CHAPTER 12
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
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.
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.
"One thing’s certain—they’ll never catch you moonlighting!"
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
Vocabulary

- Infection
- Inflammation
- Erythema
- Edema
- Purulent
- Auscultate
- percuss
- capillary refill
- PERRL
- palpate
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
"I'm afraid the surgeon couldn't perform your operation, because you weren't wearing clean underpants."
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
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.

(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
  - Neurologic
    - Level of consciousness
    - Level of orientation
    - Hand grips
Assessment

– Head-to-Toe Assessment (continued)

◆ Head and neck
  – Note facial expression.
  – Note symmetry of features.
Assess skin turgor by grasping fold of skin on back of patient’s hand, sternum, forearm, or abdomen.

Palpation of arterial pulses.

(From Seidel, H.M., Ball, J.W., Dains, J.E., Benedict, G.W. [2003]. Mosby’s guide to physical examination. [5th ed.]. St. Louis: Mosby.)