NATIONAL OPEN UNIVERSITY OF NIGERIA

SCHOOL OF HEALTH SCIENCES

DEPARTMENT OF NURSING SIENCE

Source: www.nsphs.org

COURSE CODE: NSC 209

COURSE TITLE: HEALTH AND PHYSICAL ASSESSMENT

COURSE UNITS: 2

NATIONAL OPEN UNIVERSITY OF NIGERIA

COURSE GUIDE

NSC 209 – HEALTH AND PHYSICAL ASSESSMENT

Source: www.coursewareobjects .com

COURSE UNITS – 3 Credit units (3-0-2)

COURSE GUIDE

Table of Contents **Page**

COURSE GUIDE

GENERAL INTRODUCTION

Welcome to this fundamental course for professional nursing pratice. Health and Physical Assesssment (NSC 209) is an essential requirement that provides you with knowledge and competencies required of you to be able to efficiently use the Nursing Process as the professional tool in practice. The first phase of the Nursing Process is Assessment. To be able to achieve the goals and objectives of this phase, you must be able to conduct health and physical assessment, to document the state of health and determine deviations from normal. It is important that you learn, practice the skills in the laboratories and in clinical settings. It is also necessary that you revise the courses you have done earlier on in this programme. You will need to have mastered the contents of Anatomy, Physiology, Biochemistry, Cellular and General Pathology and be conversant with culturant variations in human responses to health and illness. In this course, you will improve upon your use of various interview techniques and you will learn how to enagage in step by step physical assessment techniques. This course will also build your critical thinking skills as you gain mastery of recognizing abnormal findings, conditions of risks and diseases in clients. You will also learn up-to-date assessment documentation skills. It is required that you have the reommended textbooks to help you.

COURSE INFORMATION

COURSE CODE: NSC 209

COURSE TITLE: Health and Physical Assessment

COURSE UNITS: 3 Credit units (45 hours of instruction online; 48 hours of laboratory & Clinical Practice)

YEAR: 2

SEMESTER: 1st Semester

PRE-REQUISITE COURSES: NSC 102, 103,

CON-CURRENT COURSES: All courses at the 200, 1st Semester of the BNSc degree programme

SESSION: 2014/2015

COURSE WEBSITE: *www.noun.edu.ng/*

COURSE WRITERS

Dr F.D. Omisakin, RN, PhD

Dr O.O. Irinoye, RN, PhD

COURSE EDITORS:

Dr O.O. Irinoye and Mr A.S. Igbinlade

COURSE COORDINATOR: To be appointed by the School

COURSE FACILITATORS: As appointed by the School

COURSE OVERVIEW

COURSE DESCRIPTION

This course provides you with knowledge and skill in the area of health and physical assessment across the lifespan. Content will focus on interviewing, the health history, comprehensive health assessment on an individual, and physical assessment of body systems. A systems approach is used as a guide for establishing a comprehensive nursing database. This approach allows for a systematic and standardized approach to data collection. It includes the skillful collection of subjective data during the interview; the analysis of objective data by inspection, palpation, percussion, and auscultation of each body system, and the synthesis of the combined information to formulate a nursing diagnosis, determine priorities and therapeutic nursing interventions. This

provides you with the opportunity to develop proficiency in health assessment skills which will increase your ability to make effective decisions in order to diagnose, plan, implement, and evaluate nursing care.

COURSE OBJECTIVES

Upon completion of this course you will be able to:

1. Conduct a nursing health history, which includes the systematic collection of subjective data to determine health status including collection of physiological, psychological, socio cultural, developmental, and spiritual data.
2. Critically analyze findings from the collection of subjective and objective data and to distinguish between the data consistent with health, and the data which indicates alteration in health.
3. Demonstrate competency in documentation and communication of health assessment data in written and verbal format.
4. Collect and analyze comprehensive health data from clients, including holistic health history, physical examination, diagnostic tests and screening mechanisms for the development of nursing diagnosis and plan of care.
5. Obtain a health assessment using proficient interviewing skills and perform a systematic physical examination using: inspection, auscultation, palpation, and percussion.
6. Describe normal findings across the lifespan, and differentiate between normal findings and those that require further investigation.
7. Identify nursing diagnoses by using data obtained in the assessment and develop a therapeutic plan of care identifying outcomes and specific nursing measures that include resources to promote and maintain health.

COURSE IMPLEMENTATION

DOING THE COURSE

The course will be delivered adopting the blended learning mode, 70% of online but interactive sessions and 30% of face-to-face during laboratory sessions. You are expected to register for this course online before you can have access to all the materials and have access to the class sessions online. You will have hard and soft copies of course materials, you will also have online interactive sessions, face-to-face sessions with instructors during practical sessions in the laboratory. The interactive online activities will be available to you on the course link on the Website of NOUN. There are activities and assignments online for every unit every week. It is important that you visit the course sites weekly and do all assignments to meet deadlines and to contribute to the topical issues that would be raised for everyone's contribution.

You will be expected to read every module along with all assigned readings to prepare you to have meaningful contributions to all sessions and to complete all activities. It is important that you attempt all the Self Assessment Questions (SAQ) at the end of every unit to help your understanding of the contents and to help you prepare for the in-course tests and the final examination

You will also be expected to keep a portfolio where you keep all your completed assignments.

Specifically, each unit has activities and videos that will guide your ability to learn the health history and physical assessment skills. Do take the time to perform and practice these skills at the end of each module, and ongoing throughout the course. Leaving the practice portion until the end tends to increase levels of performance anxiety related to the hands on physical assessment and health history exam (OSCE). The equipment required to practice skills during this course

include ***Stethoscope with bell and diaphragm, Small ruler, Otoscope/Ophthalmoscope, Reflex hammer, Penlight, Tuning fork (128Hz & 512 Hz)***

You should make attempts to access resources in your place of work so that you have opportunity to practice. You may also benefit from approaching a primary health care nurse practitioner or physician who can demonstrate some of the techniques. You can make an appointment to book time for self study practice in the NOUN Nursing laboratories in your zone.

COURSE REQUIREMENTS AND EXPECTATIONS OF YOU

Attendance of 95% of all interactive sessions, submission of all assignments to meet deadlines; participation in all CMA, attendance of all laboratory sessions with evidence as provided in the log book, submission of reports from all laboratory practical sessions and attendance of the final course examination. You are also expected to:

1. Be versatile in basic computer skills
2. Participate in all laboratory practical up to 90% of the time
3. Submit personal reports from laboratory practical sessions on schedule
4. Log in to the class online discussion board at least once a week and contribute to ongoing discussions.
5. Contribute actively to group seminar presentations.

EQUIPMENT AND SOFTWARE NEEDED TO ACCESS COURSE

You will be expected to have the following tools:

1. A computer (laptop or desktop or a tablet)
2. Internet access, preferably broadband rather than dial-up access
3. MS Office software – Word PROCESSOR, Powerpoint, Spreadsheet
4. Browser – Preferably Internet Explorer, Moxilla Firefox

5. Adobe Acrobat Reader

NUMBER AND PLACES OF MEETING (ONLINE, FACE-TO-FACE, LABORATORY PRACTICALS)

The details of these will be provided to you at the time of commencement of this course

DISCUSSION FORUM

There will be an online discussion forum and topics for discussion will be available for your contributions. It is mandatory that you participate in every discussion every week. You participation link you, your face, your ideas and views to that of every member of the class and earns you some mark.

COURSE EVALUATION

There are two forms of evaluation of the progress you are making in this course. The first are the series of activities, assignments and end of unit, computer or tutor marked assignments, and laboratory practical sessions and report that constitute the continuous assessment that all carry 30% of the total mark. The second is a written examination with multiple choice, short answers and essay questions that take 70% of the total mark that you will do on completion of the course.

Students evaluation: The students will be assessed and evaluated based on the following criteria

In-Course Examination:

You will be required to conduct health history and review of systems (ROS) of a number of clients and present them as cases. In line with the university's regulation, in-course assessment will be done in the middle of the semester. These would come in form of Computer Marked Assignment. This will be in addition to one compulsory Tutor Marked Assignment (TMA's) and three Computer marked Assignment that comes after every module.

Laboratory/Clinical Practice: Attendance, record of participation, demonstration and other assignments will be graded and added to the other scores to be added to the scores from examinations; weekly physical assessment and recording of findings.

Performance Examination: You must be prepared to be tested on 2 systems to be selected by faculty from among thorax and lungs; cardiovascular System, Abdomen, Neurological system.

Final Examination: The final written examination will come up at the end of the semester comprising essay and objective questions covering all the contents covered in the course and practical examination. The final examination will amount to 60% of the total grade for the course.

Learner-Facilitator evaluation of the course

This will be done through group review, written assessment of learning (theory and laboratory practical) by you and the facilitators.

GRADING CRITERIA

Grades will be based on the following Percentages

Tutor Marked Individual Assignments	10%	
Computer marked Assignment	10%	
Group assignment	5%	40%
Discussion Topic participation	5%	
Laboratory practical	10%	
End of Course examination	60%	

GRADING SCALE

A = 70-100

B = 60 - 69

C= 50 - 59

F = ≤ 49

SCHEDULE OF ASSIGNMENTS WITH DATES

To be provided for each module by the facilitator in addition to the ones already spelt out in the course materials.

SPECIFIC READING ASSIGNMENTS

To be provided by each module

REFERENCE TEXTBOOKS

Required Textbooks:

Jarvis, Carolyn (2012) *Physical Examination and Health Assessment*, 6th Edition, Philadelphia, PA. W.B. Saunders Co.

Jarvis, Carolyn (2012) *Laboratory Manual for Physical Exam and Health Assessment*, Philadelphia, PA. W.B. Saunders Co.

D'amico, D. and Barbarito C. (2007). *Health and Physical Assessment in Nursing.* New Jersey Pearson Education Inc.

Recommended:

Jarvis, Carolyn (2012) *Pocket Guide to Physical Examination and Health Assessment*, Philadelphia, PA. W.B. Saunders Co.

COURSE MATERIAL

Table of Contents **Page**

MODULE 1: GENERAL CONSIDERATIONS

UNIT ONE: AN OVERVIEW OF HEALTH ASSESSMENT

CONTENT

1.0 Introduction

Health assessment is an essential nursing function which provides foundation for quality nursing care and intervention. It helps to identify the strengths of the clients in promoting health. Health assessment also helps to identify client's needs, clinical problems or nursing diagnoses and to evaluate responses of the person to health problems and intervention (Fuller & Schaller-Ayers,

2000). An accurate and thorough health assessment reflects the knowledge and skills of a professional nurse.

The focus of nursing care is attainment, sustenance, and recovery of health. Helping clients to achieve, sustain and restore healththe diagnosis and treatment of human responses to actual or potential health problems or life processes. The information obtained from the nursing history and physical examination is used to determine the strengths of the client or responses that the client exhibits in response to health problem. You will obtain a client's health history and perform a physical examination during the assessment phase of the nursing process. The results of the assessment (1) contribute to a database that identifies the client's current and past health status and (2) provide a baseline against which future changes can be evaluated. The purpose of the nursing assessment is to enable you to make a clinical judgment or diagnosis about a client's health status. Although assessment is identified as the first step of the nursing process, it is performed continuously throughout the nursing process to validate nursing diagnoses, evaluate client's response to nursing interventions, and determine the extent to which client outcomes and goals have been met. An assessment describes a hand-on data collection process, while a database identifies a specific list of data to be collected. The database is all the health information about a client. It includes the nursing history and physical examination, the medical history, and physical examination, results of laboratory and diagnostic tests, and information contributed by other health professionals.

The process of obtaining a health history and performing a physical examination is an intimate experience for both you and the client. During the interview and physical examination, you need to be sensitive to issues of eye contact, space, modesty, and touching. Your scope of focus must be more than problems presented by the client. You will use variety of sources to gather the

objective and subjective data. Knowledge of the natural and social sciences is a strong foundation for you. Effective communication techniques and use of critical thinking skills are essential in helping you to gather detailed, complete, relevant, objective, subjective, and measurable data needed to formulate a plan of care to meet the needs of the client.

2.0 Objectives

At the end of this unit, you should be able to:

1. Ask appropriate questions when conducting a comprehensive health history to elicit data that will be used to guide a physical examination
2. List the components of the comprehensive physical examination and review of systems based on red flags identified in the patient history
3. Collect objective data about the client. Objective data are observable or measurable pieces of information. Objective data can be seen, heard, touched, or smelled. Examples of objective data are the color of urine, vital signs, moisture on skin and breath color. Laboratory results are also objective data.
4. Collect subjective data from the client. Subjective data are experiences only the client can describe. Examples of subjective data are nausea, pain, and itching.
5. Collect information about the client's family, community, culture, ethnicity, and religion.
6. Identify past and present client behaviors that support health or increase the risk of illness.
7. Identify data that suggest risk for or actual health problems.

3.0 Main Content

3.1 What is Health Assessment?

Health assessment – is 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. During nursing history, interview and physical examination, you will obtain data to support the identification of a nursing diagnosis. The data includes 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 weakness, and risk factors.

3.2 Principles of Health Assessment

In planning and performing health assessment, the nurse (YOU) needs to consider the following:

1. An accurate and timely health assessment provides foundation for nursing care and intervention.
2. A comprehensive assessment incorporates information about a client's physiologic, psychosocial, spiritual health, cultural and environmental factors as well as client's developmental status.
3. The health assessment process should include data collection, documentation and evaluation of the client's health status and responses to health problems and intervention.
4. All documentation should be objective, accurate, clear, concise, specific and current.
5. Health assessment is practiced in all healthcare settings whenever there is nurse-client interaction.
6. Information gathered from health assessment should be communicated to other health care professionals in order to facilitate collaborative management of clients and for continuity of care.
7. Client's confidentiality should be kept.

3.3 Components of Health Assessment

Health assessment includes the interview, physical assessment, documentation, and interpretation of findings.

The interview

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

Subjective data is information that the client experiences and communicates to the nurse. Perception of pain, nausea, dizziness, itching sensations, or feeling nervous are examples of subjective data. Only the client can describe these feelings. Subjective data is 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 or caregivers could report subjective data based on perceptions the client has shared with them. This information is very 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, you must validate subjective data obtained from other sources. The accuracy subjective data depends on your ability to clarify the information gathered with follow-up questions and to obtain supporting data from other pertinent sources.

The purpose of client interview is to obtain a health history about the client's past and present health state. Effective communication is a key factor in interview process. Creating a climate of trust and respect is critical to establishing a therapeutic relationship. You need to communicate an acceptance of the client as an individual by using an open, responsive, nonjudgmental

approach. You communicate not only through language but also your manner of dress, gestures, and body language. In addition to understanding the principles of effective communication, you need to develop a personal style of relating to clients. Although single style fits all people, your wording of specific questions in certain ways will increase the probability of eliciting needed information. Ease at asking questions, particularly those related to sensitive areas such as sexual functioning and economic status, comes with experience.

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. Biographical 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 most important aspect of the assessment process.

The amount of time you need to complete a nursing history may vary with the format used and your experience. It may be completed in one or several sessions, depending on the setting and the client. In the case of an older adult client with a low energy level, you may need to schedule several short sessions. It is important to allow time for the client to volunteer information about particular area of concerns. When a client is unable to provide the necessary data (e.g., unconscious or aphasic), you ask the caregiver to provide as much information as possible. Inform clients that federal legislation affects the electronic exchange, privacy, and security of an individual's health information. Inform clients that they can see and get copy of their health records, can have corrections added to their health information, and can decide whether to give their permission before their information can be used or shared for certain purposes.

You need to judge the reliability of the client as a historian. An older adult may give a false impression about his or her mental status because of a prolonged response time or visual and hearing impairments. The complexity and long duration of health problems may also make it difficult for an older adult or a chronically ill younger client to be an accurate historian.

It is important for you to determine the client's priority concerns and expectations. Occasionally there is a lack of congruency between your priorities and those of the client. For example, your priority may be to obtain needed information and complete necessary documentation, whereas the patient is interested only in getting relief from symptoms. Until the client's priority is met, you will probably be unsuccessful in obtaining complete data.

You must also make a judgment about the amount of information that should be collected on initial contact with the client. In interviews with older adult clients, clients with long-term chronic disease, clients with pain, and clients in emergency situations, you may choose to ask only those questions that are pertinent to a specific problem and to defer the complete history interview until a more appropriate time.

The focused interview

The focused interview enables you to clarify points, to obtain missing information, and to follow up on verbal and nonverbal cues identified in the health history. You need not use a prepared set of questions for the focused interview. You will apply 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.

Physical assessment

Physical assessment is hand-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, provides a sound database from which care planning may proceed. Objective data is observed or measured by the professional nurse. This is also known as overt data or a sign once it is detected by the nurse. This 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. This objective data is needed to validate subjective data and to complete database. The accuracy of objective data is also increased by attention to detail and verification.

In addition, data from all secondary sources including charts, reports from diagnostic and laboratory testing, family, and all healthcare professionals involved in client care are part of the database from which decisions about care are derived. Both subjective and objective data may further be categorized as constant or variable. Constant data is information that does not change over time such as race, sex, or blood type. Variable data may change within minutes, hours, or days. Blood pressure, pulse rate, blood counts, and age are examples of variable data.

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. Further, the client record provides information used for reimbursement of services, is often a source of data for research, and is reviewed by accrediting agencies to determine adherence to standards.

Documentation must be accurate, confidential, appropriate, complete, and detailed. When documenting, you 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. 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. For example, rather than writing that the client had severe pain and swelling in the left lower extremity, you would document that a had pain rated 8 on a scale of 1 to 10, and edema and redness on the dorsal surface of the foot over the first through third phalanges.

Interpretation of findings

Interpretation of findings can be defined as making determination about all of the data collected in the health assessment process. You 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.

Assessment data must be systematically obtained and organized in such a manner that you can readily analyze and make a judgment about the client's health status and any health problems. Some assessment forms are organized to ask the client about symptoms and problems associated with body systems. Although this information is helpful, it is incomplete because areas such as health promotion behaviors sleep, coping, and values are not always addressed.

3.4 The Role of Nurses in Health Assessment

Health assessments are used by nurses to gather information about a patient's condition. This information is used to formulate a nursing plan of care for the patient, manage problems, evaluate patient's condition, prepare discharge teaching, and advocate for the patient.

Nursing Diagnoses and Care Planning

A nurse takes note of actual or potential problems her patient may have during a health assessment. From the list of problems, she formulates diagnoses, which she uses to create a care plan.

Managing Problems

The nurse continuously does a health assessment on her patient to see if her care plan is having the desired effect. If not, she makes changes to her care plan to address the patient's health problems.

Evaluation

Evaluation of a patient's health status is done through health assessments. Evaluations determine if a patient has responded to nursing care sufficiently enough to be recommended for discharge.

Discharge Teaching

During a health assessment, a nurse may become aware that a patient is lacking information that may help improve his condition. This provides the nurse with an opportunity to impart this information before he is discharged.

Advocate

When a nurse performs a health assessment, she may find a problem that requires the expertise of other members of the health care team. In this case, the nurse notifies the proper health care

team member of the problem and makes sure the patient receives the expert care that they need. Here, she becomes an advocate for her patient.

3.5 Your Responsibilities as a Nurse

1. You have the responsibility to carry out health assessment on every person under his/her care.
2. You should regularly perform focused assessments in response to client needs.
3. The nurse needs to obtain client's consent prior to health assessment.
4. You should demonstrate a caring attitude, respect and concern for each client when doing a health assessment.
5. You have the responsibility in keeping confidentiality about the data being collected from his/her client.
6. You obtain information on a client using various techniques and tools, such as history taking, physical examination, reviewing clients' records and results of diagnostic tests. He/She has to draw inferences from data collected in order to make appropriate and sound clinical judgment.
7. You have to acquire specialized skills and competence in collecting accurate and relevant information on the patient's health in performing health assessment in order to make sound clinical decisions.
8. You should document the results of health assessment, analyze the data collected, evaluate the client's response to health problems and interventions, and provide feedback to the client as appropriate.
9. You should continuously advance their competence in health assessment throughout one's nursing career.

10. You takes up an advanced practice role has the responsibility to prepare himself/herself in order to perform advanced and focused health assessment.

4.0 Conclusion

Health assessment is a systematic, deliberative and interactive process by which nurses use critical thinking to collect, validate, analyze and synthesize the collected information in order to make judgments about the health status and life processes of individuals, families and communities.

5.0 Summary

In this unit, you have learnt that:

i) The purpose of the nursing assessment is to enable you to make a clinical judgment or diagnosis about a client's health status.
ii) An assessment describes a hand-on data collection process, while a database identifies a specific list of data to be collected.
iii) Health assessment – is 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.
iv) Health assessment includes the interview, physical assessment, documentation, and interpretation of findings.
v) Health assessments are used by nurses to gather information about a patient's condition to formulate a nursing plan of care for the patient, manage problems, evaluate patient's condition, prepare discharge teaching, and advocate for the patient.
vi) Nurses have various responsibilities during health assessment.

6.0 Tutor Marked Assignments

6.1 Activity

Demonstrate how to prepare a patient for health assessment and identify equipment required for health assessment.

6.2 Tutor Marked Tests

a. Define the term health assessment

b. List the principles of health assessment

c. Describe the components of health assessment

d. Enumerate nurse's role and responsibilities during health assessment

7.0 References and other resources

Jarvis, C. (2012). Physical examination and health assessment, (6th ed). St. Louis: W.B. Saunders.

UNIT TWO: TYPES OF ASSESSMENT

CONTENT

1.0 introduction

Assessment is the first step of the nursing process. It is the orderly collection of information concerning the patient's health status. An assessment describes a hands-on data collection process. Various types of assessment are used to obtain information about a client. These approaches can be divided into three types: comprehensive, focused, and emergency (Table 2.1). You need to decide what type of assessment is required for an individual client based on the clinical situation (e.g., admission history and physical examination, start of shift, throughout shift). Sometimes the health care agency provides guidelines and other times it is a nursing judgment.

2.0 Objectives

After successful completion of this unit, you will be able to:

1. Determine when to perform different types of health assessments:

• Complete or comprehensive

• Focused

• Emergency

2. Use various assessment approaches

3. Investigate and interpret client symptoms.

3.0 Main Content

3.1 Types of Assessment

Comprehensive Assessment

A comprehensive assessment includes a detailed health history and physical examination of one body system or many body systems (see Table 1). It is typically done on admission to the hospital or onset of care in a primary care setting.

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.

Focused Assessment

A focused assessment is a more abbreviated assessment used to evaluate the status of previously identified problems and monitor for signs of new problems. It can be done when a specific problem (e.g., pneumonia) is identified. The client's clinical manifestations should alert you to the appropriate focused assessment. For example, abdominal pain indicates the need to do a focused examination of the abdomen.

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 at 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. 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, 2012).

Emergency Assessment

In an emergency or critical situation, an emergency assessment may be done by rapid, specific questioning of a client while assessing and maintaining vital functions.

TABLE 2.1: DESCRIBES TYPES OF ASSESSMENT THAT YOU MAY USE IN VARIOUS SITUATIONS

DESCRIPTION	WHEN AND WHERE PERFORMED
Comprehensive • Detailed assessment that focuses on one or more body systems, including those not directly involved in presenting problem or admission diagnosis. • Used for head-to-toe assessment.	• Onset of care in primary or ambulatory care setting. • On admission to hospital or long-term care setting. • On initial home care visit.
Focused • Abbreviated assessment that focuses on one or more body systems that are the	• Throughout hospital admission – at beginning of a shift and as needed

focus of care. • Includes an assessment related to a specific problem. • Monitor for signs of new problems.	throughout shift. • Revisits in ambulatory care setting or home care setting.
Emergency • Limited to assessing life-threatening conditions (e.g., inhalation injuries, myocardial infarction). • Conducted to ensure survival. Assessment focuses on airway, breathing, circulation, and disability. • After life-saving interventions are initiated, a brief systematic assessment is performed to identify any/all injuries/problems.	Performed in any setting when signs or symptoms of a life-threatening condition appear (e.g., emergency department, critical care unit, surgical setting).

Using Assessment Approaches

Assessment in a hospital inpatient setting demands a high degree of consistency among different health care professionals. As you provide ongoing care for a client, you will be constantly refining your mental image of the client. As you gain experience, you will derive a mental image of the status of a client from a few basic details. During your assessment, you will confirm or

revise the findings that you read in the medical record and what you heard from other health care professionals.

Keep in mind that the process does not end once you have done your first assessment on a client during your rounds. You will continue to gather information about your clients throughout your shift. Everything that you learned previously about the client is considered in the light of new information. For example, when you are doing your respiratory assessment on your client with COPD, you hear crackles in her lungs. This finding should lead you to do a cardiovascular assessment because cardiac problems (e.g., heart failure) can also cause crackles. Adding to the challenge is the reality that you are required to perform such assessments on many clients at once. As you gain experience, the importance of new findings will be more obvious to you.

Symptom Investigation

At any time during the assessment the client may report a symptom such as pain, fatigue, or weakness. Because symptoms are experienced by the client and not necessarily observable, the symptom must be investigated. Table 2 lists eight areas that you should investigate if symptom is reported.

TABLE 2: INVESTIGATION OF CLIENT-REPORTED SYMPTOM

Location	
Ask	"where do you feel it? Where is it located?"
Record	Region of the body; local or radiating, superficial or deep.
Quality	
Ask	"what does it (feel, look) like?
Record	The client's own words (e.g., "like being burned")
Quantity	

Ask "How often do you have this feeling? How bad is it? On a scale of 0 to 10, rate your pain.

Record Frequency (mild, moderate, severe), volume, size, extent, pain rating number.

Chronology

Ask "when was the first time it occurred? Any particular time of day, week, month, or year?

Record Time of onset, duration, periodicity and frequency, course of symptoms.

Setting

Ask "Where are you when this occurs? What are you doing?"

Record Where client is when symptom occurs, what client is doing, if symptom is related to anything

Aggravating or Alleviating Factors

Ask "What makes it better? Worse? is there any activity that seems to cause it? What have you done for it? Did it help? Was there some reason you didn't do anything about it?

Record influence of physical and emotional activities, client's attempts to alleviate (or treat) the symptom.

Associated Manifestations

Ask "What other things do you see or feel when it occurs?
Has it affected your appetite? Elimination? Sleeping?"

Record Other symptoms

Meaning of the Symptom to the Client

Ask "How has it affected your life? Why have you sought care now? What do you think

	may be cause?
Record	client's statement about the effect of the symptom and the cause of the symptom.

4.0 Conclusion

Health assessment provides foundation for quality nursing care and intervention. It helps to identify the strengths of the clients in promoting health. Health assessment also helps to identify client's needs, clinical problems or nursing diagnoses and to evaluate responses of the person to health problems and intervention

5.0 Summary

An assessment describes a hands-on data collection process. Three types of assessment (comprehensive, focused, and emergency) are used to obtain information about a client.

6.0 Tutor Marked Assignments

6.1 Activity

6.2 Tutor Marked Tests

a. Describe different types of assessment and give examples of situations each are conducted.

7.0 References and other resources

Jarvis, Carolyn (2012) *Physical Examination and Health Assessment*, 6th Edition, Philadelphia, PA. W.B. Saunders Co.

UNIT THREE: NURSING ASSESSMENT OF PAIN

CONTENT

1.0 Introduction

The highly subjective nature of pain makes pain assessment and management challenges for every clinician. The report of pain is a social transaction; thus assessment and management of pain require a good rapport with the person in pain. In assessing a client with pain, the nurse reviews the client's description of the pain and other factors that may influence pain (e.g., previous experience, anxiety, and age) as well as the person's response to pain relief strategies. Documentation of the pain level as rated on a pain scale becomes part of the client's medical record, as does a record of the pain relief from interventions.

Pain assessment includes determining what level of pain relief the acutely ill client believes is needed to recover quickly or improve function, or what level of relief the chronically or

terminally ill client requires to maintain comfort. Part of a thorough pain assessment is to understand the client's expectations and misconceptions about pain. A person who understands that pain relief not only contributes to comfort but also hastens recovery is more likely to request or self-administer treatment appropriately.

Pain is essential in comprehensive health assessment. Pain is an entirely subjective and personal experience. When pain is present, it impacts every aspect of an individual's health and well-being. Pain can be acute and chronic, severe or mild, but overall it is an experience unique to the individual. The perception of pain and the ways in which the individual responds to pain vary according to age, gender, culture, and developmental level. When conducting a pain assessment, you must consider all factors influencing the individual's experience with pain.

2.0 Objectives

After successful completion of this unit, you will be able to:

1. Evaluate objectively the nature of the patient's pain, including location, duration, quality, and impact on daily activities.
2. Assess patient history and physical examination findings and laboratory values to differentiate expected pain from pain due to a new problem.
3. Use a pain intensity scale of 0 (no pain) to 10 (worst possible pain) or other pain scale as appropriate.

3.0 Main Content

3.1 Definitions and Dimensions of Pain

Pain is a complex multidimensional experience. For many people, it is a major problem that causes suffering and reduces quality of life. Pain is one of the major reasons that people seek health care. It is important for you to understand the physiologic and psychosocial dimensions of

pain to effectively assess and manage patients with pain. You also need to know what therapies are available for pain to successfully help patients in pain. Margo McCaffery, a nurse and pioneer in pain management, defined pain as "whatever the person experiencing the pain says it is, existing whenever the person says it does". The International Association for the Study of Pain (IASP) defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage". Note that these definitions emphasize the subjective nature of pain, in which the patient's self-report is the most valid means of assessment.

In defining pain as a human experience, successful pain assessment and treatment must incorporate multiple dimensions. One dominant framework that acknowledges the multidimensional nature of pain is the bio-psychosocial model of pain. This model includes the physiologic, affective, cognitive, behavioral and sociocultural dimensions of pain. Pain can be categorized in several ways. Most commonly, pain is categorized as nociceptive or neuropathic based on underlying pathology. Another useful scheme is to classify pain as acute or chronic.

3.2 Pain Assessment

Most components of a pain assessment involve direct interview or observation of the patient. Diagnostic studies and physical examination findings complete the initial assessment. Although the assessment will differ according to the clinical setting, patient population, and point of care (i.e., whether the assessment is part of an initial workup or a reassessment of pain following therapy), the evaluation of pain should always be multidimensional.

Before beginning any assessment, you need to recognize that patients may use words other than "pain". For example, older adults may deny that they have pain but respond positively when

asked if they have soreness or aching. Document the specific words that the patient uses to describe pain. Then consistently ask the patient about pain using those words.

The nurse typically initiates pain assessment because many individuals do not discuss their pain until asked about it. Pain assessment consists of two phases. The first phase is a pain history, and the second phase is observation of behaviors and response to pain.

Pain History

A pain history includes collection of data about the location, intensity, quality, pattern, precipitating factors, actions aimed at relief of pain, impact on activities of daily living (ADLs), coping strategies, and emotional responses.

Location. You should ask the client to point the specific location of pain. Charts in which body outlines are depicted are a useful method for children and adults to accurately identify the site of pain. When recording the location, the body outline chart may be used. You are also expected to record locations, using appropriate terminology in relation to the proximity or distance from known landmarks (pain in the substernal area 3 cm below the xiphoid process).

Intensity. The intensity of pain is most accurately assessed with pain rating scales. Most scales use a numerical rating of 0 to 5 or 0 to 10, with 0 indicating the absence of pain. Descriptors accompany the number rating in many scales. The descriptors assist the client to "quantify" the intensity of the pain. For children and adults who cannot read or are unable to numerically rate their pain, faces rating scales are available. Number accompany each facial expression so that pain intensity can be identified.

Quality. Quality of pain is assessed by asking the client to apply an adjective to the pain. For example pain may be expressed as burning, stabbing, piercing, or throbbing. Children may have difficulty describing pain; therefore it is important to use familiar terminology such as "boo-

boo," "feel funny" or "hurt." You must use quotation marks to record the description of the pain in the exact words spoken by the client.

Pattern. The pattern of pain refers to the onset and duration of the pain experience. In addition, the nurse assesses whether the pain is constant or intermittent. If the pain is intermittent, the nurse must assess the length of time without pain or between episodes of pain.

Precipitating factors. A variety of factors can precipitate pain. These precipitating factors include activity, exercise, and temperature, or other climatic changes. Fear, anxiety, and stress can also precipitate pain.

Actions to achieve pain relief. Assessment of pain includes gathering data about the measures taken by the client to relieve or alleviate the pain. The nurse will inquire about the use of medications, home and folk remedies, and alternative or complementary therapies, such as acupuncture, massage, and imagery. The nurse must also gather data about the effectiveness of the measures.

Impact on activities of daily living. Assessment of the impact of pain on ADLs enables the nurse to understand the severity of the pain and the impact of the pain on the client's quality of life. ADLs include work, school, household and family management, mobility and transportation, leisure activities, and marital and family relationships. The nurse may ask the client to rate the impact of the pain on each of the ADLs.

Coping strategies. There are variety of ways in which individuals cope with pain. Various coping strategies include but are not limited to prayer, yoga, tai chi, chi quong, support groups, distraction, relaxation techniques, or withdrawal. The strategies are often unique to the individual or reflect cultural values and beliefs. The nurse attempts to identify coping strategies employed by the client to determine if they are effective in pain management.

Emotional responses. An assessment of the client's emotional response to pain is important. Pain, especially chronic or debilitating pain, can result in depression, anxiety, and physical and emotional exhaustion. The emotional response to pain is often related to the type, intensity, and duration of pain.

Observation

The observation phase of pain assessment includes the direct observation of the client's behavior and physiological responses.

Behavior. A variety of behaviors indicate the presence of pain. Many of these behaviors are nonverbal or consist of vocalizations. Behaviors indicative of pain include facial grimace, moaning, crying or screaming, guarding or immobilization of a body part, tossing and turning, and rhythmic movements.

Physiological responses. The site of the pain and the duration of the pain influence physiological responses to pain. The sympathetic nervous system is stimulated in the early stage of acute pain. The response is demonstrated in elevation of blood pressure, pulse and respiratory rates, pallor, and diaphoresis, parasympathetic stimulation often accompanies visceral pain. This results in lowered blood pressure and pulse rate, and warm dry skin.

4.0 Conclusion

5.0 Summary

6.0 Tutor Marked Assignments

6.1 Activity

6.2 Tutor Marked Tests

7.0 References and other resources

MODULE 2: CLINICAL NURSING ASSESSMENT

UNIT FOUR: NURSING HISTORY AND PHYSICAL EXAMINATION

CONTENT

1.0 Introduction

2.0 Objectives

3.0 Main Content

3.1 Nursing History

Nursing history consists of important health information and client's functional health pattern. Functional health patterns format developed by Gordon (2010) includes an initial collection of important health information followed by assessment of 11 areas of health status or function. (Table 3). Data organized in this format promote the identification of areas of wellness (or positive function), as well as health problems.

Important health information

Important health information provides an overview of past and present medical conditions and treatments. Past health history, medications, and surgery or other treatment are included in this part of the history. During the interview and physical examination, you need to be sensitive to issues of eye contact, space, modesty, and touching. Adhering to cultural practices related to male-female relationships and gender identification is especially important during the physical examination. To avoid violating any culturally based practices, you should ask the patient about cultural gender beliefs and if the patient would like to have a friend or caregiver present during the history and/or physical examination.

The **past health history** provides information about the patient's prior state of health. Ask the patient about major childhood and adult illnesses, injuries, hospitalizations, and surgeries. Specific questions are more effective than simply asking if the patient has had any illness or health problems in the past. For example, "Do you have any history of diabetes?" will elicit better information than "Do you have any history of chronic illnesses?"

Medications. Ask the patient specific details related to past and current medications. This includes the use of prescription drugs, over-the-counter drugs, vitamins, herbal products, and dietary supplements. Clients frequently do not consider herbal products and dietary supplements as drugs. Because they can interact adversely with existing medications, it is important to specifically ask about their use. Also ask about allergies to any medications. Older adult patients, in particular, should be questioned about medication routines. Changes in absorption, metabolism, reaction to drugs, and elimination of drugs, as well as surgery and concurrent disease, make drug-related concerns a serious potential problem for older adults.

Surgery or Other Treatments. Record all surgeries along with the date of the event, the reason for the surgery, and the outcome. The outcome includes whether the problem was completely resolved or if there are residual effects. Be sure to ask about and record any blood products that the client may have received.

Functional Health Patterns

You assess the client's functional health patterns to identify positive functions and to determine if dysfunctional health patterns and/or potential dysfunctional patterns exist (see Table 2). Dysfunctional health patterns result in nursing diagnoses, and potential dysfunctional patterns identify risk conditions for problems. In addition, you may identify clients with effective function who express a desire for a higher level of wellness.

Health Perception-health Management Pattern. Assessment of the health perception-health management functional health pattern focuses on the client's perceived level of health and well-being and on personal practices for maintaining health. Ask about the type of health care provider that the patient uses. Culture may play a role in who the patient selects as the primary health care provider. There are several ways to identify client's perceived level of well-being. First, when questioning the client determine the client's feelings of effectiveness at staying healthy by asking what helps and what hinders. Next, ask the client to describe his or her personal health and any concerns about it. It is often useful to determine whether the client considers his or her health to be excellent, good, fair, or poor. Record this information in the client's own words.

The questions of this pattern also seek to identify risk factors by obtaining a family history, history of personal health habits (e.g., smoking, alcohol, drug use), and exposure to environmental hazards. If the client is hospitalized, ask the client what he or her expectations are

of this experience. Obtain a description of the client's understanding of the current health problem, including a description of its onset, course, and treatment. It is also important to determine what the patient usually does when he or she is ill. This questions elicit information about a client's knowledge of the health problem, awareness of what should be done, and ability to use appropriate resources to manage the problem.

Nutritional-Metabolic Pattern. The processes of ingestion, digestion, absorption, and metabolism are assessed in this pattern. Obtain a 24-hour dietary recall from the patient. From this information, evaluate the quantity and quality of foods and fluids consumed. If a problem is identified, you may request that the client keep a 3-day food diary for a more careful analysis of dietary intake. Food frequency questionnaires based on weekly intake are also available to obtain information from the client. Assess the impact of psychological factors such as depression, anxiety, and self-concept on nutrition. Additionally, determine socioeconomic and cultural factors such as food budget, who prepares the meals, and food preferences.

Determine how the client's present condition has interfered with eating and appetite. If the the client's present condition has produced symptoms such as nausea, intestinal gas, or pain, determine the effect of these symptoms on appetite. Food allergies should be differentiated from food intolerances, such as lactose intolerance.

Elimination Pattern. Assess bowel, bladder, and skin function in this pattern. Ask the client about the frequency of bowel and bladder activity. The skin is assessed again in the elimination pattern in terms of its excretory function.

Activity-Exercise Pattern. Assess the client's usual pattern of exercise, activity, leisure, and recreation. Question the client about his or her ability to perform the activities of daily living. If

the client is unable to perform activities of daily living, note the specific problems that limit an activity.

Sleep-Rest Pattern. This pattern describes the client's perception of his or her pattern of sleep, rest, and relaxation in a 24-hour period. This information can be elicited by asking, "Do you feel rested when you wake up?"

Cognitive-Perceptual Pattern. Assessment of this pattern involves a description of all the senses and the cognitive functions. In addition, pain is assessed as a sensory perception in this pattern. Ask the client about any sensory deficits that affect the ability to perform activities of daily living. Discuss and record ways in which the client compensates for any sensory-perceptual problems. Ask how the client communicates best and about the client's understanding of his or her illness and treatment. You will use this information to plan client teaching.

Self-Perception-Self-Concept Pattern. This pattern describes the client's self-concept, which is critical in determining the way the person interacts with others. Included are attitudes about self, perception of personal abilities, body image, and general sense of worth. Ask the client for a self-description and about how his or her health condition affects self-concept. Expressions of hopelessness or loss of control by the client frequently reflects an inability to care for oneself.

Role-Relationship Pattern. This pattern describes the roles and relationship of client, including major responsibilities. It also examines the client's self-evaluation of hbis or her performance of the expected behaviors related to these roles. Ask the client to describe family, social, and work relationships. Determine if patterns in these relationships are satisfactory or if strain is evident. Note the client's feelings about his or her role in these relationships and the effect the present condition has on his or her role and relationship.

Sexuality-Reproductive Pattern. This pattern describes satisfaction or dissatisfaction with personal sexuality and describes the reproductive pattern. Assessing this pattern is important because many illnesses, surgical procedures, and medications affect sexual function. A client's sexual and reproductive concerns may be expressed, teaching needs and treatable problems may be identified, and normal growth and development may be monitored through information obtained in this pattern.

Specifically, you should determine if there is a lack of knowledge in relation to sexuality and reproduction. Determine whether the client perceives a problem in area of sexuality. Note the effect of the client's present condition or treatment on personal sexuality.

Obtaining information related to sexuality may be difficult for you. However, it is important to take a health history and screen for sexual function and dysfunction. Based on the complexity of the problem, you, as the nurse, may be able to provide limited information or refer the client to a more experienced professional.

Coping-Stress Tolerance Pattern. This pattern describes the client's general coping pattern and the effectiveness of the coping mechanisms. Assessment of this pattern involves analyzing the specific stressors or problems that confront the client, the client's perception of the stressor, and the client's response to the stressor.

The major losses or changes experienced by the client in the previous year are important to document. Current major stressors confronting the client are also important. Note strategies used by the client to deal with stressors and relieve tension, as well as individuals and groups who make up the client's social support networks.

Value-Belief Pattern. This pattern describes the values, goals, and beliefs (including spiritual) that guide health-related choices. Document the client's ethnic background, and the effects of

culture and beliefs on health practices. Note and honor the client's wishes about continuation of religious or spiritual practices and the use of religious articles.

TABLE 3: HEALTH HISTORY	
Functional Health Pattern Format	
Demographic Data	**Important Health Information**
Name, address, age, occupation	Past Health History
Race, ethnicity, culture	Medications/supplements
	Surgery or other treatments
QUESTIONS TO ASK	

3.2 Physical Examination

The physical examination is the systematic assessment of the physical and mental status of a patient, and findings are considered objective data. Throughout the physical examination, explore any positive findings using the same criteria as the investigation of a symptom during the nursing history. A positive finding indicates that the client has or has had the particular problem or sign under discussion (e.g., if the client with jaundice has an enlarged liver, it is a positive finding). Relevant information about this problem should then be gathered.

Negative findings may also be significant. A pertinent negative is the absence of a sign or symptom usually associated with a problem. For example, peripheral edema is common with advanced liver disease. If edema is not present in a client with advanced liver disease, this should be specifically noted as "no peripheral edema."

4.0 Conclusion

The process of obtaining a nursing history and performing a physical examination is an intimate experience for both you and the patient. Nursing history is the process of obtaining information about patient's health status through communication. Physical examination is the systematic assessment of the physical and mental status of a patient, and findings are considered objective data. During physical examination there is direct contact with the patient in attempt to further obtain information about the patient through the use of senses.

5.0 Summary

The nursing history

a. Subjective data obtained by interviewing the patient, family members, or significant other and reviewing past medical records.
b. Provides the opportunity to convey interest, support, and understanding to the patient and to establish a rapport based on trust.

The physical examination

a. Objective data obtained to determine the patient's physical status, limitations, and assets.
b. Should be done in a private, comfortable environment with efficiency and respect.

6.0 Tutor Marked Assignments

6.1 Activity

6.2 Tutor Marked Tests

7.0 References and other resources

UNIT FIVE: GENERAL SURVEY AND PHYSICAL EXAMINATION TECHNIQUES

CONTENT

1.0 Introduction

The general survey is a statement of general impression of a patient, including behavioral observations. Four major techniques are used in performing the physical examination: inspection, palpation, percussion, and auscultation, which are usually performed in that sequence.

2.0 Objectives

After successful completion of this unit, you will be able to:

1. Conduct a general health survey on patients to obtain necessary data
2. Use physical examination techniques to collect data to substantiate the information obtained through general survey.
3. Write health assessment report.

4. Identify use and maintain equipments for physical examination.

3.0 Main Content

3.1 General Survey

Following the nursing history, make general survey statement. The general survey is a statement of general impression of a patient, including behavioral observations. This initial survey is considered a scanning procedure, begins with your first encounter with client, and continues during the health history interview.

Although you may include other data that seem pertinent, the major areas usually included in the general survey statement are:

1. Body features
2. State of consciousness and arousal
3. Speech
4. Body movements
5. Obvious physical signs
6. Nutritional status
7. Behavior, vital signs and body mass index (BMI) (calculated from height and weight) are often included in the general survey statement.

Observe general state of health (client is seated). Observations of these areas provide the data for the general survey statement. The following is a sample of a general survey statement:

> *A, is a 45-year-old Yoruba woman, BP 130/80 mmHg, P 84, R 20. No distinguishing body features. Alert but anxious. Speech rapid with trailing thoughts. Wringing hands and shuffling feet during interview. Skin flushed, hands clammy. Overweight relative to height. Sits with eyes downcast and shoulders slumped and avoids eye contact.*

3.2 Physical Examination Techniques

Four major techniques are used in performing the physical examination: inspection, palpation, percussion, and auscultation, which are usually performed in that sequence. The only exception to this sequence is for the abdominal examination, in which the sequence is inspection, auscultation, percussion, and palpation. Performing palpation and percussion of the abdomen before auscultation can alter bowel sounds and produce false findings. Not every assessment area requires the use of all four assessment techniques (e.g., assessment of musculoskeletal system requires only inspection and palpation).

Inspection. Inspection is the visual examination of a part or region of the body to assess normal conditions and deviations from normal. Inspection is more than just looking. This technique is deliberate, systematic, and focused. You need to compare what is seen with the known, generally visible characteristics of the body parts you are inspecting. For example, most 30-year-old men have hair on their legs. Absence of hair may indicate a vascular problem and signals the need for further investigation, or it may be normal for a client of a particular ethnicity. Often, important findings are revealed when you compare one side of the client's body to the other.

Palpation. Palpation is the examination of the body through the use of touch. Using light and deep palpation can yield information related to masses, pulsations, organ enlargement, tenderness or pain, swelling, muscular spasm or rigidity, elasticity, vibration of voice sounds, crepitus, moisture, and differences in texture. Different parts of the hand are more sensitive for specific assessments. For example, use the tips of your fingers to palpate lymph nodes, the dorsa (back) of your hands and fingers to assess temperatures, and the palmar surface to feel vibrations.

Percussion. Percussion is an assessment technique involving the production of sound to obtain formation about the underlying area. You may produce the percussion sound directly or

indirectly. Evaluate the sounds and vibrations relative to the underlying structures. Deviation from an expected sound may indicate a problem. For example, the usual percussion sound in the right lower quadrant of the abdomen is tympany. Dullness in this area may indicate a problem that should be investigated.

Auscultation. Auscultation is listening to sounds produced by the body to assess normal conditions and deviations from normal. Auscultation is usually performed with a stethoscope. The bell of the stethoscope is more sensitive to low-pitched sounds; the diaphragm of the stethoscope is more sensitive to hig-pitched sounds. Auscultation is particularly useful in evaluating sounds from the heart, lungs, abdomen and vascular system.

Equipment for Physical Examination

The equipment needed for the physical examination should be easily accessible during the examination (Table 4) organizing equipment before the examination saves time and energy for you and the client.

Table 4: Equipment for Physical Examination

• Stethoscope (with bell and diaphragm, tubing15-18 in (38-46 cm)) • Watch (with second hand or digitalized). • Blood pressure cuff • Ophthalmoscope/otoscope set. • Eye chart (wall chart or Snellen pocket eye card). • Pocket flashlight.	• Tongue blades. • Cotton balls. • Percussion harmer • Turning fork • Alcohol swabs • Patient gown • Paper cup with water. • Examining table or bed.

Organization of examination. You should perform the physical examination systematically and efficiently. Provide explanation to client as the examination proceeds and consider the client's comfort, safety, and privacy. Perform the examination in an efficient, organized manner. You are less likely to forget a procedure, a step in the sequence, or a portion of the body if you follow the same sequence every time.

Adaptations of the physical examination are often useful for the older adult clients, who may have age-related problems such as decreased mobility, limited energy, and perceptual changes. An outline listing some of the useful adaptation is found in Table 5.

Table 5: Gerontologic Differences in Assessment

Adaptations in Physical Assessment Techniques
General approach Keep client warm and comfortable, because loss of subcutaneous fat decreases ability to stay warm. Adapt positioning to physical limitations. Avoid unnecessary changes in position. Perform as many activities as possible in the position of comfort for the client.
Skin Handle with care because of fragility and loss of subcutaneous fat.
Head and Neck Provide quiet environment free from distraction because of possible sensory impairment (e.g., decreased vision, hearing).
Extremities Use gentle movements and reinforcement techniques. Avoid having client hop on one foot or perform deep knee bends because of client's limited range of motion of the extremities, decreased reflexes, and diminished sense of balance.

Thorax

Adapt examination for changes due to decreased force of expiration, weakened cough reflex, and shortness of breath.

Abdomen

Use caution in palpating client's liver because it is readily accessible because of a thinner, softer abdominal wall. The older adult client may have diminished pain perception in abdominal wall

Recording Physical Examination. Only record abnormal findings during the actual examination. This prevents needless interruptions in the examination to write lengthy normal findings. At the conclusion of the examination, combine the normal and abnormal findings in a carefully recorded physical examination.

How to Write a Health Assessment Report

Health care professionals conduct health assessment reports for a variety of reasons and patient populations. The setting and purpose of the assessment determine the format of and information included in the report. For example, a state school health assessment conducted by a school nurse will focus on a set of health criteria established by the state and school district, whereas a health assessment report prepared by a physician for an adult patient undergoing an annual physical may be more comprehensive and flexible in format. While parameters differ, a few common elements are present among assessments.

Instructions

1. Begin with the patient's personal data including name, age, weight, height, Social Security number or identification (if appropriate), and parent information when applicable. Always include the date of the assessment and your name and credentials for the patient and other health care providers to reference.

2. List the patient's immunisation history. Include the dates of each prior immunisation, if known, and note any standard or recommended immunisation the patient does not have. If you are creating your own health assessment form, consider adding lines to document when any boosters or subsequent immunisation should take place. For patients who have acquired antibodies through disease -- as is often the case with varicella or chickenpox -- note the date of disease, if known, and corresponding titres.

3. Review known health problems such as diabetes, heart conditions and mental health disorders, including any corresponding medications the patient may take. When the health assessment is for the patient's use and benefit, include targets and goals related to known problems. For example, if a patient has high blood pressure, you might suggest the following goals: exercise for at least 30 minutes at least three times a week, take blood pressure medication and reduce intake of fats and sodium.

4. Record any hospital or emergency room visits the patient may have had within the last year. Include reasons for the visits and outcomes.

5. Document the patient's personal and lifestyle behaviours that impact health such as smoking, drinking and recreational drug use. Depending on the assessment purposes, scope and guidelines, you may include the patient's sexual health and history -- if he is sexually active, in a relationship and/or knowingly exposed to diseases such as

tuberculosis or sexually transmitted diseases. Some reports include the patient's physical activities and sports. It may be appropriate to note a stressful life situation such as caring for an elderly or disabled family member, working in a high-pressure job or going through a divorce.

6. Note physical limitations or disabilities. With geriatric patients, health care providers measure mobility and range of motion. Many also assess self sufficiency in a variety of tasks and functions. The same goes for children based on developmental levels. Health care assessments often include any age-appropriate tasks, functions or abilities a child does not exhibit as well as learning and social challenges the child may face.

7. Conclude with any patient or provider concerns. Document any complaints the patient has regarding his health as well as any expected treatments or additional examinations necessary for known medical conditions. Note any issues you want to flag and review or refer to another provider for further investigation.

MODULE 3 ASSESSING THE INDIVIDUAL FROM HEAD TO TOE

UNIT SIX: The integumentary, neurological and muscular system.

- **Integumentary System (Hair, Skin and Nails)**
- **Nuerological system**
- **Musculoskeletal**

Introduction

Assessment of the integumentary system includes gathering subjective and objective data about the skin, hair, and nails. Subjective data collection occurs during the interview, before the actual physical assessment. The nurse will use a variety of communication techniques to elicit general and specific information about the conditions of the client’s skin, hair, and nails. Health records

and the results of laboratory tests are important secondary sources to be reviewed and included in the data gathering process. In physical assessment of the integumentary system, the techniques of inspection and palpation will be used. The questions in the focused interview form part of the subjective data and provide valuable information to meet the objectives related to integumentary health.

Focused interview

The focused interview for the integumentary system concerns data related to the structures and functions of that system. Subjective data related to the condition of the skin, hair, and nails are gathered during the focused interview. The nurse must be prepared to observe the client and listen for cues related to the integumentary system. The nurse may use closed or open-ended questions to obtain information. A number of follow-up questions or requests for description may be required to clarify data or gather missing information. Follow-up questions are used to identify the source of problems, determine the duration of difficulties, identify measures to alleviate problems, and provide clues about the client's knowledge of his or her own health.

The focused interview guides the physical assessment of the integumentary system. The information is always considered in relation to norms and expectations about the function of the integument. Therefore, the nurse must consider age, gender, race, culture, environment, health practices, and past concurrent problems and therapies when forming questions and using techniques to elicit information. In order to address all of the factors when conducting a focused interview, categories of questions related to the status and function of each part of the integumentary system have been developed. These questions include general questions that are asked of all clients; those addressing illness or infection; questions related to symptoms, pain, or

behaviors; those related to habits or practices; questions that are specific to clients according to age; those for pregnant females; and questions that address environmental concerns.

The nurse must consider the client's ability to participate in the focused interview and physical assessment. Further, the nurse must consider that the appearance of the skin has an impact on self-image. A client with clear, healthy skin may have a heightened self-esteem. Clients with changes in the skin due to the normal aging process or from skin disorders may be anxious about the way they appear to others. Clients with visible skin disorders are often sensitive about the condition and their appearance. The nurse must select communication techniques that demonstrate caring and preserve dignity of the client (see the reference materials for focused interview questions).

Physical assessment of the skin, hair, and nails

Physical assessment of the skin, hair, and nails requires the use of inspection, and palpation. Inspection includes looking at the skin, hair, and nails to determine color, consistency, shape, and hygiene-related factors. Knowledge of norms or expected findings is essential in determining the meaning of the data as the nurse performs the physical assessment.

The skin of the adult should be clean, free from odor, and consistent in color. It should feel warm and moist and should have a smooth texture. The skin should be mobile with blood vessels visible beneath the surfaces of the abdomen and eyelids. It should be free of lesions except for findings of freckles and birthmarks. The skin is sensitive to touch and temperature.

The scalp and hair in the adult should be clean. Hair color is determined by the amount of melanin. Gray hair can occur as a result of decreased melanin, genetics, or aging. Hair texture may be coarse or thin. Hair distribution is expected to be even over the scalp. Male pattern baldness is a normal finding. Fine hair is distributed over the body with coarser, darker, longer

hair in the axillae and pubic regions in adults. The nails should have a pink undertone and lie flat or form a convex curve on the nail bed.

Physical assessment of the skin, hair, and nails follows an organized pattern. It begins with a survey and inspection of the skin, followed by palpation of the skin. Inspection and palpation of the hair and nails is then carried out. When lesions are present, measurements are used to identify the size of the lesions and the location in relation to accepted landmarks.

Equipment

- Examination gown and drape
- Examination light
- Examination gloves. clean and nonsterile.
- Centimeter ruler
- Magnifying glass.
- Penlight.
- Wood's lamp (filtered ultraviolet light) for special procedures.

HELPFUL HINTS

A warm, private environment will reduce client anxiety

Provide special instructions and explain the purpose for removal of clothing, jewelry, hairpieces, nail enamel.

Maintain the client's dignity by using draping techniques.

Monitor one's verbal responses to skin conditions that already threaten the client's self-image.

Be sensitive to cultural issues. In some cultures touching or examination by members of the opposite sex is prohibited.

Covering the head, hair, face, or skin may be part of religious or cultural beliefs. Provide careful

explanations regarding the need to expose these areas for assessment.

Direct sunlight is best for assessment of the skin; if it is not available, lighting must be strong and direct. Tangential lighting may be helpful in assessment of dark skinned clients.

Use standard precautions throughout the assessment.

Survey

A quick survey enables the nurse to identify any immediate problem and the client's ability to participate in the assessment. The nurse inspects the overall appearance of the client, notes hygiene and odor, and observes for signs of anxiety.

Inspection of the skin

Position the client

-The client should be in a sitting position with all clothing removed except the examination gown.

Instruct the client

-Explain that you will be looking carefully at the client's skin.

Observe for cleanliness and use the sense of smell to determine body odor

-Body odor is produced when bacterial waste products mix with perspiration on the skin surface. During heavy physical activity, body odor increases. Amounts of urea and ammonia are excreted in perspiration.

Observe the client's skin tone

-Evaluate any widespread color changes such as cyanosis, pallor, erythema, or jaundice. For example, always assess cyanotic clients for vital signs and level of consciousness.

-The amount of melanin and carotene pigments, the oxygen content of the blood, and the level of exposure to the sun influence skin color.

Inspect the skin for even pigmentation over the body

-In most cases, increased or decreased pigmentation is caused by differences in the distribution of melanin throughout the body. These are normal variations. For example, the margins of the lips, areolea, nipples, and external genitalia are more darkly pigmented.

Inspect the skin for superficial arteries and veins

-A fine network of veins or a few dilated blood vessels visible just beneath the surface of the skin are normal findings in areas of the body where skin is thin (e.g., the abdomen and eyelids).

Palpation of the skin

1**. Instruct the client**

-Explain that you will be touching the client in various areas with different part of your hand.

2. Determine the client's skin temperature

-Use the dorsal surface of your hand, which is most sensitive to temperature. Palpate the forehead or face first. Continue to palpate inferiorly, including the hands and feet, comparing the temperature on the right and left side of the body.

-Local skin temperature is controlled by the amount and rate of blood circulating through a body region. Normal temperatures range from mildly cool to slightly warm.

-The skin on both sides of the body is warm when tissue is perfused. Sometimes the hand s and feet are cooler than the rest of the body, but the temperature is normally similar on both sides.

3. **Assess the amount of moisture on the skin surface**

-Inspect and palpate the face, skin folds, axillae, palms, and soles of the feet, where perspiration is most easily detected.

-A fine sheen of perspiration or oil is not abnormal finding, nor is moderately dry skin, especially in cold or dry climates.

4. **Palpate the skin for texture**

-Use the palmar surface of fingers and finger pads when palpating for texture. Normal skin feels smooth, firm, and even.

5. **Palpate the skin to determine its thickness**

-The outer layer of the skin is thin and firm over most parts of the body except the palms, soles of the feet, elbows, and knees, where it is thicker. Normally, the skin over the eyelids and lips is thinner.

6. **Palpate the skin for elasticity**

-Elasticity is a combination of turgor (resiliency, or the skin's ability to return to its normal position and shape) and mobility (the skin's ability to be lifted).

-Using the forefinger and thumb, grasp a fold of skin beneath the clavicle or on the medial aspect of the wrist.

-Notice the reaction of the skin both as you grasp and as you release. Healthy skin is mobile and returns rapidly to its previous shape and position.

-Finally palpate the feet, ankles, and sacrum. Edema is present if your palpation leaves a dent in the skin.

- Grade any edema on a four-point scale. 1 indicates mild edema, and 4 indicates deep edema.

- Note that because the fluid of edema lies above the pigmented and vascular layers of the skin, skin tone in the client with edema is obscured.

7. Inspect and palpate the skin for lesions

- Lesions of the skin are changes in normal skin structure. Primary lesions develop on previously unaltered skin. Lesions that change over time or because of scratching, abrasion, or infection are called secondary lesions.

- Carefully inspect the client's body, including skin folds and crevices, using a good source of light.

- When lesions are observed, palpate lesions between the thumb and index finger. Measure all lesion dimensions (including height, if possible) with a small, clear flexible ruler.

- Document lesion size in centimeters. If necessary, use a magnifying glass or a penlight for closer inspection.

- Shine a wood's lamp on the skin to distinguish fluorescing lesions.

- Assess any drainage for color, odor, consistency, amount, and location.. if indicated, obtain a specimen of the drainage for culture and sensitivity.

- Some fungal infections including tinea capitis do not fluorescence.

- Healthy skin is typically smooth and free of lesions; however, some lesions such as freckles, insect bites, healed scars, and certain birthmarks are expected findings.

8. Palpate the skin for sensitivity

- Palpate the skin in various regions of the body and ask the client to describe the sensations.

- Give special attention to any pain or discomfort that the client reports, especially when palpating skin lesions.

- Ask the client to describe the sensations as closely as possible, and document the findings.

- The client should not report any discomfort from your touch.

ALERT!

Localized hot, red, swollen painful areas indicate the presence of inflammation and possible infection. These areas should not be palpated, because the slightest disturbance may spread the infection deeper into skin layers.

Inspection of the scalp and hair

1. Instruct the client

- Explain that you will be looking at the client's scalp and hair. Tell the client you will be parting the hair to observe the scalp.

2. Observe for cleanliness

- Ask the client to remove any hairpins, hair ties, barrettes, wigs, or hairpieces and to undo braids. If the client is unwilling to do this, examine any strands of hair that are loose or undone,

- Part and divide the hair at 1-in. intervals and observe.

- A small amount of dandruff (dead, scaly flakes of epidermal cells) may be present.

3. Observe the client's hair color

- Like skin color, hair color varies according to the level of melanin production. Graying is influenced by genetics and may begin as early as the late teens in some clients.

4. Assess the texture of the hair

- Roll a few strands of hair between your thumb and forefinger.

- Hold a few strands of hair taut with one hand while you slide the thumb and forefinger of your other hand along the length of the strand.

- Hair may be thick or fine and may appear straight, wavy, or curly.

5. Observe the amount and distribution of the hair throughout the scalp

- The amount of hair varies with age, gender, and overall health. Healthy hair is evenly distributed throughout the scalp.

- In most men and women, atrophy of the hair follicles causes hair growth to decline by the age of 50. Male pattern baldness, a genetically determined progressive loss of hair beginning at the anterior hairline, has no clinical significance. It is the most frequent reason for hair loss in men.

- Remember to assess the amount, texture, and distribution of body hair. Some practitioners prefer to perform this assessment with the regions of the body.

6. Inspect the scalp for lesions

- Dim the room light and shine a Wood's lamp on the client's scalp as you part the hair.

- The healthy scalp is free from lesions and areas of fluorescent glow.

Assessment of the nails

1. Instruct the client

- Explain that you will be looking at and touching the client's nails and that you will ask the client to hold the hands and fingers in certain positions while you are inspecting the fingernails.

2. Assess for hygiene

- Confirm the nails are clean and well groomed.

3. Inspect the nails for an even, pink undertone

- Small, while markings in the nail are normal findings and indicate minor trauma

4. Asses capillary refill

- Depress the nail edge to blanch, and then release. Color returns to healthy nails instantly upon release.

5. Inspect and palpate the nails for shape and contour

- Perform the Schamroth techniques to assess clubbing. Ask the client to bring the dorsal aspect of corresponding fingers together, creating a mirror image.

- Look at the distal phalanx and observe the diamond-shaped opening created by nails. When clubbing is present, the diamond is not formed and the distance increases at the fingertip.

- The nails normally form a slight convex curve or lie flat on the nail bed. When viewed laterally, the angle between the skin and the nail base should be approximately 160 degrees.

6. Palpate the nails to determine their thickness, regularity, and attachment to the nail bed

- Healthy nails are smooth, strong, and regular and are firmly attached to the nail bed, with only a slight degree of mobility.

7. Inspect and palpate the cuticles

- The cuticles are smooth and flat in healthy nails.

3.2 Neurological Assessment

Introduction

Health assessment of the neurologic system includes gathering subjective and objective data. Subjective data is collected during the client interview, prior to the physical assessment. During the interview, various communication techniques are used to elicit general and specific information about the status of the client's neurologic system and ability to function. Health records, results of laboratory tests, x-rays, and imaging reports are important secondary sources to be included in the data-gathering process. During the physical assessment, the techniques of inspection and palpation, as well as techniques and methods specific to neurologic function, will be used.

Focused interview

The focused interview for the neurologic system concerns data related to the structures and functions of this body system. Subjective data is collected during the focused interview. The nurse must be prepared to observe the client and listen for cues related to the neurologic system.

The nurse may use closed or open-ended questions to obtain information. A number of follow-up questions or requests for description may be required to clarify data or gather missing information. Follow-up questions are used to identify the source of problems, determine the duration of difficulties, identify measures to alleviate problems, and provide clues about the client's knowledge of his or her own health.

The focused interview guides the physical assessment of the neurologic system. The information is always considered in relation to norms and expectations of neurologic function. Therefore, the nurse must consider age, gender, race, culture, environment, health practices, and past concurrent problems and therapies when forming questions and using techniques to elicit information. In order to address all of the factors when conducting a focused interview, categories of questions related to the status and function of each part of the neurologic system have been developed. These categories include general questions that are asked of all clients; those addressing illness or infection; questions related to symptoms, pain, or behaviors; those related to habits or practices; questions that are specific to clients according to age; those for pregnant females; and questions that address environmental concerns.

The nurse must consider the client's ability to participate in the focused interview and physical assessment of the neurologic system. Participation in the focused interview is influenced by the ability to communicate in the same language. Language barriers interfere with accuracy of the data and cause anxiety in the client. The nurse may have to use a translator in conducting an interview and in physical assessment. If the client is experiencing pain, recent injury, or anxiety, attention must focus on relief of symptoms or discomfort before proceeding with an in-depth interview (see the reference materials for focused interview questions).

Physical assessment

Physical assessment of the neurologic system requires the use of inspection, palpation, auscultation, and special equipment and procedures to test the functions of the system. During each part of the assessment, the nurse is gathering objective data related to the functioning of the client's central and peripheral nervous systems. The examination begins with the assessment of the client's mental status and includes cranial nerves, motor and sensory function, balance, and reflexes. Knowledge of normal or expected findings is essential in interpretation of the data.

Adults have erect posture and a smooth gait. Facial expressions correspond to the content and topic of discussion. The speech is clear and vocabulary and word choice are appropriate to age and experience. Adults are well groomed, clean, and attired appropriately for the season and setting. The adult is oriented to person, place, and time and can respond to questions and directions. The adult demonstrates intact short- and long- term memory, is capable of abstract thinking, and can perform calculations. The cranial nerves are intact. Motor function is intact, and movements are coordinated and smooth. Sensory function is demonstrated in the ability to identify touch, pain, heat, and cold; to sense vibrations, to identify objects; and to discriminate between place and points of touch on the body. The response to testing of reflexes is 2+ on a scale of 0 to 4+. Carotid arteries are without bruits.

Physical assessment of the neurologic system follows an organized pattern. It begins with assessment of the client's mental status and proceeds to assessment of cranial nerves, motor and sensory function, reflexes, and auscultation of carotid arteries. Assessment proceeds in a cephalocaudal manner. The nurse tests distal to proximal and moves from gross function to fine function, always comparing corresponding body parts. More than one technique can be used to assess one function. For more information about neurologic assessment, link through the Companion Website.

EQUIPMENT

- Examination gown
- Clean, nonsterile examination gloves
- Percussion hammer
- Tuning fork
- Sterile cotton balls
- Penlight
- Ophthalmoscope
- Stethoscope
- Sterile needle
- Tongue blade
- Applicator
- Hot and cold water in test tubes
- Objects to touch such as coins, paper clips, or safety pins
- Substances to smell, for example, vanilla, mint, and coffee
- Substances to taste such as sugar, salt, lemon, and grape.

HELPFUL HINTS

- Data gathering begins with the initial nurse-client interaction. As nurses meet clients, they make assessments regarding their general appearance, personal hygiene, and ability to walk and sit down. These activities are related to cerebral function.
- Physical assessment of the neurologic system proceeds in a cephalocaudal and distal to proximal pattern, and includes comparison of corresponding body parts.

- Several assessments may occur at one time. For example, asking the client to smile tests cranial nerve VII, hearing and the functions of the cerebral cortext, indicated by the ability to follow directions and initiate voluntary movements.
- Provide specific information about what is expected of the client. Demonstrate movements.
- Explain and demonstrate the purposes and uses of the equipment.
- Use Standard Precausions.

Mental status

The nurse assesses the mental status of the client when meeting the client for the first time. This process begins with taking the health history and continues with each client contact.

1. **Instruct the client**
    - Explain to the client that you will be conducting variety of tests. Tell the client that you will provide instructions before beginning each examination. Explain that moving about and changing position during the examination will be required. Provide reassurance that then tests will not cause discomfort; however, the client must inform you of problems if they arise during any part of the assessment. Identify the types of equipment you will use and describe the purpose in relation to neurologic function. Tell the client you will begin the assessment with some general questions about the present and past. Then you will ask the client to respond to number and word questions.
2. **Position the client**
    - The client should be sitting on the examination table wearing an examination gown.

3. Observe the client
    - Look at the client and note hygiene, grooming, posture, body language, facial expressions, speech, and ability to follow directions.
4. Note the client' speech and language abilities
    - Throughout the assessment, note the client's rate of speech, ability to pronounce words, tone of voice, loudness or softness (volume) of voice, and ability to speak smoothly and clearly.
    - Assess the client's choice of words, ability to respond to questions, and ease with which a response is made.
5. Assess the client's sensorium
    - Determine the client's orientation to date, time, place, and reason for being here. Grade the level of alertness on a scale from full alertness to coma.

3.3 Musculoskeletal Assessment

General Approach to Musculoskeletal Assessment

1. Assist the patient to a comfortable position.
2. Offer pillows or folded blankets to support a painful part.
3. If necessary because of a painful body part or limited mobility, provide the patient assistance in disrobing. Allow the patient extra time to remove clothing.
4. To maximize patient comfort during physical assessment, maintain a warm temperature in the exam room.
5. Be clear in your instructions to the patient if you are asking the patient perform a certain body movement or to assume a certain position. Demonstrate the desired movement if necessary.

6. Notify a patient before touching or manipulating a painful body part.
7. Inspection, palpation, range of motion, and muscle testing are performed on the major skeletal muscles and joints in a cephalocaudal, proximodistal manner. Always compare paired muscles and joints.
8. Examine non-affected body parts before examining affected body parts.
9. Avoid unnecessary or excessive manipulation of a painful body part. If the patient complains of pain, stop the aggravating motion.
10. If necessary because of a painful body part or limited mobility, provide the patient assistance in dressing after the physical assessment. Allow the patient extra time to get dressed.
11. Some musculoskeletal disorders may affect the patient more during certain parts of the day. Arrange for the follow-up appointment to be during the patient's time of optimal function.

General Assessment

Overall Appearance

1. Obtain height and weight.
2. Observe the patient's ability to tolerate weight bearing on the lower limbs during and ambulation. Assess the amount of weight bearing placed on each of the lower limbs.
3. Identify obvious structural abnormalities (e.g., atrophy, scoliosis, kyphosis, amputated limbs, contractures).
4. Note indications of discomfort (e.g., restricted weight bearing or movement, frequent shifting of position, facial grimacing, excessive fatigue).

Posture

1. Stand in front of the patient.
2. Instruct the patient to stand with the feet together.
3. Observe the structural and spatial relationship of the head, torso, pelvis, and limbs. Assess for symmetry of the shoulders, scapulae, and iliac crests.
4. Ask the patient to sit; observe posture.

Gait and Mobility

1. Instruct the patient to walk normally across the room.
2. Ask the patient to walk on the toes and then on the heels of the feet.
3. Ask the patient to walk by placing one foot in front of the other, in a "heel-to-toe" fashion.
4. Instruct the patient to walk forward, then backward.
5. Ask the patient to side step to the left, then to the right.
6. Instruct the patient to ambulate forward a few steps with the eyes closed.
7. Observe the patient during transfer between the standing and sitting position.

INSPECTION

Muscle Size and shape

1. Survey the overall appearance of the muscle mass.
2. Ask the patient to contract the muscle without inducing movement (isometric muscle contraction), relax the muscle, and then repeat the muscle contraction.
3. Look for any obvious muscle contraction.

Joint Contour and Periarticular Tissue

1. Observe the shape of the joint while the joint is in its neutral anatomic position.

2. Visually inspect the 5 to 7.5 cm of the skin and subcutaneous tissue surrounding that joint. Assess the periarticular area for erythema, swelling, bruising, nodules, deformities, masses, skin atrophy, or skin breakdown.

PALPATION

Muscle Tone

1. Palpate the muscle by applying light pressure with the finger pads of the dominant hand.
2. Note the change in muscle shape as the muscle belly (wide central aspect of the muscle) tapers off to become a tendon.
3. Ask the patient to alternately perform muscle relaxation and isometric muscle contraction. Note the change in palpable muscle tone between relaxation and isometric muscle contraction.
4. Palpate the muscle belly during contraction induced by voluntary movement of a nearby joint.
5. Perform passive range of motion to all extremities and note whether these movements are smooth and sustained.

Joints

1. With the joint in its neutral anatomic position, begin palpating the joint by applying light pressure with the finger pads of the dominant hand 5 to 7 cm away from the center of the joint.
2. Palpate from the periphery inward to the center of the joint.
3. Not any swelling, pain, tenderness, warmth, or nodules.

RANGE OF MOTION (ROM)

1. Ask the patient to move the joint through each of the various ROM movements.

2. Note angle of each joint movement.
3. Note any pain, tenderness, or crepitus.
4. If the patient is unable to perform active ROM, then passively move each joint through its ROM.
5. Always stop if the patient complains of pain, and never push a joint beyond its anatomic angle.
6. Use a goniometer to determine exact ROM in joints with limited ROM.

Muscle Strength

Each muscle group is assessed for strength via the same movements as are performed in range of motion.

1. Note whether muscle groups are strong and equal.
2. Always compare right and left sides of paired muscle groups.
3. Note involuntary movements.

NURSING CHECKLIST

Assessing Patients with Musculoskeletal Assistive Devices

Assistive devices may be necessary to support musculoskeletal structure and function. The need for such devices automatically indicates an underlying musculoskeletal disorder. For each assistive device, determine the reason for its use.

Crutches

Determine the following:

1. Amount of weight bearing allowed on affected lower limb.
2. Appropriate crutch height.
3. Type of crutch gait and appropriateness for the amount of weight bearing on affected leg:

two-point crutch gait (partial weight bearing); three-point crutch gait (partial or full nonweight bearing); swing gait (nonweight bearing).

4. Condition of crutches (padded handles, rubber tips).
5. Ease of transfer into and out of a chair.
6. Ease of stair climbing with the crutches.
7. Patient wearing flat, properly fitted shoes with nonskid surfaces.
8. Signs or symptoms of skin breakdown or distal limb hypoperfusion.

Cane

Determine the following:

1. Shape of handle (C or T)
2. Number of points on contact surface.
3. Appropriateness for patient's height.
4. Cane used on unaffected side.
5. Refer to numbers 4-8 in the section on crutches.

Walker

Determine the following:

1. Amount of weight bearing allowed on the lower limb.
2. Type of walker (e,g., rolling or pickup walker).
3. Appropriateness for patient's height.
4. Patient's ability to grip and propel the walker forward with rolling walker; patient's ability to grip, lift, and propel walker forward with pickup walker.
5. Refer to numbers 4-8 in the section on crutches.

Brace, Splint, Immobilizer

Determine the following:

1. Location of device (e,g., limb, neck, torso, lower back, or pelvis).
2. Joint position maintained by device (e.g., extension, flexion, or abduction).
3. Joint motion allowed by device.
4. If a movable device is used, is the hinge joint of the device aligned with the skeletal joint.
5. Padding under pressure points of device.
6. Amount of weight bearing allowed on the affected leg (lower leg device).
7. Refer to numbers 7 and 8 in the section on crutches.

Cast

Determine the following:

1. Plaster or nonplaster (e.g., synthetic, fiberglass).
2. Location of cast.
3. Joint position maintained (e.g., extension, flexion, or abduction)
4. Joint motion allowed.
5. Edges of cast covered ("petaled") with tape to prevent skin irritation
6. Amount of weight bearing allowed (lower leg cast)
7. Damage to cast (e.g., cracked, flaking or crumbling, dented, wet, softening)
8. Visible discolouration on the cast (e.g., from underlying wound drainage or bleeding).
9. Significant odor around the cast (e.g., a musty or foul smell).
10. Refer to number 8 in the section on crutches.

UNIT SEVEN: FROM THE SHOULDERS UP

- **Assessment of the Head and Neck**
- **Eyes, Ears, Mouth, Nose, and Pharnyx**

Inspection of the Shape of the Head

1. Have the patient sit in a comfortable position.
2. Face the patient, with your head at the same level as the patient's head.
3. Inspect the head for shape and symmetry.

Palpation of the head

1. Place the finger pads on the scalp and palpate its entire surface, beginning in the frontal area and continuing over the parietal, temporal, and occipital areas.
2. Assess for contour; masses, depressions, tenderness.
3. Palpate the superficial temporal artery, which is located anterior to the trgus of the ear.

Inspection and palpation of the scalp

1. Part the hair repeatedly all over the scalp and inspect the scalp for lesions or masses.
2. Place the finger pads on the scalp and palpate for lesions of masses.

Inspection of the Face

Symmetry

1. Have the patient sit in a comfortable position facing you.
2. Observe the patient's face for expression, shape, and symmetry of the following structures: eyebrows, eyes, nose, mouth, ears.

Shape and features

1. Face the patient.
2. Observe the shape of the patient's face.

3. Note any swelling, abnormal features, or unusual movement.

Palpation and Auscultation of the mandible

1. use the fingers of both index and middle fingers to locate temporomandibular joint anterior to the tragus of the ear on both sides.
2. Hold the fingertips firmly in place over the joints and ask the patient to open and the mouth.
3. As the patient opens and closes the mouth , observe the relative smoothness of the movement and whether or not the patient notices any discomfort.
4. Remove the hands.
5. Hold the bell of the stethoscope over the joint.
6. Listen for any sound while the patient opens and closes the mouth.

Inspection and Palpation of the Neck

Inspection of the Neck

1. Have the patient sit facing you, with the head held in a central position.
2. Inspect for symmetry of the sternocleidomastoid muscles interiorly, and the trapezii posterior.
3. Have the patient touch the chin to the chest, to each side, and to each shoulder.
4. Assess for limitation of motion.
5. Note the presence of a stoma or tracheostomy.

Palpation of the Neck

1. Stand in front of the patient.
2. With the finger pads, palpate the sternocleidomastoids.
3. Note the presence of masses or tenderness.

4. Stand behind the patient.
5. With the finger pads, palpate the trapezius.
6. Note the presence of masses or tenderness.

Inspection of the Thyroid Gland

1. Secure tangential lighting, and shine at an oblique angle on the patient's anterior neck./
2. Face the patient.
3. Ask the patient to look straight ahead with the head slightly extended.
4. Have the patient drink a sip of water and swallow twice.
5. As the patient swallows, observe the front of the neck in the area of the thyroid and the isthmus for masses and symmetrical movement.

Palpation of the Thyroid Gland

Palpation of the thyriod gland may be done using both anterior and posterior approaches.

Posterior approach

1. Have the patient sit comfortably, stand behind the patient.
2. Have the patient lower the chin slightly in order to relax the neck muscles.
3. Place the thumbs on the back of the patient's neck and bring the other fingers around the neck anteriorly with their tips resting on the lower portion of the neck over the trachea.
4. Move the finger pads over the trachea rings.
5. Instruct the client to swallow. Palpate the isthmus for nodules or enlargement.
6. Have the patient incline the head slightly forward.
7. Press the fingers of the left hand against the left side of the thyroid cartilage to stabilize it while placing the fingers of the right hand gently against the right side.
8. Instruct the patient to swallow sips of water.

9. Note consistency, nodularity, or tenderness as the gland moves upward.
10. Repeat on the other side.

Anterior Approach

1. Stand in front of the patient.
2. Ask the patient to flex the head slightly forward.
3. Place the right thumb on the thyroid cartilage and displace the cartilage to the patient's right.
4. Grasp the elevated and displaced right lobe of the thyroid gland with the thumb and index and middle fingers of the left hand.
5. Palpate the surface of the gland for consistency, modularity, and tenderness.
6. Have the patient swallow, and palpate the surface again.
7. Repeat the procedure on the opposite side.

Auscultation of the Thyroid Gland

If the thyroid is enlarged auscultation should be done.

1. Stand in front of the patient.
2. Place the bell of the stethoscope over the right thyroid lobe.
3. Auscultate for bruits.
4. Repeat on the left thyroid lobe.

Inspection of the Lymph Nodes

1. Stand in front of the patient.
2. Expose the area of the head and neck to be assessed.
3. Inspect the nodal areas of the head and neck for any enlargement or inflammation.

Palpation of the Lymph Nodes

1. Have the patient sit comfortable.
2. Face the patient and conduct the assessment of both sides of the neck simultaneously
3. Move the pads and tips of the middle three fingers in small circles of palpation using gentle pressure.
4. Follow a systematic, routine sequence beginning with the preauricular, postauricular, occipital, submental, submandibular, and tonsilar nodes. Moving down to the neck, and the supraclavicular nodes.
5. Note the size, shape, delimitation (discrete or matted together). Modality, consistency, and tenderness.

3.2 Eyes, Ears, Mouth, Nose, and Pharnyx

General Approach to Eye, Ears, Nose, Mouth and Throat Assessment

1. Greet the patient and explain the assessment techniques that you will be using.
2. Use a quite room that will be free from interruptions.
3. Ensure that the light in the room provides sufficient brightness to allow adequate observation of the patient.
4. Place the patient in an upright sitting position on the examination table.
5. Visualize the underlying structures during the assessment process to allow adequate description of findings.
6. Always compare right and left eyes. Use a systematic approach that is followed consistently each time the assessment is performed.

Assessment of the Eye

Assessment of the eyes should be carried out in an orderly fashion, moving from the extraocular structures to the intraocular structures. The eye assessment usually includes testing of associated cranial nerves and can be performed in the following order:

1. Determine visual acuity
2. Determine visual fields.
3. Assessment of the external eye and lacrimal apparatus.
4. Evaluation of extraocular muscle function.
5. Assessment of the anterior segment structures.
6. Assessment of the posterior segment structures.

Assessment of the Ear

Physical assessment of the ear consists of three parts:

1. Auditory screening.
2. Inspection and palpation of the external ear.
3. Otoscopic assessment.

Assessment of the Nose

External Inspection

- Inspect the nose, nothing any trauma, bleeding, lesions, masses, swelling and asymmetry.

Patency

1. Have the patient occlude one nostril with a finger.
2. Ask the patient to breathe in and out through the nose as you observe and listen for air movement in and out of the nostril.
3. Repeat on the other side.

Internal Inspection

1. Position the patient with the head in an extended position.
2. Place the nondominant hand firmly on top of the patient's head.
3. Using the thumb of the same hand, lift the tip of the patient's nose.
4. Gently insert a nasal speculum or an otoscope with a short, wide nasal speculum. If using a nasal speculum, use a penlight to view the nostrils.
5. Assess each nostril separately.
6. Inspect the mucous membranes for color and discharge.
7. Inspect the middle and inferior turbinates and the middle meatus for color, swelling, drainage, lesions, and polyps.
8. Observe the nasal septum for deviation, perforation, lesions, and bleeding.

Assessment of the Sinuses

Inspection

- Observe the patient's face for swelling around the nose and eyes.

Palpation and Percussion

To palpate and percuss the frontal sinuses:

1. Stand facing the patient.
2. Gently press the thumbs under the bony ridge of the upper orbits. Avoid applying pressure on the globes themselves.
3. Observe for presence of pain.
4. Percuss the areas using the middle or index finger of the dominant hand (immediate persussion).
5. Note the sound.

To palpate and percuss the maxillary sinuses:

1. Stand facing the patient.
2. Apply gentle pressure in the area under the infraorbital ridge using the thumb or middle finger.
3. Observe for presence of pain.
4. Percuss the areas using the middle or index finger.
5. Note the sound.

Assessment of the Mouth and Throat

1. Physical assessment of the oral cavity should include the following: Breath, lips, tongue, buccal mucosa, gums and teeth, hard and soft palates, throat (oropharynx), and temporomandibular joint.
2. If the patient is wearing dentures or removable orthodontia, ask that they be removed before the examination begins.
3. Use gloves and a good light source such as a penlight for optimum visualization of the oral cavity and pharynx.

(Note: Use the recommended texts to perform the above activities initially)

UNIT EIGHT: THE TORSO

- **Breasts and Regional Lymphatics**
- **Assessment of Thorax and Lungs**
- **Assessment of Heart and Neck Vessels**

Assessment of the Female Breasts and Regional Nodes

General Approach to Breast Assessment

Prior to the assessment:

1. When possible, instruct the patient to neither use creams, lotions, nor powders, nor shave her underarms 24 to 48 hours before the scheduled examination. Application of toiletry products may mask or alter the nature of the surface integument of the breasts, and shaving the underarms may cause folliculitis, which may result in pain upon palpation.
2. Encourage the patient to express any anxieties and concerns about the physical examination. Acknowledge anxieties and validate concerns. Many women avoid having their breasts assessed because they fear abnormal findings. Assure the patient that she has taken a positive step in her own health care by having her breasts assessed.
3. Inform the patient that the examination should not be painful but may be uncomfortable at times. This is especially true if the patient is currently experiencing menses, ovulation, or pregnancy.
4. Adopt a nonjudgmental and supportive attitude.
5. Be aware of impact of culture on breast assessment and breast self-examination. In Asian cultures, breast self-examination may be considered a form of masturbation. In some Middle Eastern cultures, baring the breasts to a male is taboo, even if the male is a health care provider.

6. Instruct the patient to remove any jewelry that might interfere with the assessment.
7. Ensure that the room is warm enough to prevent chilling, and provide additional draping material as necessary.
8. Warm your hands with warm water or by rubbing them together prior to the assessment.
9. Ensure that privacy will be maintained during the examination. Provide screens, closed doors, and door sign stating that an examination is in progress.

During the assessment:

1. Inform the patient of what you are going to do before you do it.
2. Use this time to educate the patient about her body.
3. Offer the patient the opportunity to ask questions about her body and sexuality.
4. Keep areas not being assessed appropriately draped.
5. Always compare right and left breasts.
6. Wear gloves if the patient has any discharge from her breast.

After the assessment:

1. Assess whether the patient needs assistance in dressing.
2. After the patient is dressed, discuss the experience with her, invite questions and comments, listen carefully, and provide her with information regarding the examination.

Note: Assessment of the female breasts and regional nodes includes inspection and palpation.

3.2 Assessment of Thorax and Lungs

General Approach to Thorax and lung Assessment

1. Greet the patient and explain the assessment techniques that you will be using.
2. Ensure that the examination room is at warm, comfortable room temperature to prevent patient chilling and shivering.

3. Use a quite room that will be free from interruptions.
4. Ensure that the light in the room provides sufficient brightness to adequately observe the patient.
5. Instruct the patient to remove all street clothes from the waist up and to don an examination gown.
6. Place the patient in an upright sitting position on the examination table, or for patient who cannot tolerate the sitting position, rotate the spine, bedridden patient from side to side to gain access to the thorax.
7. Expose the entire area being assessed. Provide drape that women can use to cover their breasts (if desired) when the posterior thorax is assessed.
8. When palpating, percussing, or auscultating the anterior thorax of female or obese patients, ask them to displace the breast tissue. Assessing directly over breast tissue is not an accurate indicator of underlying structures.
9. Visualize the underlying respiratory structures during the assessment process in order to accurately describe the location of any pathology.
10. Always compare the right and the left sides of the anterior thorax and the left lateral thorax.
11. Use a systematic approach every time the assessment is performed. Proceed from the lung apices to the bases, right to left to lateral.

Thorax and Lung Assessment

Inspection

- Shape of the thorax
- Symmetry of chest wall

- Presence of superficial veins
- Costal angle
- Angle of the ribs
- Intercostal spaces
- Muscles of repiration
- Respiration

- Rate
- Pattern
- Depth
- Symmetry
- Audibility
- Patient position
- Mode of breathing

- Sputum

Palpation

- General palpation

- Pulsations
- Masses
- Thoracic tenderness
- Crepitus

- Thoracic expansion
- Tactile fremitus
- Tracheal position

Percussion

- General percussion
- Diaphragmatic excursion

Auscultation

- General auscultation
- Breath sounds
- Voice sounds

Advanced Techniques

- Locating the site of a fractured rib.
- Forced expiratory time

Assistive Devices

- Oxygen
- Incentive spirometer
- Endotracheal tube
- Tracheostomy tube
- Mechanical ventilation
- Pulse oximeter
- Peak flow meter

Assessing Patients with Respiratory Assistive Devices

Oxygen

- Mode of delivery (e.g., nasal cannula, face mask)
- Percentage of oxygen that is being delivered (e.g., 25%, 40%)

  - Flow rate of the oxygen (2 liters per minute, 4 liters per minute)
  - Humidification provided and oxygen warmed.

- Incentive spirometer
  - Frequency of use
  - Volume achieved (e.g, 1000 ml, 1,500 ml)
  - Number of times patient reaches goal with each use.
- Endotracheal Tube
  - Size of the endotracheal tube
  - Nasal or oral insertion
  - Tube secured to the patient
  - Length of the endotracheal tube as it exits the nose or the mouth (e.g., 24 cm at the tips or 27 cm at the tip of the nare)
  - Cuff inflated or deflated
- Tracheostomy Tube
  - Size of the tracheostomy tube
  - Cuff present; if yes, cuff inflated or deflated
  - Tracheostomy ties secure the tube
- Mechanical ventilation
  - Type of ventilator (e.g., Servo, Bear, Emersion)
  - FiO_2 setting
  - Mode used (e.g., assit. Intermittent mandatory ventilation)
  - Amount of positive end-expiratory pressure
  - Rate and tidal volume

- Peak inspiratory pressure
- Temperature of the humidification
- Alarms set

- Pulse Oximeter
  - Determine the monitor's settings
  - The monitor's alarms are on. The appropriate limits are set.
  - If using the probe on a nail, the patient's nail polish has been removed.
  - If using the probe on the ear, the skin is intact and earrings are not interfering.
- Peak Flow Meter
  - Patient is seated while performing the maneuver
  - Indicator line is lowered to the baseline level
  - Patient exhales as deeply as possible while maintaining a firm seal with the lips around the mouthpiece
  - Patient doe not obstruct the exhalation outlet

3.3 Assessment of Heart and Neck Vessels

General Approach to Heart Assessment

1. Explain to the patient what you are going to do
2. Ensure that the room is warm, quite, well lit
3. Expose the patient's chest only as much as is needed for the assessment
4. Position the patient in supine or sitting position
5. Stand to the patient's right side. The light should come from the opposite side of where you are standing so that shadows can be accentuated.

Note: The cardiovascular physical assessment has two major components:

1. Assessment of the pericardium (the area on the anterior surface of the body overlying the heart, great vessels, pericardium, and some pulmonary tissue) and
2. Assessment of the periphery.

Inspection, palpation, and auscultation should be performed in a systematic manner, using certain cardiac landmarks. Percussion has limited usefulness in the cardiovascular assessment because X rays and other diagnostic tests provide the same information in a much more accurate manner. The cardiac landmarks are defined as follows:

1. The aortic area is the second intercostals space (ICS) to the right of the sternum
2. The pulmonic area is the second ICS to the left of the sternum.
3. The midprecordial are. Erb's point is located in the third ICS to the left of the sternum.
4. The tricuspid area is the fifth ICS to the left of the sternum. Other terms for this area are the right ventricular area or the septal area
5. The mitral area is the fifth ICS at the left midclavicular line. Other terms for this area are the left ventricular area or the apical area.

General approach to Heart Auscultation

1. Explain to the patient what you are going to do
2. Expose the patient's chest only as much as needed for the assessment. Never auscultate through any type of clothing.
3. Position the patient in a supine or sitting position. The left lateral position may be used for auscultation of the mitral and tricuspid areas. Also, the upright, leaning forward position may be used for thorough auscultation of the aortic area.
4. Stand to the patient's right side.

5. Use the correct headpiece of the stethoscope. The diaphragm transmits high-frequency sounds whereas the bell is used for low-pitched sounds. keep in mind when using the bell that it should rest lightly on the skin. If too much pressure is applied, the bell will act like a diaphragm.
6. Warm the headpiece in your hands prior to touching it to the patient.
7. Listen to all four of the valvular cardiac landmarks at least twice. During the first auscultation, identify S_1 and S_2, and then listen for a possible S_3 and S_4. During the second auscultation, listen for murmurs and friction rubs. As you gain expertise, you may be able to listen for S_1, S_2, S_3, S_4, murmurs, and friction rubs at the same time.
8. Listen for at least a few cardiac cycles (10 to 15 seconds) in each area.

3.4 Assessment of Peripheral Vasculature

General approach to Peripheral Vasculature Assessment

1. Explain to the patient what you are going to do.
2. Use a drape and uncover only those areas that are necessary as the assessment is done
3. Position the patient in a supine or sitting position.

Assessment of the periphery is the second major component of a comprehensive cardiovascular assessment. The components of the assessment of the periphery include:

1. Inspection of the jugular venous pressure
2. Inspection of the hepatojugular reflux
3. Palpation and auscultation of the arterial pulses
4. Inspection and palpation of peripheral perfusion.
5. Palpation of the epitrochlear node.

3.5 Assessment of the Abdomen

General Approach to Abdominal Assessment

1. Greet the patient and explain the assessment technique.
2. Ensure that the room is at a warm, comfortable temperature to prevent patient chilling and shivering.
3. Use a quite room that will be free from interruptions.
4. Utilize an adequate light source. This includes both a bright overhead light and a freestanding lamp for tangential lighting.
5. Ask the patient to urinate before the exam
6. Drape the patient from the xiphoid process to the symphysis pubis, then expose the patient's abdomen.
7. Position the patient comfortably in a supine position with knees flexed over a pillow or positions the patient so that the arms are either folded across the chest or at the sides to ensure abdominal relaxation.
8. Stand to the right side of the patient for examination.
9. Visualize the underlying abdominal structures during the assessment process in order to accurately describe the location of any pathology.
10. Have the patient point to tender areas; assess these last. Mark these and other significant findings (scars, dullness, and so on) on the body diagram in the patient's chart.
11. Watch the patient's face closely for signs of discomfort or pain.
12. Help the patient relax by using an unhurried approach, diverting attention with questions, and so on.
13. Ensure that your hands and the stethoscope are warm to promote patient comfort.

3.6 Assessment of Male and Female Genitalia

General Approach to Male Genitalia Assessment

1. Greet the patient and explain the assessment techniques that you will be using.
2. Ensure that the examination room is at a warm, comfortable room temperature to prevent patient chilling and shivering.
3. Use a quite room that will be free from interruptions.
4. Ensure that the light in the room provides sufficient brightness to adequately observe the patient.
5. Assess the patient's apprehension level about the assessment and address this with him, reassuring him this is normal.
6. Instruct the patient to remove his pants and underpants.
7. Place the patient on the examination table in the supine position with the legs spread slightly, and covers with a drape sheet. Stand to the patient's right side. Or have the patient stand in front of you while you are sitting.
8. Don clean gloves.
9. Expose the entire genital and groin area.

General Approach to Female Genitalia Assessment

Prior to the assessment:

1. Ensure that the patient will not be menstruating at the time of the examination for optimal cytological specimen collection.
2. Instruct the patient not to use vaginal sprays, to douche, or to have coitus 24 to 48 hour before the scheduled physical assessment. The products of colitis and commercial sprays and douches may affect the Pap smear and other vaginal cultures.

3. Encourage the patient to express any anxieties and concerns about the physical assessment. Reassure the patient by acknowledging anxieties and validating concerns. Virgins need reassurance that the pelvic should not affect the hymen.
4. Show the speculum and other equipment to the patient and allow her to touch and explore any items that do not have to remain sterile.
5. Inform the patient that the assessment should not be painful but may be uncomfortable at times, and tell her to inform you if she is experiencing any pain.
6. Instruct the patient to empty her bladder and then to undress from the waist to the ankles.
7. Ensure that the room is warm enough to prevent chilling, and provide additional draping material as necessary.
8. Place drapes or sheep skin over the stirrups to increase patient comfort.
9. Warm your hands with warm water prior to gloving.
10. Ensure that privacy will be maintained during the assessment. Provide screens and a closed door.
11. Warm the speculum with warm water or a warming device before insertion.

During assessment:

1. Inform the patient of what you are going to do before you do it. Tell her she may feel pressure when the speculum is opened and a pinching sensation when the Pap smear is done.
2. Adopt a nonjudgmental and supportive attitude.
3. Maintain eye contact with the patient as much as possible to reinforce a caring relationship.

4. Use a mirror to show the patient what you are doing and educate her about her body. Help her with positioning the mirror during the examination so she will feel comfortable using this technique at home to assess her genitalia.
5. Offer the patient the opportunity to ask questions about her body and sexuality.
6. Encourage the patient to use relaxation techniques such as deep breathing or guided imagery to prevent muscle tension during assessment.

After the assessment:

1. Assess whether the patient needs assistance in dressing.
2. Offer tissues with which to wipe excess lubrication.
3. After the patient is dressed, discuss the experience with her, invite questions and comments, listen carefully, and provide her with information.
4. Tell the patient she may experience a small amount of spotting following the Pap smear.

3.7 Assessment of Anus, Rectum and Prostate

General Approach to Anus, Rectum, and Prostate Assessment

1. Greet the patient and explain the assessment techniques that you will be using.
2. Ensure that the examination room is at a warm, comfortable temperature to prevent patient chilling and shivering.
3. Use a quite room that will be free from interruptions.
4. Ensure that the light in the room provide sufficient brightness to adequately observe the patient. It may be helpful to have a gooseneck lamp available for additional lighting when lesions are observed.
5. Instruct the patient to void prior assessment.
6. Instruct the patient to remove pants and underpants and to cover up with a drape sheet.

7. Assess the patient's apprehension level about the assessment and reassure the patient that apprehension is normal.
8. For inspection, place the patient in the left lateral decubitus position and visualize the perianal skin. This position can also be used for palpation.
9. For palpation, have the patient stand at the side or end of the examination table, bending over the table resting elbows on the table and spreading the legs slightly apart. For the patient who cannot stand, have the patient assume the knee-chest position. For the female who is undergoing a rectovaginal examination, have her assume the lithotomy position.
10. Don nonsterile gloves.
11. Use a systematic approach every time the assessment is performed. Proceed from the anus to the rectum in the female patient. Proceed from the anus to the prostate in the male patient.