CHAPTER 4
Physical Assessment

OBJECTIVE DATA DEFINED

- Objective data as OBSERVED by the examiner
- Can be seen, heard, & measured
  - Examples: rashes, altered vital signs, visible drainage or SWELLING/EDEMA
  - Lab results, diagnostic imaging, and other studies

“No broken bones. You’re lucky, looks like the tree helped break your fall.”
OBJECTIVE VERSES

SUBJECTIVE

- Subjective data is what the **patient** says it is
- Examples: pain, nausea, vertigo, and anxiety

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**Signs and Symptoms**

- **Disease**
  - It is any disturbance of a structure or function of the body.
  - It is recognized by a set of signs and symptoms.

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**Signs and Symptoms**

- **Risk Factors for Development of Disease**
  - A risk factor is any situation, lifestyle, habit, environmental condition, genetic predisposition, physiologic condition, and other that increases the vulnerability of an individual or a group to illness or accident.
Signs and Symptoms

- **Terms Used to Describe Disease**
  - **Chronic**
    - 6 months and longer, often for a person’s lifetime
  - **Acute**
    - Begins abruptly, severe signs and symptoms and then often subsides after a period of treatment
Assessment

- Process of making an evaluation or appraisal of the patient’s condition
- Collection of subjective (pt. feels) and objective data (what the caregiver observes)

Assessment

- Medical Assessment
  - Functions That May Be Expected of the PT
    - Preparing the exam room
      - Assisting with equipment
      - Preparing the patient
      - Collecting specimens
Assessment

- Initiating the **Nurse-Patient Relationship** (remember it helps reduce potential liability)
  - Introduce yourself and state name, position, and purpose of the interview.
  - Convey competence and professionalism.
  - Convey empathy

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**Guess what? Time to put you in the driver seat.**

- Break into two's
- Grab your mind
- Shy ones are going to have an anxiety attack!
- Practice makes perfect
- Perform a nursing introduction to your partner
- We will discuss the process after the exercise
Assessment

◆ Nursing Health History
  – Reasons for Seeking Health Care
    ◆ Chief complaint
      – Document information in patient’s own words.
      – “I have been having a lot of breathing problems for last two weeks”

◆ SOAP:
  ◆ Subjective data
  ◆ Objective data,
  ◆ Assessment,
  ◆ Plan.

Assessment

– 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 them
Assessment

- Nursing Physical Assessment
  - Performing the Nursing Physical Assessment
- Items needed:

Figure 4-1

Equipment used during a physical examination:
Assessment

- Head-to-Toe Assessment
  - Neurologic
    - Level of consciousness
    - Level of orientation
    - Hand grips

Assess skin turgor by grasping fold of skin on back of patient's hand, sternum, forearm, or abdomen.

(From Elkin, M.K., Perry, A.G., Potter, P.A. [2004]. Nursing interventions and clinical skills [3rd ed.]. St. Louis: Mosby.)

Assessment

- Head-to-Toe Assessment (continued)
  - Head and neck
    - Note facial expression.
    - Note symmetry of features.
TIME FOR YOUR PHYSICAL

"My name is wee-wee and I will be doing your head to toe assessment today"