Chapter 12
Physical Assessment

Signs and Symptoms

- Signs
  - Objective data as perceived by the examiner
  - Can be seen, heard, and measured and can be verified by more than one person
  - Examples: rashes, altered vital signs, visible drainage or exudate
  - Lab results, diagnostic imaging, and other studies

Signs and Symptoms (Cont.)

- Symptoms
  - Subjective data
  - Perceived by the patient
  - Examples: pain, nausea, vertigo, and anxiety
  - Nurse unaware of symptoms unless the patient describes the sensation
Signs and Symptoms (Cont.)

- Symptoms
  - Encourage a full description by the patient of the onset, the course, the character of the problem, and any factors that aggravate or alleviate

Signs and Symptoms (Cont.)

- Disease and diagnosis
  - Disease
    - It is any disturbance of a structure or function of the body; a pathologic condition of the body
    - It is recognized by a set of signs and symptoms
    - Signs and symptoms are clustered in groups to help the health care provider to make a medical diagnosis

Signs and Symptoms (Cont.)

- Disease
  - The nurse also relies on assessment of signs and symptoms to formulate a nursing diagnosis
Signs and Symptoms (Cont.)

- **Origins of disease**
  - Disease or illness originates from many causes: hereditary, congenital, inflammatory, degenerative, infectious, deficiency, metabolic, neoplastic, traumatic, and environmental
  - Unknown etiology
    - Diseases that have no apparent cause

- **Risk factors for development of disease**
  - A risk factor is any situation, habit, environmental condition, genetic predisposition, physiologic condition, or other that increases the vulnerability of an individual or a group to illness or accident
  - Risk factors do not necessarily mean that a person will develop a disease condition, only that the chances of disease are increased
  - Categories of risk factors
    - Genetic and physiologic, age, environment, and lifestyle

- **Terms used to describe disease**
  - Chronic
    - Develops slowly and persists over a long period, often for a person’s lifetime
  - Remission
    - Partial or complete disappearance of clinical and subjective characteristics of a disease
  - Acute
    - Begins abruptly with marked intensity of severe signs and symptoms and then often subsides after a period of treatment
Signs and Symptoms (Cont.)

- Terms used to describe disease
  - Organic disease
    - Results in structural change in an organ that interferes with its functioning
  - Functional disease
    - May be manifested as organic disease, but careful examination fails to reveal evidence of structural or physiologic abnormalities

- Frequently noted signs and symptoms
  - Infection
    - Caused by an invasion of microorganisms, such as bacteria, viruses, fungi, or parasites that produce tissue damage
  - Inflammation
    - Protective response of the body tissues to irritation, injury, or invasion by disease-producing organisms

- Frequently noted signs and symptoms
  - Cardinal signs of infection and inflammation
    - Erythema
    - Edema
    - Heat
    - Pain
    - Purulent drainage
    - Loss of function
Question 1

There are many risk factors for disease. An example of an environmental risk factor is:
1. thinning skin.
2. malnutrition.
3. extremes of heat and cold.
4. alcohol and substance abuse.

Assessment

- Process of making an evaluation or appraisal of the patient’s condition
- Medical assessment
  - Physical examination is conducted by the health care provider
  - The nurse is often expected to carry out certain functions

Assessment (Cont.)

- Medical assessment
  - Functions that may be expected of the nurse
  - Equipment and supplies
    - Preparing the exam room
    - Assisting with equipment
    - Preparing the patient
    - Collecting specimens
Assessment (Cont.)

- Nursing physical assessment
  - Performing the nursing physical assessment
    - Items needed: penlight, stethoscope, blood pressure cuff, thermometer, gloves, and a tongue blade
    - Nurse also makes use of the senses of touch, smell, sight, and hearing
    - Always wash your hands before beginning assessment
    - Documentation of the interview and assessment is necessary utilizing facility forms
    - Telephone consultation

Question 2

When assisting the health care provider with a gynecologic examination, the nurse would position the client in which position?
1. Supine
2. Dorsal
3. Lithotomy
4. Prone

Assessment

- Nursing assessment
  - Initiating the nurse-patient relationship
    - The first interview is the most challenging to conduct
    - Introduce yourself and state name, position, and purpose of the interview
    - Give an estimate of time
    - Ask if the patient has any questions and answer them appropriately
    - Communicate trust and confidentiality
    - Convey competence and professionalism
Assessment (Cont.)

- **Nursing assessment**
  - The interview
    - Project relaxed, unhurried manner
    - Conduct in a quiet, private, well-lighted setting
    - Convey feelings of compassion and concern
    - Determine by what name the patient wishes to be addressed
    - Nurse should have an accepting posture, relaxed, eye level, and pleasant facial expression

Assessment (Cont.)

- **Nursing health history**
  - The initial step in assessment process
  - Information on patient’s wellness, changes in life patterns, sociocultural role, and mental and emotional reaction to illness
  - Biographic data

Assessment (Cont.)

- **Nursing health history**
  - Reasons for seeking health care
    - Chief complaint
      - Document information in patient’s own words
      - The nurse can use the PQRST method
Assessment (Cont.)

- Nursing health history
  - Present illness or health concerns
  - Past health history

Assessment (Cont.)

- Nursing health history
  - Family history
    - Immediate and blood relatives
    - Includes health or cause of death, as well as history of illness
    - Objective is to determine patient’s risk for illnesses of a genetic or familial nature
    - Provides information about family structure, interaction, and function

Assessment (Cont.)

- Nursing health history
  - Environmental history
  - Provides data about patient’s home environment
  - Psychosocial and cultural history
    - Data about primary language, cultural groups, educational background, attention span, and developmental stage
    - Coping skills and family support
    - Identify major beliefs, values, and behaviors when treating patient
Assessment (Cont.)

- Nursing health history
  - Review of systems
    - Systematic method for collecting data on all body systems
    - Record in clear and concise manner with appropriate terminology
    - Ask specific questions relating to functioning of each system

Assessment (Cont.)

- Nursing physical assessment
  - The purpose is to determine the patient's state of health or illness
  - Initial step of the nursing process and in forming the nursing care plan
  - When to perform a physical assessment
    - Perform assessment as soon after admission as possible
    - Initial assessment is done by an RN
    - Ongoing assessment is the responsibility of LPN and RN

Assessment (Cont.)

- Nursing physical assessment
  - Where to perform a nursing assessment
  - Methods of nursing physical assessment
Assessment (Cont.)

- Nursing physical assessment
  - Performing the nursing physical assessment
    - Items needed: penlight, stethoscope, blood pressure cuff, thermometer, gloves, and a tongue blade
    - Nurse also makes use of the senses of touch, smell, sight, and hearing
    - Always wash hands before beginning assessment
    - Documentation of the interview and assessment is necessary utilizing facility forms
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Assessment (Cont.)

- Performing the nursing physical assessment
  - Head-to-toe assessment
    - Neurologic
      - Level of consciousness
      - Level of orientation
      - Hand grips

Assessment (Cont.)

- Head-to-toe assessment
  - Neurologic
    - Vital signs
    - Glasgow coma scale
Assessment (Cont.)

- Head-to-toe assessment
  - Skin and hair
    - Observe skin for color, temperature, moisture, texture, turgor, and evidence of injury or skin lesions
    - Note color of sclera, mucous membranes, tongue, lips, nail beds, palms, and soles
    - Determine the quantity, quality, and distribution of hair
    - Hair should be smooth, not oily or dry
    - Scalp should be free from dandruff, lesions, or parasites

- Head-to-toe assessment
  - Head and neck
  - Mouth and throat
  - Eyes
  - Ears
  - Nose

- Chest, lungs, heart, and vascular system
  - Inspect bilateral chest expansion
  - Note rate, depth of respirations
  - Note audible sounds without stethoscope
  - Assess oxygen saturation
Assessment (Cont.)

- Head-to-toe assessment
  - Chest, lungs, heart, and vascular system
    - Breasts
    - Lung sounds
  - Spine
  - Heart sounds

- Peripheral vascular system
Assessment (Cont.)

- Head-to-toe assessment
  - Gastrointestinal system
    - Abdomen
  - Genitourinary system
    - Inspect labia/genitalia and pubic hair
    - Palpate the scrotum
    - Palpate suprapubic area

- Rectum
- Legs and feet

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Question 3

To auscultate the anterior chest, the nurse would begin by placing the stethoscope:
1. just above the clavicle starting on the client's right side.
2. on the posterior chest wall starting distal to the clavicle.
3. at the fifth intercostal space to the left of midline.
4. inferior to the thorax and proximal to the dorsal cavity.
Documentation

- Follow institution protocol and forms used for history and physical assessment
- Be objective, clear, complete, and concise

Telephone Consultation

- It is essential to follow Health Insurance Portability and Accountability Act (HIPAA) guidelines
- Used in a variety of health care settings

Cultural Considerations

- Culture includes knowledge, skills, art, morals, law, customs, and any other acquired habits and capabilities of a group of people
- Ways to develop cultural and ethnic sensitivity
  - Recognize that cultural and ethnic diversity exist
  - Demonstrate respect for people as individuals
  - Respect the unfamiliar
Cultural Considerations (Cont.)

- Ways to develop cultural and ethnic sensitivity
  - Identify and examine the nurse’s own cultural and ethnic beliefs
  - Recognize some have definitions of health and illness that will differ from nurse’s own
  - Interpret patients’ signs and symptoms and respond to them with cultural norms
  - Be willing to modify health care delivery in keeping with patient’s cultural background
  - Do not expect all members of a culture to behave in exactly the same manner

Question 4

A male patient is admitted for abdominal pain. How would the nurse best document the information the patient gives about his symptoms?

1. Use the patient’s own words in quotation marks.
2. Briefly summarize what the patient says.
3. Interpret the patient’s comments using medical terminology.
4. Use the information for the chief complaint from the admission sheet.