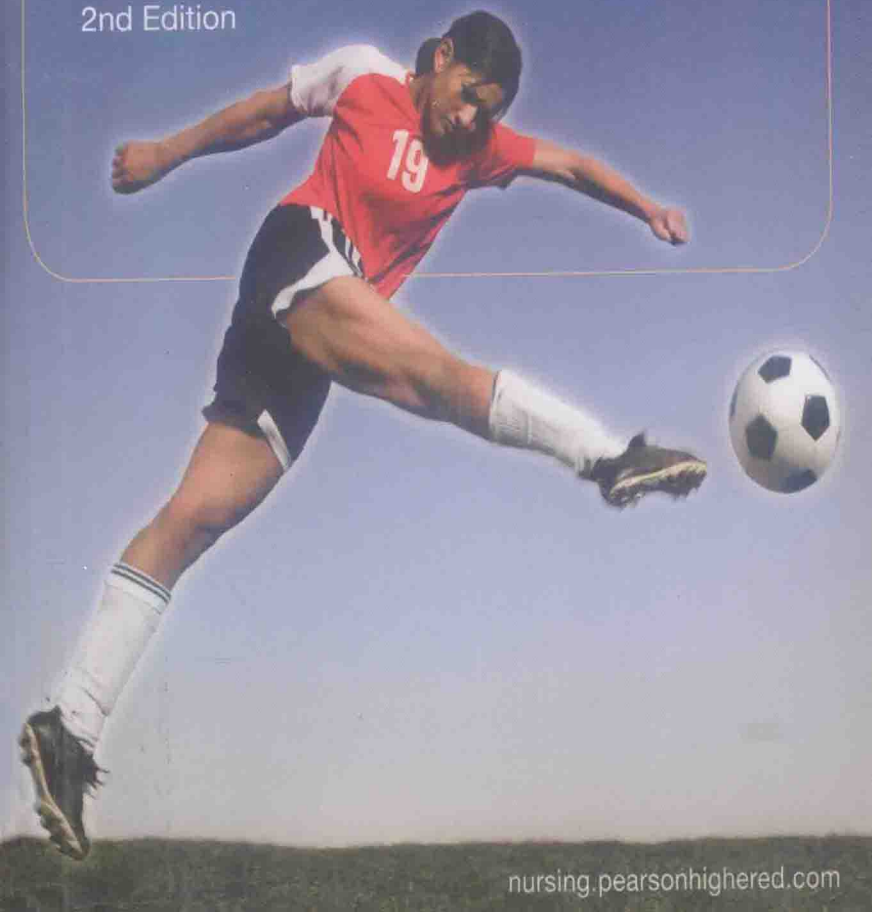
Clinical Pocket Guide

Health & Physical Assessment in Nursing

Colleen Barbarito • Donita D'Amico

2nd Edition



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藏书章

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Preface

Clinical Pocket Guide for Health & Physical Assessment in Nursing is a resource that can be used by both novice students and professional nurses. For students who don't take a separate health assessment course who want to supplement their medical-surgical nursing text, the Clinical Pocket Guide is designed to be used as a health assessment primer; it guides the user through the steps of collecting health assessment data.

The focus of this text is comprehensive health assessment, which includes the collection of subjective and objective data. Subjective data encompasses both the client's health history and the focused interview. The nurse collects Objective data during the physical assessment.

To help readers use this guide effectively, the following features were developed for the body system chapters, chapters 5 through 18:

- The **Anatomy and Physiology Review** includes pertinent diagrams and illustrations.
- **Special Considerations** sections highlight differences in infants and children, pregnant women, and older adults.
- **Cultural Considerations** boxes alert the reader to variations related to cultural differences nurses encounter while performing the assessment.
- **Gathering the Data** guides the reader through the interviewing process, with specific questions.
- The **Physical Assessment** process includes Techniques, Normal Findings, Abnormal Findings, and Special Considerations.
- The sections on **Common Abnormal Findings** describe and illustrate common conditions.

The first two chapters of this guide introduce the concepts of assessment. Chapter 1 defines health and health assessment. In addition, it describes the steps of the nursing process, critical thinking, and documentation, using a variety of methods. Chapter 2 describes the techniques of inspection, palpation, percussion, and auscultation. It describes the role of the nurse and the identification of client cues, emphasizing a safe and clean environment.

Chapters 3 and 4 introduce the assessment process. Chapter 3, General Survey, describes the initiation of data collection. It includes components of the general survey, age-related considerations, measurement of the five vital signs, and a functional assessment. Chapter 4, The Health History, describes the health history and the component parts.

Chapter 19, "Putting It All Together," applies all the concepts of the preceding chapters. Chapter 20, "The Complete Health Assessment," describes the recommended procedure and pattern for completing a head-to-toe assessment. Chapter 21, "The Hospitalized Client," walks the reader through the recommended assessment procedure for the hospitalized client.

A sincere and deep expression of thanks is extended to our chapter contributors. Their time, effort, and expertise so willingly given for developing and writing chapters helped foster the project's success.

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Colleen Barbarito received a nursing diploma from Orange Memorial Hospital School of Nursing, graduated with a baccalaureate degree from William Paterson College, and earned a master's degree from Seton Hall University, all in New Jersey. She received her Doctor of Education from Teachers College, Columbia University. Prior to a position in education, Dr. Barbarito's clinical experiences included medical-surgical, critical care, and emergency nursing. Dr. Barbarito has been a faculty member at William Paterson University since 1984, where she has taught physical assessment and a variety of clinical laboratory courses for undergraduate nursing students and curriculum development at the graduate level.

Dr. Barbarito coauthored three books with Donita D'Amico—*Modules for Medication Administration, Comprehensive Health Assessment: A Student Workbook,* and *Health & Physical Assessment in Nursing,* 1st edition. She published articles on anaphylaxis in *American Journal of Nursing* and *Coping with Allergies and Asthma.* Her research includes physical assessment and collaboration on revising a physical assessment project with results published as a brief in *Nurse Educator.*

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Donita D'Amico earned her baccalaureate degree in nursing from William Paterson College. She earned a master's degree in Nursing Education at Teachers College, Columbia University, with a specialization in Adult Health. Ms. D'Amico has been a faculty member at William Paterson University for more than 25 years. Her teaching responsibilities include physical assessment, medical-surgical nursing, nursing theory, and fundamentals in the classroom, skills laboratory, and clinical settings.

Ms. D'Amico co-authored several textbooks, including *Health & Physical Assessment in Nursing,* 1st edition and its companion clinical handbook by Sims, D'Amico, Stiesmeyer, and Webster; as well as *Comprehensive Health Assessment: A Student Workbook* and *Modules for Medication Administration* with Dr. Colleen Barbarito.

Contents

1
Health Assessment

This chapter provides an overview of the aspects of nursing practice and nursing skills required for comprehensive health assessment. These include holistic assessment, nursing process, critical thinking, communication, and documentation. The skills and approaches required to meet the needs of diverse clients seeking advice and care in the changing healthcare system are illustrated throughout this text.

HEALTH

Traditionally, **health** has been thought of as the absence of disease. The terms *health* and *wellness* have been used interchangeably to describe the state when one is not sick. Today, these terms have clear distinctions in regard to definition and description of actions.

DEFINITIONS OF HEALTH

The World Health Organization (WHO) presented a definition of health that remains active and relevant today. Health is defined as a state of complete physical, mental, and social well-being (WHO, 1947). Further, the World Health Organization describes health from a holistic approach in which the individual is viewed as a total person interacting with others. The individual functions within his or her physical, psychologic, and social fields. These fields interact with each other and the external environment. The individual has the capability of maximizing the potential and fostering the most positive aspects of health.

The following definitions of health reflect the work of nursing theorists:

- A process and a state of being and becoming whole and integrated in a way that reflects person and environment mutuality (Roy & Andrews, 1999).
- The state of a person as characterized by soundness or wholeness of developed human structures and mental and bodily functioning that requires therapeutic self-care (Orem, 1971).
- A culturally defined, valued, and practiced state of well-being reflective of the ability to perform role activities (Leininger, 2007).
- A state of well-being and use of every power the person possesses to the fullest extent (Nightingale, 1860/1969).

Health is highly individualized and the definition one develops for oneself will be influenced by many factors. These factors will include but not be limited to age, gender, race, family, culture, religion, socioeconomic conditions, environment, previous experiences, and self-expectations.

Nurses must recognize that each client will have a personal definition for health, illness, and wellness. The behaviors one uses to maintain these changing states will be most individualized. Nurses must be aware of their own personal definition of health and at the same time accept and respect the client's definition of health, for this will influence practice. When health is defined in terms of physical change, the practice focus is on improvement of physical function. When health is considered to be reflective of physical, cultural, environmental, psychologic, and social factors, the focus of nursing practice is more holistic and wide ranging.

HEALTH ASSESSMENT

Health assessment may be defined as a systematic method of collecting data about a client for the purpose of determining the client's current and ongoing health status, predicting risks to health, and identifying health-promoting activities. The data include physical, social, cultural, environmental, and emotional factors that impact the overall well-being of the client. The health status will include wellness behaviors, illness signs and symptoms, client strengths and weaknesses, and risk factors. The scope of focus must be more than problems presented by the client. The nurse will use a variety of sources to gather the objective and subjective data. Knowledge of the natural and social sciences is a strong foundation for the nurse. Effective communication techniques and use of critical thinking skills are essential in helping the nurse to gather detailed, complete, relevant, objective, subjective, and measurable data needed to formulate a plan of care to meet the needs of the client. Health assessment includes the interview, physical assessment, documentation, and interpretation of findings. All planning for care is directed by interpretation of findings from objective and subjective data collected throughout the assessment process.

THE INTERVIEW

The **interview,** in which subjective data are gathered, includes the health history and focused interview. The data collected will come from primary and secondary sources. The primary source from which data are collected is the client, and the client is considered to be the direct source. An indirect or secondary source would include family members, caregivers, other members of the health team, and medical records.

Subjective data are items of information that the client experiences and communicates to the nurse. Perceptions of pain, nausea, dizziness, itching sensations, or feeling nervous are examples of subjective data. Only the client can describe these feelings. Subjective data are usually referred to as covert (hidden) data or as a symptom, when it is perceived by the client and cannot be observed by others. Family members or caregivers could report subjective data based on perceptions the client has shared with them. This information is most helpful when the client is very ill or unable to communicate and is required when the client is an infant or child. However, to ensure accuracy, the nurse must validate subjective data obtained from other sources. The accuracy of subjective data depends on the nurse's ability to clarify the information gathered with follow-up questions and to obtain supporting data from other pertinent sources.

THE HEALTH HISTORY

The purpose of the **health history** is to obtain information about the client's health in his or her own words and based on the client's own perceptions. Biographic data, perceptions about health, past and present history of illness and injury, family history, a review of systems, and health patterns and practices are the types of information included in the health history. The health history provides cues regarding the client's health and guides further data collection. The health history is the most important aspect of the assessment process.

THE FOCUSED INTERVIEW

The **focused interview** enables the nurse to clarify points, to obtain missing information, and to follow up on verbal and nonverbal cues identified in the health history. The nurse does not use a prepared set of questions for the focused interview. The nurse applies knowledge and critical thinking when asking specific and detailed questions or requesting descriptions of symptoms, feelings, or events. Therefore, the focused interview provides the means and opportunity to

expand the subjective database regarding specific strengths, weaknesses, problems, or concerns expressed by the client or required by the nurse to begin to make reliable judgments about information and observations as part of planning care. In-depth information about the focused interview in health assessment is included in each chapter of this text.

PHYSICAL ASSESSMENT

Physical assessment is hands-on examination of the client. Components of physical assessment are the survey and examination of systems. Objective data gathered during physical assessment, when combined with all other reliable sources of information, provide a sound database from which care planning may proceed. **Objective data** are observed or measured by the professional nurse. This is also known as overt data or a sign since they are detected by the nurse. These data can be seen, felt, heard, or measured by the professional nurse. For example, skin color can be seen, a pulse can be felt, a cough can be heard, and a blood pressure can be measured. These objective data are needed to validate subjective data and to complete the database.

INTERPRETATION OF FINDINGS

Interpretation of findings can be defined as making determinations about all of the data collected in the health assessment process. One must determine if the findings fall within normal and expected ranges in relation to the client's age, gender, and race and then the significance of the findings in relation to the client's health status and immediate and long-range, health-related needs. Interpretation of findings is influenced by a number of factors. These factors include the ability to obtain, recall, and apply knowledge; to communicate effectively; and to use a holistic approach. In a holistic approach, the nurse recognizes that developmental, psychological, emotional, family, cultural, and environmental factors will affect immediate and long-term actual and potential health goals, problems, and plans.

NURSING PROCESS

Nursing practice is concerned with health promotion, wellness, illness prevention, health restoration, and care for the dying. The nursing process in which the nurse uses comprehensive assessment to identify a client's health status and actual or potential needs guides the practice of nursing. The nursing process then directs the nurse in the development of plans and the use of nursing interventions to meet those identified needs. The **nursing process** is a systematic, rational, dynamic, and cyclic process used by the nurse for planning and providing care for the client. The steps of the nursing process are assessment, diagnosis, planning, implementation, and evaluation. The nursing process can be used in any setting, with clients of all ages, and in all levels of health and illness (Figure 1.1).

1. **Assessment,** the first step, is the collection, organization, and validation of subjective and objective data. The data collected form the database used by the nurse. As the data change, the nurse must update the database. The database will describe the physical, emotional, and spiritual health status of the client. Strengths and weaknesses are identified as are responses to any treatment modalities.

   Assessment begins at the moment the nurse meets the client and begins to gather information. Each piece of information collected about a client is a cue, because it hints at the total health status of the client. The baseline data act as a marker during future assessment. These data become a guide

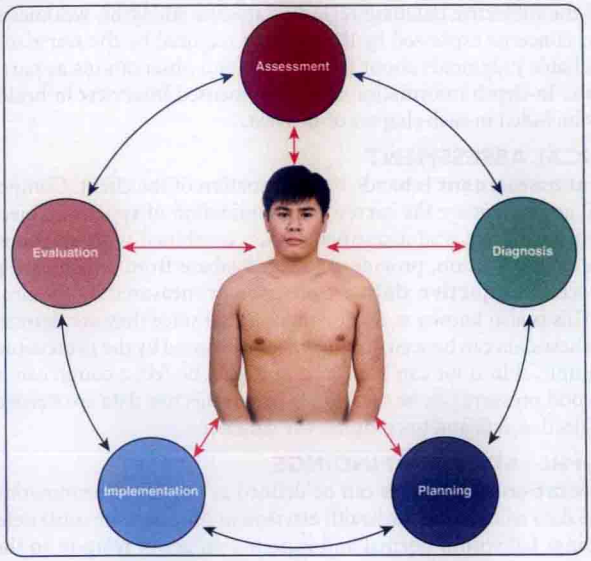

Figure 1.1 • Nursing process.

for the nurse as to what questions to ask and what additional information is needed.

2. **Diagnosis** is the second step of the nursing process. The nurse uses critical thinking and applies knowledge from the sciences and other disciplines to analyze and synthesize the data. Client strengths, risks, and weaknesses are clearly identified. Data are compared to normative values and standards. Normative values and standards include but are not limited to charts for growth and development, laboratory values (hemoglobin, hematocrit, total cholesterol, blood glucose, etc.), the degree of flexion in the joints, the rate and characteristics of pulses, blood pressure, heart sounds, skin texture, core body temperature, language development, role performance, and interdependent functions.

   Similar data are clustered or grouped together. The professional nurse makes a judgment after analysis and synthesis of collected data. This then becomes the nursing diagnosis, which is the basis for planning and implementing nursing care.

3. **Planning,** the third step, involves setting priorities, stating client goals or outcomes, and selecting nursing interventions, strategies, or orders to deal with the health status of the client. When possible, these activities need to include input from the client. Consultation or additional input may be needed from other healthcare professionals and family members. The developed nursing care plan acts as a guide for client care. This will help to enhance client strengths and help to negate, change, or prevent a weakness or problem for the client.

4. **Implementation** is the fourth step of the nursing process. Now the care plan is put into action. Putting the nursing interventions into action, the professional nurse determines the client's need for assistance or the ability to function independently to achieve the stated goals. The professional

nurse continues with the ongoing assessment of the client to update the database as behaviors change. The documentation of the implemented actions will include the client's response to nursing care. These actions will help meet the stated goals or outcomes, promote wellness, or convert illness to an improved state of health.

5. **Evaluation** is the final step of the nursing process. The professional nurse compares the present client status to achievement of the stated goals or outcomes. At this time the nurse will need to modify the nursing care plan. This modification can be to continue, change, or terminate the nursing care plan based on goal achievement.

CRITICAL THINKING

Critical thinking is a cognitive skill employed in all nursing activities that enhances the application of the nursing process. Alfaro-LeFevre (2003) defined and explained the critical thinking process. This work provided the foundation for the following discussion. **Critical thinking** is a process of purposeful and creative thinking about resolutions of problems or the development of ways to manage situations. It demands that nurses avoid bias and prejudice in their approach while using all of the knowledge and resources at their disposal to assist clients in achieving health goals or maintaining well-being.

When critically thinking about the client's health status, problems, or situations, one applies essential elements and skills. The five essential elements of critical thinking are collection of information, analysis of the situation, generation of alternatives, selection of alternatives, and evaluation. Figure 1.2 depicts the elements of critical thinking. Each element has working skills to help the nurse be complete, thorough, and competent with the cognitive processes of critical thinking. Critical thinking skills are linked with each of the essential elements.

1. **Collection of information,** the first of the elements in critical thinking, involves the five skills of identifying assumptions, organizing data collection, determining the reliability of the data, identifying relevant versus irrelevant data, and identifying inconsistencies in the data. In use of this first skill, the nurse must be able to identify assumptions that can misguide or misdirect the assessment and intervention processes. For example, when interviewing a client, one must not assume that lack of eye contact indicates lack of attention, dishonesty, or apathy when it occurs in Asian, Native American, and other individuals.

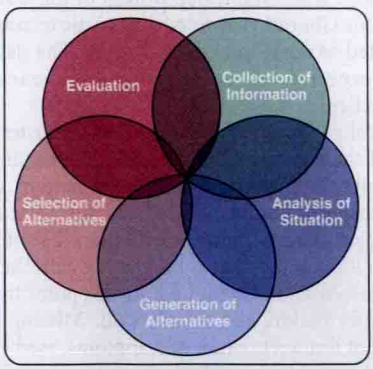

Figure 1.2 • Elements of critical thinking.

The second skill of collection of information is organizing data collection. Collection of subjective and objective data must be carried out in an organized manner. In health assessment the nurse first determines the client's current health status, level of distress, and ability to participate in the assessment process. The aim of data gathering in a client in acute distress is rapid identification of the problem and significant predisposing and contributory factors in order to select and initiate interventions to alleviate the distress. In nonacute situations, assessment follows an accepted and organized framework of survey, interview, and physical assessment.

The third skill of collection of information is determining the reliability of the data. One must recall that client information is valuable if it is reliable and accurate. The client is generally the best source of information, especially historic. However, physical and psychologic factors may interfere with that capability. Information is then sought from a family member or caregiver who can provide reliable information. Other reliable sources of information include charts, medical records, and notes from other health professionals. One must also be certain that objective data are accurate. Measuring devices must be standardized, calibrated, and applied correctly.

A wealth of information is obtained when carrying out a comprehensive health assessment. One then applies the fourth critical thinking skill, which is to determine the relevance of the information in relation to the client's current, evolving, or potential condition or situation. Consider the relevance of nonimmunization or contraction of German measles in a male client seeking care for a fracture versus a 26-year-old sexually active female having an annual examination.

Identifying inconsistencies is the last of the skills associated with the element of collection of information. The nurse must be able to recognize discrepancies in the information. Further, one must determine if the inconsistency is a result of an oversight, misunderstanding, linguistic factor, or cultural factor. Indication of confusion, memory impairment, and subtle or overt communication indicating discomfort with a topic or area of questioning must also be considered.

2. **Analysis of the situation** includes the following five skills: distinguish data as normal or abnormal, cluster related data, identify patterns in the data, identify missing information, and draw valid conclusions. The first of the skills is distinguishing normal from abnormal data. The nurse uses knowledge of human behavior as well as anatomy and physiology to compare findings with established norms in these areas. The nurse will use standards for laboratory results, diagnostic testing, charts, scales, and measures related to development and aging. The data must be analyzed in relation to expected ranges for age, gender, genetic background, and culture of the client.

When critically thinking, the nurse will then cluster related information by sorting and categorizing information into groupings that may include but are not limited to cues, symptoms, body systems, or health practices.

Once the clustering has been completed, the nurse must apply the third skill of identifying patterns in the information. Use of this skill enables the nurse to get an idea about what is happening with the client and to determine if more information is required. At this point the nurse would identify missing information, the fourth skill. Missing information would include but is not limited to onset of symptoms, medication history, family history of similar problems, and measures the client has taken to alleviate

the problems. Additional information would include laboratory studies of hematologic, metabolic, or hormonal function.

The nurse has acquired information necessary to apply the last skill of drawing valid conclusions. This skill requires using all of one's knowledge and reasoning skills to draw logical conclusions about a problem or situation. The critical thinking process continues as the nurse works with the client to develop a treatment plan for his or her problem.

3. **Generation of alternatives** incorporates the skills of articulating options and establishing priorities. Articulation of options is simply stating possible paths to follow or actions to take to resolve a problem. Once the options have been enumerated, the nurse and client work together to establish priorities. This process must reflect the acuity of the problem and the client's ability to interpret the information required to weigh the advantages and disadvantages of each of the options in relation to health, lifestyle, cultural, and socioeconomic factors.
4. **Selection of alternatives** is the next element of critical thinking, and linked with it are the skills of developing outcomes and developing plans. Outcomes are statements of what the client will do or be able to do in a specific time period. The plan includes all of the actions required by the client independently or in coordination with healthcare professionals and others to achieve the stated outcomes. A plan is developed to guide the client toward meeting expectations in the stated outcomes.
5. **Evaluation** is the last element in critical thinking. This element includes the skills of determining if the expected outcomes have been achieved and reviewing the application of each of the critical thinking skills to be sure that omissions and misinterpretations did not occur. In addition, the nurse must evaluate thinking and judgment in the situation. One must be sure that decisions and actions were based on knowledge and the use of reliable resources and information. Furthermore, one must be sure that acts are based on moral and ethical principles and that the effects of values and biases have been considered.

DOCUMENTATION

Documentation of data from health assessment creates a client record or becomes an addition to an existing health record. The **client record** is a legal document used to plan care, to communicate information between and among healthcare providers, and to monitor quality of care.

Documentation is used to communicate information between and among the health professionals involved in the care of the client. In order for that communication to be effective documentation must be accurate, confidential, appropriate, complete, and detailed. When documenting, the nurse must use standard and accepted abbreviations, symbols, and terminology and must reflect professional and organizational standards.

Accuracy means that documentation is limited to facts or factual accounts of observations rather than opinions or interpretations of observations. When recording subjective data, it is important to use quotation marks and quote a client exactly rather than interpret the statement. In health assessment, accuracy also requires the use of accurate measurement and location of symptoms and physical findings.

Confidentiality means that information sharing is limited to those directly involved in client care. Information is considered appropriate for inclusion in a health record only if it has direct bearing on the client's health. Complete

documentation means that all information required to develop a plan of care for the client has been included. Methods for documentation include narrative notes, problem-oriented charting, scales, flow sheets or check sheets, charting by exception, focus documentation, and computer documentation.

Narrative Notes. When implementing narrative notes, the nurse utilizes words, phrases, sentences, and paragraphs to record information. The information may be recorded in chronologic order from initial contact through conclusion of the assessment, or in categories according to the type of data collected. The narrative record includes words, sentences, phrases, or lists to indicate judgments made about the data, plans to address concerns, and actions taken to meet the health needs of the client.

Problem-Oriented Charting. Problem-oriented records include the SOAP and APIE methods. The letters SOAP refer to recording **S**ubjective data, **O**bjective data, **A**ssessment, and **P**lanning. Subjective data are those reported by the client or reliable informant. Objective data are derived from the physical examination, client records, and reports. Assessment refers to conclusions drawn from the data. Planning indicates the actions to be taken to resolve problems or address client needs. The letters APIE refer to **A**ssessment, **P**roblem, **I**ntervention, and **E**valuation. When using this method, documentation of assessment includes combining the subjective and objective data. The nurse will draw conclusions from the data, identify and record the problem or problems, and plan to address these problems. Interventions are documented as they are carried out. Evaluation refers to documentation of the response to the plan.

Flow Sheets. Documentation of health assessment data can be accomplished through the use of scales, check sheets, or flowcharts. These forms are usually formatted for a specific purpose or need. They may use columns or categories for recording data and may include lists of expected findings with associated qualifiers for ranges of normal or abnormal findings. Charts and check sheets often provide space for narrative descriptions or comments.

Focus Documentation. Focus documentation is a method that does not limit documentation to problems, but can include client strengths. This type of documentation is intended to address a specific purpose or focus, that is, a symptom, strength, or need. A comprehensive health assessment may result in one or more foci for documentation. The format for focus documentation is a column to address subjective and objective data, nursing action, and client response.

Charting by Exception. Charting by exception is a system in which documentation is limited to exceptions from pre-established norms or significant findings. Flow sheets with appropriate information and parameters are completed. This type of documentation eliminates much of the repetition involved in narrative and other forms of documentation.

Computer Documentation. Computer-generated documentation may include all of the previously mentioned methods for recording data. The amount and types of information to be documented vary according to the computer program and the policies and standards of the agency in which computer documentation is utilized.

2
Techniques and Equipment

Concepts to be considered when assessing the overall health status of the client include but are not limited to health, wellness, growth and development, culture, and psychosocial considerations. Much of the data gathered in relation to these concepts are subjective and are obtained through client interviews during the health history and focused interview sessions. Objective data must be gathered as part of the **database.** This is accomplished through the physical assessment of the client.

BASIC TECHNIQUES OF PHYSICAL ASSESSMENT

When performing physical assessment, the nurse will utilize four basic techniques to obtain objective and measurable data. These techniques are inspection, palpation, percussion, and auscultation and are performed in an organized manner. This pattern of organization varies when assessing the abdomen. The sequence for abdominal assessment is inspection, auscultation, percussion, and palpation. Percussion and palpation could alter the natural sounds of the abdomen; therefore, it is important to auscultate and listen to the unaltered sounds.

INSPECTION

Inspection is the skill of observing the client in a deliberate, systematic manner. It begins the moment the nurse meets the client and continues until the end of the client-nurse interaction. Inspection begins with a survey of the client's appearance and a comparison of the right and left sides of the client's body, which should be nearly symmetric. As the nurse assesses each body system or region, he or she inspects for color, size, shape, contour, symmetry, movement, or drainage. When inspecting a large body region, the nurse should proceed from general overview to specific detail. One should remember to look at the client, listen for natural sounds, and use the sense of smell to detect odors. Use of each of the senses enhances the findings.

Although the nurse will perform most of the inspection without the help of instruments, some special tools for visualizing certain body organs or regions are important. For example, the ophthalmoscope is used to inspect the inner aspect of the eye.

PALPATION

Palpation is the skill of assessing the client through the sense of touch to determine specific characteristics of the body. These characteristics include size, shape, location, mobility of a part, position, vibrations, temperature, texture, moisture, tenderness, and edema. The nurse must learn how much pressure to use during palpation with the examination hand. Too much pressure may produce pain for the client. Too little pressure may not permit the nurse to perceive the data accurately. This is a skill that requires practice and is developed over time.

The hand has several sensitive areas; therefore, it is important to use the part of the hand most responsive to body structures and functions. The nurse will use the fingertips, finger pads, base of the fingers, palmar surface of the fingers, and the dorsal and ulnar surfaces of the hand (Figure 2.1).

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