry and note facial expressions (cranial nerve [CN] VII).
- Test sensation on face (CN V).
- Palpate temporomandibular joint for popping or tenderness.
- Test range of motion (ROM) of neck and assess muscle strength.

Eyes

- Test visual acuity (CN II) with Snellen test or pocket vision screener.
- Perform test of extraocular movements (CNs III, IV, VI).
- Perform cover test and corneal light reflex test.
- Test visual fields by confrontation.
- Inspect general appearance and eyelids.
- Inspect cornea, iris, and lens with oblique lighting.
- Observe sclera and conjunctivae.
- Perform pupillary reaction to light and accommodation.
- Perform fundoscopic examination to test for red reflex and to observe disks and retinal vessels.

Ears

- Inspect external ear and canal.
- Inspect position and angle of attachment.
- Palpate tragus, mastoid, and helix for tenderness.
- Perform Weber test for lateralization, Rinne test for bone and air conduction, and whisper test for low-pitched or low-tone hearing loss (CN VIII).
- Perform otoscopic examination of canal and tympanic membrane.

Nose

- Test for patency of each nostril.
- Test sense of smell (CN I).
- Palpate for sinus tenderness.
- Observe nasal mucosa, septum, and turbinates with speculum.

Mouth/Pharynx

- Inspect and palpate lips and oral mucosa.
- Inspect teeth, gingiva, and palate.
- Inspect pharynx and tonsils.
- Test gag and swallow reflexes, and have patient say "ah" (CNs IX, X).
- Test taste on anterior and posterior tongue (CNs VII, IX).
- Inspect tongue for abnormalities, and check ROM of tongue by having patient say "d, l, n, t" (CN XII).

Neck

- Inspect and palpate thyroid gland.
- Inspect for masses, abnormal pulsations, or tracheal deviation.
- Palpate carotid pulse and listen for bruits.
- Inspect jugular veins.
- Measure jugular venous pressure.
- Palpate lymph nodes in head, neck, and clavicular areas.
- Test ROM of neck.
- Test muscle strength of neck and shoulder muscles (CN XI).

Upper Extremities

- Test for ROM and muscle strength.
- Inspect joints for swelling, redness, and deformities.
- Test hand grip.
- Test superficial and deep sensations.
- Palpate radial, ulnar, and brachial pulses.
- Test for deep tendon reflexes of biceps, triceps, and brachioradialis.
- Test coordination, rapid alternating movements, and finger-thumb opposition.
- Inspect and palpate nails, checking capillary refill and angle of attachment.
- Test for pronator drift.
- Test for accuracy of movements with point-to-point movements.

Posterior Thorax/Back

- Palpate thyroid from behind (if not done previously).
- Inspect spine and palpate muscles along spine.
- Percuss and auscultate lung fields.
- Fist/blunt percuss costovertebral angle tenderness.

- Palpate and percuss chest excursion.
- Palpate tactile fremitus.
- Note normal curvatures of spine.
- Test for kyphosis, scoliosis, and lordosis.
- Check ROM of spine.

Anterior Thorax

- Inspect, palpate, percuss, and auscultate lungs.
- Inspect and palpate precordium for pulsations, point of maximal impulse, and thrills.
- Auscultate heart.
- Inspect and palpate breasts.
- Palpate axillary and epitrochlear lymph nodes.

Abdomen

- Inspect for shape, scars, movements, and abnormalities.
- Auscultate for bowel sounds and vascular sounds.
- Percuss abdomen and organs for size.
- Obtain a liver measurement.
- Palpate lightly for tenderness.
- Palpate deeply for masses and enlarged liver, spleen, kidneys, and aorta.
- Palpate femoral arteries and inguinal lymph nodes.
- If ascites suspected, percuss for shifting dullness.

Lower Extremities

- Inspect for skin color, hair distribution, temperature, edema, and varicose veins.
- Test for ROM, muscle strength, and superficial and deep sensations.
- Palpate pulses.
- Test deep tendon reflexes and plantar reflex.
- Observe gait, toe walk, heel walk, heel-to-toe walk, and deep knee bend.
- Perform Romberg's test and proprioception test.
- Test coordination with toe tapping and heel down shin.
- If indicated, test knees for fluid with bulge sign or patellar tap.
- If indicated, test for torn meniscus with Apley's or McMurray's test.
- Observe ROM of lower extremities.
- Test muscle strength of lower extremities.

Female Genitalia/Rectum

- Inspect and palpate external genitalia and inguinal lymph nodes.
- Perform internal examination: Inspect vagina and cervix, collect Pap smear and cultures.
- Palpate uterus and adnexa.
- Inspect perianal area and palpate anal canal and rectum.
- Test stool for occult blood.

Male Genitalia/Rectum

- Inspect and palpate external genitalia.
- Palpate for hernias.
- Inspect perianal area for hemorrhoids or abnormalities.
- Palpate anal canal, rectum, and prostate.
- Test stool on glove for occult blood.

Documenting Physical Assessment Findings

Document physical assessment findings by system, using the following sequence:

- General survey, including anthropometric measurements and vital signs
- Integumentary
- Head, face, and neck
- Eyes
- Ears, nose, and throat
- Respiratory
- Cardiovascular
- Breasts
- Abdomen
- Male/female genitourinary
- Musculoskeletal
- Neurologic

Focused Physical Assessments

- Focused assessments are only partial ones, dealing only with systems that relate to the patient's problem, so less data are collected.
- Focused assessments are used when the patient's condition or time restraints preclude a comprehensive assessment.
- A focused physical assessment should include:

- A general survey with vital signs and weight.
- Assessment of level of consciousness.
- Assessment of skin color, temperature, and texture.
- Testing of gross motor balance and coordination.
- Testing of extraocular movements.
- Testing of pupillary reaction.
- Testing of gross vision and hearing.
- Inspection of oral mucosa as patient says "ah."
- Auscultation of anterior and posterior breath sounds.
- Palpation of apical impulse, point of maximal impulse.
- Auscultation of heart sounds.
- Inspect abdomen.
- Auscultation of abdomen.
- Percussion of abdomen.
- Palpation of abdomen.
- Palpation of peripheral pulses.
- Testing sensation to touch on extremities.
- Palpation of muscle strength of upper and lower extremities.