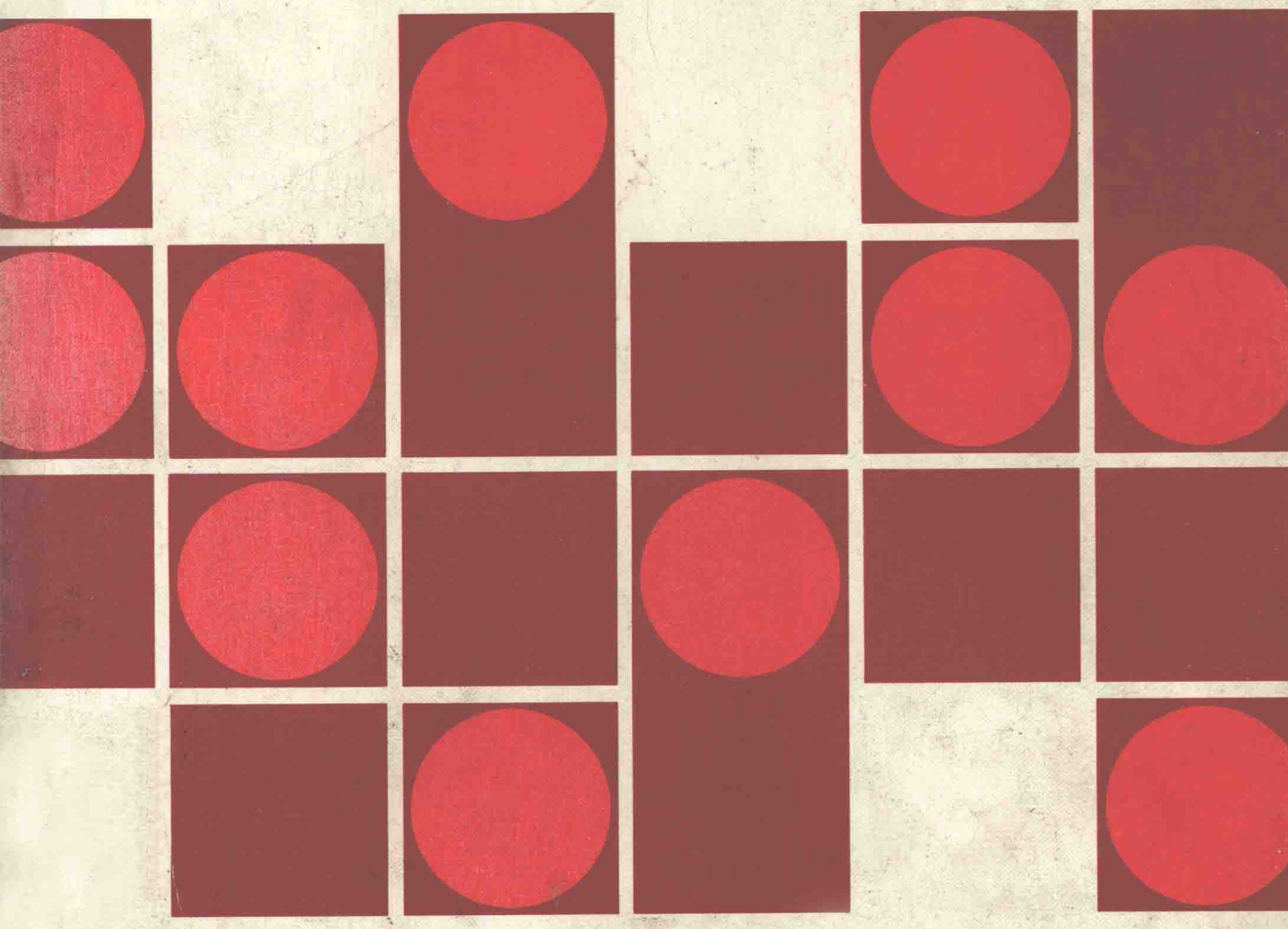
PHYSICAL ASSESSMENT SKILLS FOR NURSING PRACTICE



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SECOND EDITION

Physical Assessment Skills for Nursing Practice

Second Edition

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Preface

Reader recommendations have guided the revisions incorporated into this second edition. We appreciate the reactions to our first edition and hope that our revisions will enhance this text's usefulness.

The illustrations have been expanded greatly both in number and in detail to facilitate reader comprehension. We are indebted to Professor Gerald P. Hodge, Director, Medical and Biological Illustration Unit of The University of Michigan, Associate Professor Lou Sadler, and their staff artists for their help in planning and preparing the new illustrations.

The sectioned format has been maintained to serve the varying reference needs of clinicians and students.

The nursing framework perspective, fundamental to clinical applications of the assessment process presented in Sections II and III in the first edition, has been retained in Section I. New material related to the very crucial quality assurance component in nursing has been added to Chapter 3.

All chapters have been reviewed and modified as contributing authors and editors considered necessary in light of changing knowledge and practice needs.

References and suggested reading lists have been updated. Our central focus remains, as before, to provide a nursing context for the physical assessment process with sufficient detail for application by the nurse or student in different clinical settings. A new feature has been added to serve as a quick reference source: major considerations are briefly outlined at the end of most chapters in Sections II and III and pocket-sized cue cards carrying the same information also appear in a pocket at the back of the book. We hope that they will be useful ready reference guides.

The secretarial assistance of Ms. Bernice Gittens deserves mention, and we are especially grateful for the invaluable counsel and assistance of Ann West, Nursing Developmental Editor, Little, Brown and Company.

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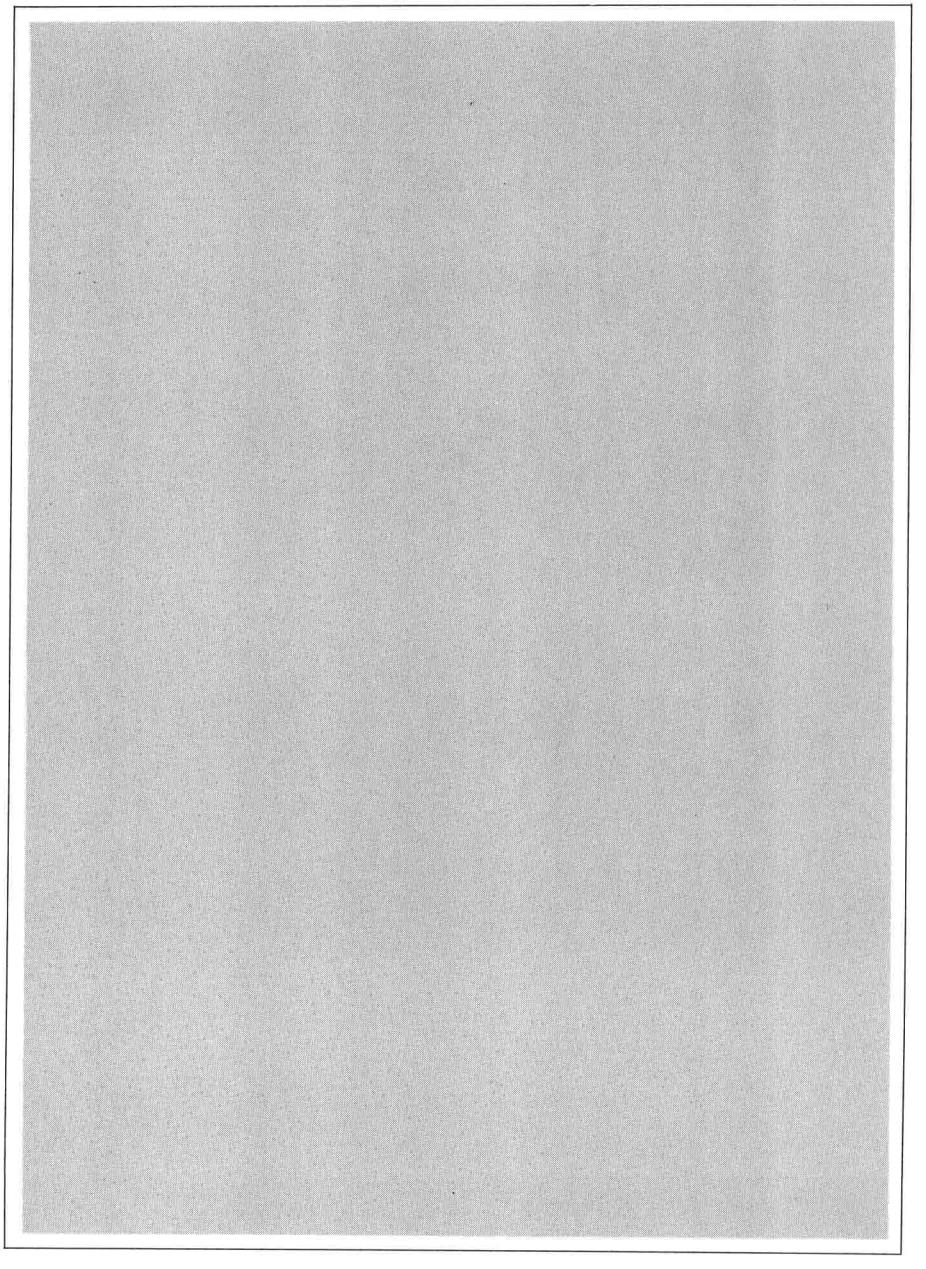

Marjorie M. Jackson

1. Expanded Nursing Practice

A popular phrase in nursing parlance today is the "expanded role of the nurse." Ever so quickly, like a burst of Chinese firecrackers, the phrase has caught the fancy of the nursing profession. In haste, it has been rejected or endorsed in its embryonic stage without being seriously studied, completely understood, and fully tested in practice. *Expanded role* is a term that means whatever the user wishes it to mean. It is used interchangeably with "extended role" or to characterize a variety of new nursing roles: nurse practitioner, nurse clinician, or clinical nurse specialist. A selective use of the term emphasizes changing role and function; a wider and richer perspective focuses on changing nursing practice. The position presented here is that true expansion of nursing practice will be achieved when nurses assume greater responsibility and accountability for patient cure and restoration in acute, chronic, and preventive health care settings.

Expanded role has had its roots in the management concept of job enlargement, which grew out of an orientation toward and concern for the development of human resources in organizations. The enlargement concept includes a triad: (1) variety of knowledge and skills in doing a job; (2) a better utilization of the worker's total skills and abilities; and (3) responsibility and freedom in the performance of the job. True job enlargement is not the addition of the same kinds of tasks, but an expansion of job content with a wider variety of tasks and an increased freedom of methods.

EXTENDED ROLE VERSUS EXPANDED ROLE

Murphy [7] provides an important conceptual distinction between the job enlargement of the nurse who is a role extender and the nurse who is a role expander. She describes role extension as a unilateral lengthening, an additive process, and role expansion as a spreading out, a process of diffusion. With expansion, by definition, there is a richer mix both in the variety of tasks and in the new relationships among the tasks. The very nature of nursing practice is dynamically changed. With extension, by definition, there is continued addition of similar tasks and techniques, so that the nature of nursing practice is essentially unchanged. Nurses have always been in an extended role for, like it or not, a substantial portion of clinical nursing practice has and continues primarily to be inherited medical practice. Many of the major clinical functions in nursing are predominantly medical orders translated into action. This is strikingly evident in hospitals, which constitute the professional center of the health care world. Historically, nurses have been the physicians' assistants, implementing medical regimens and applying medical technology. The current controversy about roles and role alignments was ignited by the advent of a new breed, the physician's assistant, and is significantly influenced by the women's

liberation movement's emphasis on equity and autonomy. This controversy revolves around the scope of nursing practice as distinct from medical practice.

THE NATURE OF NURSING PRACTICE

Definitions of nursing abound, and while there is no consensus, there is consistent recognition of its nature as human service and assistance. The primary goal of nursing is to assist persons to attain and maintain optimal physical, psychologic, and social functioning. The assistance ranges along the entire health-illness continuum from birth to death and is offered in a variety of health care settings, including the home. This helping role of nursing encompasses both instrumental and expressive functions. These evolve from the needs of patients and from the needs of medical practice and of the medical practitioner. The persistent dilemma of nursing is the proper marriage of instrumental and expressive functions, and this conflict is intensified by the acceleration in the technology of therapy and the escalating demand for health care.

To care and comfort is said to be the special province of the nurse. To cure and restore is said to be the special province of the physician. Murphy has superimposed the extender-expander role concepts on this cure-care model in terms of physician-nurse responsibilities. When viewed in Murphy's juxtaposition, the nurse who takes on primarily the cure functions of medicine becomes an extender of cure, while the nurse who undertakes the care function becomes an expander of care. Yet does it not distort the reality of the bedside, of the neighborhood clinic, or of the family the public health nurse assists to distinguish care and comfort from treatment and cure? To say that cure is a secondary function of the nurse is to ignore the paradoxes that often occur at times when nurses find it impossible to secure patient comfort and preserve personal integrity because they are responsible for the very procedures that produce the discomfort or demean the patient's personal dignity.

Compounding these dilemmas is the growing complexity in the delivery of health services. Kelly [6] contends that the nurse's clinical role is shrinking and dwindling to coordinator and traffic director as more and more of the tasks central to patient care are reallocated to others: the clinical pharmacist, the inhalation therapist, the IV team. She comments that "The role is shrinking because the nurse is incapable of controlling the care situation or exerting instrumental influence over her work."

Not only is the content of nursing practice changing daily, but the emphasis and the context of practice are also rapidly shifting. Social forces and education are orienting the modern nurse to health rather than illness, to prevention rather than crises, to a holistic rather than a technical approach, to the community rather than the hospital. The National Commission for the Study of Nursing and Nursing Education [8] and the Department of Health, Education, and Welfare [3] document the urgent need for a refocusing and redefinition of roles and practice. Both these reports underline the complementary roles of physician and nurse in a new professional realignment in the vast area of pri-

mary health care and in acute and chronic health care settings. It is beyond the province of this chapter to consider the urgent issues of role and function raised by these reports, but the reports are commended as essential resources.

The development of congruent roles of the physician and the nurse can resolve many current functional and jurisdictional disputes in scope of practice. Only through mutual understanding and agreement will a synthesis occur in the two divergent perceptions about nurses' roles, i.e., the nurse as a caretaker or the nurse as an assistant to the overburdened physician.

CLINICAL DECISION-MAKING

Basic to the expansion of practice and central to the complementary roles of nurse and physician is clinical decision-making. Cleland [1] has defined the role extender and role expander in terms of decision-making and has identified the number and quality of cues each uses in clinical judgment. On the basis of the range of cues brought to bear in clinical judgments, Cleland has postulated that critical distinctions can be made between levels of practice and among roles. She states:

> At the first level of nursing there are general nurses and nurse practitioners, at the second level there are nurse specialists and nurse clinicians. General nurses and nurse specialists work in structured and defined settings, and with narrow ranges of cues involved in the decision-making and with the dimension of time extending through the patient's current hospitalization, and often extending only through the current 8 hour day. Nurse practitioners and nurse clinicians utilize data gathered from many sources to plan a broad program of patient care with a space focus which also involves the family, and a time dimension which includes the entire course of the illness [1].

Within Cleland's important framework, the crucial question is no longer whether or not the best direction in which to expand the practice of nursing is toward the assumption of more of the tasks of medicine. Rather, the crucial question is how the nurse and physician may become a decision-making team in the diagnostic and therapeutic problems of clinical care. Despite the performance of the nurse as a diagnostician and therapist in the past decade of coronary care and, more recently, in respiratory care, physicians and some nurses have been reluctant to see the nurse as a diagnostician. My use of *team* and *diagnosis* here recognizes that insofar as accuracy and validity of clinical observations and scope and continuity of management are relevant to diagnosis and treatment, and insofar as the nurse accurately validates observations and adds scope and continuity in management, the nurse and physician are interdependent, responsible, and authoritative. They are both clinicians in assessing the clinical variables at the bedside, in the clinic, or in the home and in making clinical judgments about the therapeutic management of patient care. Imperative in the concept of role expansion based on clinical decision-making is the acknowledgment that the nurse in expanded practice prescribes nursing care as independently as the medical clinician prescribes medical therapy. The fun-

damental strategies for this expansion must be derived from direct clinical experience with patients and from enhanced competencies in the methods and techniques of precise and objective clinical assessment.

Defining expanding nursing practice as expansion in the scope and methodologies of clinical decision-making turns our attention to the complexities of clinical judgments. How does the nurse acquire the clinical evidence to support her clinical judgments? One of the reasons for the selective ignorance practiced by nurses in restricting their clinical judgments has been the failure to distinguish between the different types of observational data and to understand the rigor of the reasoning processes that characterize the total diagnostic procedure. Feinstein [4] has examined the nature of clinical judgments and has identified the kinds of clinical data and relationships among them that constitute the intellectual technology of decision-making. There are data that describe disease in impersonal terms (morphologic, clinical, microbiologic, and physiologic), data that describe the host in whom disease occurs, and data that describe the interaction between the disease and its host. Feinstein has proposed that the first be referred to as the evaluation of the disease, the second as evaluation of the patient as a person, and the last, as the evaluation of illness, i.e., the consequences of pathologic processes in the patient.

Nurses tend to make gestalt observations and inferences and also to couch their observations and judgments in guarded and tentative language. "A good day," "usual night," "seems anxious" typify the all too familiar subjective and unsubstantiated documentation of patient response. The ability to make objective and measurable observations and to process them through systematic reasoning distinguishes the nurse in expanded practice. In processing clinical information and in making clinical decisions, important distinctions must be made between pure description, designation, and diagnosis. Feinstein [4] defines description as an account of an observed sensation, substance, or phenomenon. In designation, a name or classification is given to the observed entity. In diagnosis, the anatomic or other abnormality that is responsible for the observed entity is indicated.

The Nature of Clinical Judgment

Within Feinstein's perspective, the clinician makes two types of decisions: explanatory decisions and management decisions. Explanatory decisions are the name, mechanisms, and causes of disease or disability. Management decisions are therapeutic and environmental: the choosing and evaluating of the modes and technology of therapy, and the environmental strategies that enable the patient to adapt to the burdens of ailment and treatment. Feinstein [5] says the following about managerial decisions:

> Physicians have developed a splendid clinical science for explanatory decision, mechanisms of disease, etiology and pathogenetic inquiry decisions, and a magnificent technologic armamentarium of therapy, but our managerial decisions generally continue to be made as doctrinaire dogmas immersed in dissension and doubt.

As these conflicting decisions in therapeutic management inevitably merge when nurses implement medical therapy, nursing has a significant opportunity to develop and enrich the clinical decision base of expanded practice. Nursing can and does contribute to the orderly evaluation of therapy and to the management decisions about the clinical and environmental variables observed in therapy. Donabedian [2] notes that a cursory review of the nursing literature suggests that nurses are much more systematic and self-conscious than physicians in developing quality criteria of patient care. "In contrast to studies of physician care that focus on purely technical performance, there is also greater attention to social and psychological aspects of patient management."

Increasingly utilized, Lawrence Weed's [10] approach to patient record-keeping, in which medical and nursing observations and plans of care are integrated, illustrates only one methodology, but an important one, for making conjoint diagnostic and therapeutic decisions operational. For 20 years, nursing education has emphasized the problem-solving approach in nursing care, but its effectiveness has been limited by the traditional medical record and the reliance of both physicians and nurses on spoken communication. The precise skills called for in a problem-oriented system of care are specifically those required for expanded clinical judgments.

Let me amplify my definition of expanded practice. Expanded practice within a framework of patient problems and solutions demands increased skill in clinical description, in reporting observations in objective terms, in designation of observed entities, and the development of explanatory and managerial decisions that result in significant patient care outcomes. I mean, significant in that the patient and his family know they have benefited from nursing care as well as medical care. Rather than describe isolated symptoms or signs, or isolated behavior on the part of the patient, the nurse in the expanded perspective designates the patient's functional and clinical status, such as ability to walk, feed himself, maintain excretory continence, participate in activities of daily living, comply with therapeutic regimens, work at a chosen occupation, and make intellectual decisions. The severity of a symptom is indicated by an account of its concomitant effect on the patient's total function.

Even more important than developing skills in accumulating the quantitative and qualitative data base for clinical judgment is the ability to make managerial decisions, i.e., to plan and carry out care in environmental and therapeutic decisions such as how the mode and agent of therapy should be managed or modified for this particular patient in his particular situation. In addition to analyzing historical and current information about a patient's functional status, the ability to predict future clinical or environmental events becomes a necessary and new skill in expanded practice. Therefore, anticipation and forecasting based on knowledge of the natural history of health and illness, growth and development, and the aging process, as well as on understanding ethnic and cultural variations, becomes part of expanded clinical judgment.

PHYSICAL ASSESSMENT SKILLS

At nursing's present stage of development, it is difficult for nurses themselves, and for physicians, to accept the ultimate imperative of the concept of expanded nursing practice. The new focus demands a new order of interdependence and temporary dependence on physicians while the nurse learns (1) how to use diagnostic tools and reasoning and (2) the therapeutic measures to function in the decisions of cure and restoration. The dependence on the physician occurs as the nurse masters the techniques of physical examination, interview, inspection, palpation, percussion, and auscultation. The nurse moving into expanded practice needs instruction, verification, and confirmation from the physician until he or she appreciates the wide range of normal, understands the significance of negative data, and develops the ability to characterize symptoms specifically by the seven dimensions of bodily location, quality, quantity, chronology, setting, aggravating and alleviating factors, and associated manifestations. When problems of testing reliability of clinical observation and standardization of physical assessment performance are resolved, the nurse can move from dependence to interdependence in physical assessment skills.

THE NURSING PROCESS

Two challenges confront the nurse in gaining competence and mastery in expanded practice. The first challenge, the development of sound clinical judgment based on objective clinical evidence, has been discussed; the second resides in the ability to optimize the nursing process as a vehicle for expanded practice. The challenge is to transcend definitions that confine the nursing process to interpersonal or communication models. The nursing process is all these, but more. The nursing process is diagnostic and therapeutic clinical decision-making, resulting in clinical judgments that explain clinical evidence and delineate the plan and management of treatment and care.

The current debate over issues of role and function, that is, the distinction between medical and nursing practice, power, and authority, is not addressed here. The thesis here is that true expansion in nursing practice occurs within the legal definition of nursing through validated clinical judgment and in the management of therapy. The nurse as clinician does not trespass into the licensed precincts of medicine. Rather, the heretofore supporting role becomes a complementary relationship consistent with the concept of the nurse "carrying out treatment and medications prescribed by the licensed physicians" and "rendering care consistent with clinical orientation, training, and experience [9]."

Meaningful expansion of nursing practice in any health-care setting is rooted in a common focus: decision-making in patient cure and care. Expanded practice demands a critical concern with clinical judgment—the ways in which decisions are made, alternative decisions are proposed, and the consequences of decisions are examined and weighed in the balance of therapeutic accomplishment and human benefit.