King Saud University

College of Nursing

Medical Surgical Department

Application of Health Assessment

NUR 225

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Application of Health Assessment

NUR 225

Module one part I

Health History and general survey

Outline of an Adult Health History	
Information	**Practical Notes**
1-Biographical Data Name Ethnicity Address Religion Telephone Gender Source of History Birth date & place	? Most of this information is on the name plate or chart ? Indicate if a translator was used
2-Reason for Seeking Care This is a brief statement of the patient's visit	? A concrete complaint recorded in the patients words – "pain since 2 days" ? Symptom (subjective sensation) ? Sign (Objective abnormality, either physical examination, or in a laboratory reports.
3-Present Illness To obtain a chronological (time) narrative of the chief complaint of an ill person. Final Summary <u>include eight critical characteristics:</u> 1**. Location, Region, radiation**	? Note precise site, point to the location. ? Be specific e.g., "pain behind the eyes" "is the pain localized or radiating" "is the pain superficial or deep
2. Character or quality **These are descriptive terms** **Burning, sharp, dull, aching, gnawing, throbbing, shooting**	? Use images – "does blood in the stool look like sticky tar"? " does blood in vomitus look like coffee grounds"? " does the pain feel like pressure or squeezing?
3. Quantity or severity	? Attempt to quantify the sign or symptom such as "profuse blood flow soaking five pads per hour"
4. Timing **Onset, Duration, Frequency**	? When did the first symptom appear? ? How long did the symptom last? (duration) ? Was it steady (constant) or did it come and go during that time (intermittent), irregular ? Did it resolve completely and reappear days or weeks later?

5. Setting	▯ Where the person or what was the person doing when the symptom started? ▯ What brings it on?
6. Aggravating or Relieving Factors	▯ What makes the pain worse? Is it aggravated by weather, activity, food, medication, standing, bending, fatigue, time of day, season, etc? ▯ What relieves it? (e.g., rest, medication, ice pack) ▯ What is the effect of any treatment? ▯ What have you tried? ▯ What seems to help?
7. Associated Factors	▯ Is this primary symptom associated with others? (e.g., urinary burning) ▯ Review this body system now rather than wait.
8. Patient's Perception	▯ Find out the meaning of the symptom by asking how it affects daily activities. "What do you think it means"? ▯ This is important as this alerts you to potential anxiety.
PQRSTU – mnemonic that will help remember all the points. **P – Provocative or palliative** **Q – Quality or quantity** **R – Region or radiation** **S- Severity Scale** **T – Timing** **U – Understand Patient's Perception**	▯ What brings it on? ▯ How does it look, feel, sound? ▯ Where is it? Does it spread anywhere? ▯ How bad is it? (Scale 1-10) is it getting better or the same? ▯ Onset – exactly when did it occur? Duration – how long did it last? ▯ Frequency – how often does it occur? ▯ What do you think it means?
4-Past Health Past health events may have residual effect on the current health state	
-**Childhood illnesses**	▯ Mumps, measles, rubella, chicken pox, pertussis. Ask about serious illness that may have sequelae at later life. (rheumatic fever, scarlet fever, and poliomyelitis)

-**Accidents or injuries** **Serious or chronic illnesses**	? Auto accidents, fractures, penetrating wounds, head injury (especially associated with unconsciousness), and burns. ? Diabetes, hypertension, heart disease, sickle-cell anemia, cancer, seizure disorder.
-Hospitalizations	? Cause, name of hospital. How the condition was treated, how long the person was hospitalized, and the name of the physician.
-**Operations**	? Type of surgery, date, name of the surgeon, and how the person recovered.
-Obstetric history	? Number of pregnancies (gravida) number of deliveries, (full term), (pre-term), abortions, and number of children living.
-Immunizations	? Measles, mumps-rubella, polio, diphtheria-pertussis-tetanus, hepatitis B, etc.
-Last examination date	? Physical, dental, vision, hearing, EKG, chest X-ray examinations.
Allergies	? Note both the allergen (medications, food, or contact agent, such as fabric or environmental agent) and the reaction (rash, itching, runny nose, watery eyes, difficulty breathing)
Current medication	? Ask about vitamins, birth control pills, aspirin, antacids, prescription and over the counter medications.
5-Family History To identify the presence of genetic	? Heart disease, high blood pressure, stroke,
traits or disease that has familial tendencies. To assess exposure to a communicable disease in a family member. To assess the individuals reactions to disease or death in the family. To assess family relationships	diabetes, blood disorders, cancer, sickle-cell anemia, arthritis, allergies, obesity, alcoholism, mental illness, seizure disorders, kidney disease, and tuberculosis. ? Age of parents: Age and cause of death if deceased

6-Personal / Social History **To develop an understanding of the patient as an individual and as a family member**	Cultural and religious traditions Geographic location City vs. town Be sensitive to cultural value of privacy Males may answer for females

Documentation:

Instructions: Fill in the blanks or mark in with interview findings

I- Demographic data:

Patient name: age:

Sex: marital status:

Spoken language: occupation:

Address: tel. No.:

Next of kin: relationship:

Address: tel. No.:

Source of data: □Patient □Family □Friend □Medical record

III- Chief Complaint (patient exact words) (following PQRST mnemonic):

Complain:…… Provoked by:……..

Palliated by:……Region…….

Quality: ……

Radiation: □ no □ yes (location):…….

Severity: □ mild □ moderate □ severs scale (0-5)----------

Timing: Onset ----------□sudden----------□ gradual ----------
Frequency ---------- Duration ----------

IV- Present illness:……

V- Past history:

Medical: □ no □yes (specify):……

Surgical: □ no □yes (specify):……

Mental illness: □ no □ yes (specify) ……

Accidents and injuries: □no □yes (specify):…….

Immunization: □ no □yes □unknown

Hospitalization: □ no □ yes Specify:……

VI- Family history:

Deaths: □ no □ yes (cause): ……relationship
……..Age……..

Diseases: □ no □ yes (specify) ……relationship……..
Age……..

VII- Psychosocial history:

Educational level: □ illiterate □ elementary □ secondary □ higher education

Housing: □ tent □ apartment □ villa

Dependant relatives: □no:……..relationship……

Home assistance: □no □yes

Home condition: □accommodates illness stage □ doesn't accommodate illness stage

□ depression □ anxiety □ hostility □ withdrawal □ frequent change in mood.

IIX-Current health status:

1. smoking: □ no □ yes (no. packs): □ quit (date):

2. alcohol: □ no □ yes (amount):

3.allergies: □no □ yes

Medication (type):……..reaction:……..

Food (type):…… reaction:……..

Others (specify…… reaction:……..

4. Sleeping : night sleep(no of hours)…….

Am. naps: □ no □ yes (hrs):…….. P.m. naps: □ no □yes (hrs):

5- Medication taken at home: □ no □ yes (specify): …….

6- Performed special exercise: □no □yes,…….

7.daily activity level: □low □moderate □high

8 - Activity-exercise:

Activity	Dependent	Needs assistance	Independent
Ambulating			
Hygiene			
Dressing-grooming			
Feeding			
Toileting			

*Assertive devices: □ wheelchair □sticks □ crutches □dentures □prosthesis

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Performance Checklist

History Taking

Components of patient history	Done Correctly (2)	Done with assistance (1)	Not done (0)	mark
✓ Biographical data				
✓ Chief complain				
✓ History of present illness				
✓ Past Health history				
✓ Family history				
✓ Functional Assessment				

Analysis of the symptoms	Done Correctly (2)	Done with assistance (1)	Notdone (0)	mark
When				
What				
Where				
How				
Describe				

Physical examination documentation format

Instructions:follow general survey&put a mark at the term that describes your client, and specify when indicated.

I. PHYSICAL APPEARANCE

1-Age: the **person appears** _his or her stated age. _ older, _smaller, _younger
2-:Sexual development _ is appropriate for gender _ is appropriate for age
_ shows delayed puberty _ shows early puberty _ is inappropriate to gender
3-Level of consciousness: the person _alert _ oriented
_ attends to questions _ responds appropriately _ Confused
_drowsy _ Lethargic.
4-Skin : _evencolor _ intact _ Pallor _cyanosis
_ jaundice _lesions----------
5-Facial features: _ symmetric with movement _. Immobile
_ mask like _ asymmetric _ drooping.
6-signs ofacute distress:_ Not present _ Shortness of breath _ wheezing
_ facial grimace _ holding body part---------- _others---------

II. BODY STRUCTURE

1-Stature – normal _ Excessively short _ Excessively tall
2-Nutritional status: –normal _Cachectic, _emaciate_ Obese.

3-Symmetry: **body parts look** _normal _ Unilateral atrophy
_ Unilateral hypertrophy _Asymmetrically located.
4-Posture: –erect _ moves as one unit _Stiff
_tense _ deflated.
5-Position: the person _sits comfortable _ Leans forward _
arms braced on chair arms _Sits straight up _ resists lying down
_Curled up in fetal position.
6-Body build, contour: _Elongated arm span _Trunk taller than lower extremities
_ Trunk shorter than lower extremities.
7-Physical deformities :– Absent _Present----------

III. MOBILITY

1-Gait: – normal _ Exceptionally wide base _Staggered
_ stumbling _Shuffling _ dragging _non-functional limb ---------- _Limping
with injury---------- _Propulsion.
2-Range of motion : _normal _ Limited joint range of motion ---------- .
_ Paralysis _ uncoordinated movement
3-Involuntary movement: _ absent _ Tics _ tremors _ seizures

IV. BEHAVIOR

1-Facial expression: – normal _Flat _ depressed _ angry
_sad _ anxious
2-Mood and affect:the person appears –comfortable _ cooperative
_ Hostile _ distrustful _ suspicious _ crying
3-Speech: –normal _ Dysarthria _ dysphagia _ monotone _ garbled
_talks few words _ Constant talking.
4-Dress: –appropriate _ inappropriate
5-Personal hygiene: —appropriate _ inappropriate

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Medical- surgical Nursing Performance checklist

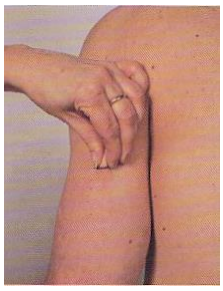
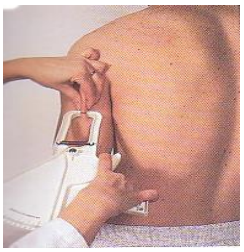
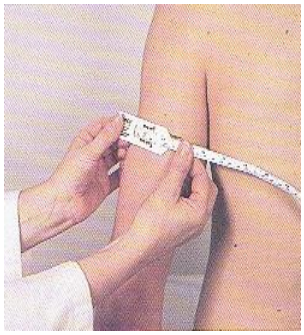
General Survey

The student nurse should be able to:

Performance Criteria	Competency level						
Collects General Survey data related to:	Trial 1			Trial 2			Comment
	Done correctly (2)	Done with assistance (1)	Not done (0)	Done correctly (2)	Done with assistance (1)	Not done (0)	
I. PHYSICAL APPEARANCE							
1. Age.							
2.Sex							
3.Level of consciousness							
4.Skin color							
5.Facial features							
6. Acute distress Signs.							
II. BODY STRUCTURE							
1.Stature							
2.Nutritional status							
3.Symmetry							
4.Posture							
5.Position							
6.Bodybuild, contour.							
7.Physical deformities							
III. MOBILITY							
1.Gait							
2. Range of motion.							
3.Involuntary movement							
IV. BEHAVIOR							
1.Facial expression							
2.Mood and affect							
3.Speech							
4.Dress							
5.Personal hygiene							
Document General Survey data according to designated format.							

Nutrition Screening Patient Interview Form

Instructions: Circle or fill in the blanks with actual physical assessment findings

Steps	*rational*
***A-Triceps skin fold thickness (TSF):--**	
1-Find the midpoint circumference of the arm by placing the tap measure halfway between the axilla and elbow.	1. to perfect measurement
2-Grasp a fold of skin and fat on the posterior aspect of the patient `s left arm with your thumb and forefinger about 1cm above the midpoint	2. to grasp fat not muscle
3-Repeat three times and average the three skin fold measurement	3. to validate measurement
4-Record the measurement to the nearest millimeter.	4. as standard normal
5-Compare the patient's measurement with standard.	5. to detect deviation from normal
	
***B-Mid upper arm circumference** 1-Measure the midarm circumference by placing the tap horizontally at midpoint ,then tighten it firmly around the arm . as shown in picture 3. 2-Recod the measurement in centimeters. 3-Compare the finding with standard.	1. to perfect measurement and to avoid compression the soft tissue 2.as standard normal 3. to detect deviation from normal
	

Nutrition Screening Patient Interview Form

Instructions: Circle or fill in the blanks with actual physical assessment findings

WNL=Within Normal Limits for age. Mark items which require additional documentation with an asterisk (*) and document in the Nurse's Notes sections of the Daily Nurses Record.

Pt. Identification data

Name---------- Age----- Sex----- occupation ---------- Marital status----------

Tel/Address---------- Known Allergies----------

General Survey

Physical appearance _ WNL, abnormality---------- Body structure _WNL, abnormality----------

---------- Mobility _WNL, abnormality---------- Behavior _ WNL, abnormality-

Present history

Chief complaint: P---------- P ----------

Q---------- R---------- R----------

S---------- T----------

Associated symptoms ----------Medication ----------

Past history----------

Family) history----------

Check if person is experiencing any of the following problems;-

÷ Reduce food intake by 1/2 in 3days ÷ recent weight loss ÷ Recent weight gain.

÷ Diabetes /renal disease /liver disease, other……..

Appetite. ÷ Good ÷ fair ÷ bad

÷ Difficulty chewing /swallowing

÷ Vomiting ÷ Diarrhea ÷Constipation

÷ Regular diet ÷ Especial diet .what type ----------?

÷ medications. What type? ----------Frequency? /duration of use?

÷ Substance abuse. What type? ----------Frequency?

Duration of use? ----------

÷ pregnancy/ lactation

Anthropometric measurement ÷ body mass index……..

÷ Triceps skin fold index……..

÷ mid upper arm circumference…….

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Performance checklist

Nutritional assessment

The student nurse should be able to

Performance Criteria	Competency level						Comment
	Trial 1			Trial 2			
	Done correctly (2)	Done with assistance (1)	Not done (0)	Done correctly (2)	Done with assistance (1)	Not done (0)	
*Collect appropriate subjective data related to nutritional history.							
*Prepare required equipment.							
*Explain procedure to the patient.							
*Perform anthropometric measurement **A**. ***Triceps skin fold thickness (TSF)***							
B. Mid upper arm circumference(MAC)							
c.***Body Mass Index (BMI)***							
*Document finding following designated Format.							

Instructor signature: ----------

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Module one part 2

Physical Examination techniques

Physical Examination Techniques Procedural Steps:

Common tasks performed prior to carrying out the procedural steps of Physical Examination:

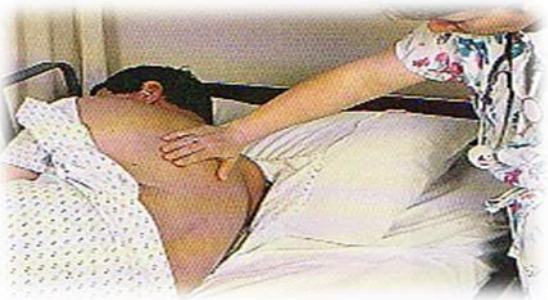
A-Prepare needed equipment: (Refer to equipment list)

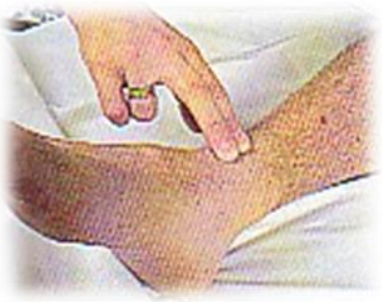
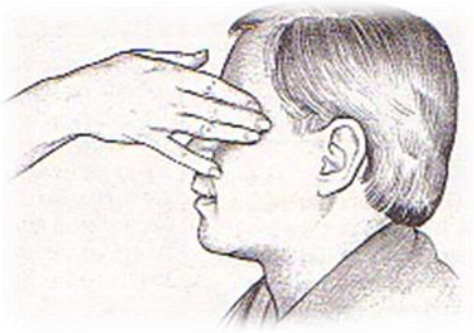
B- Patient and environment preparation:

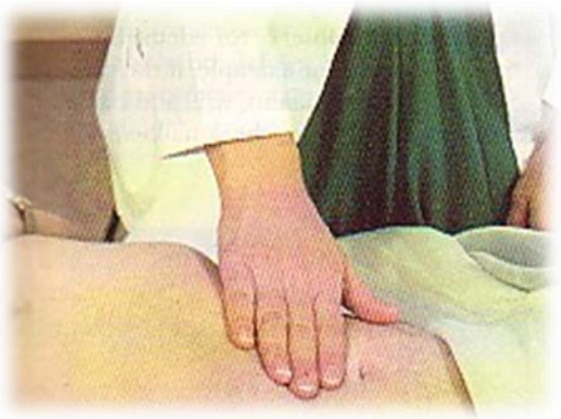
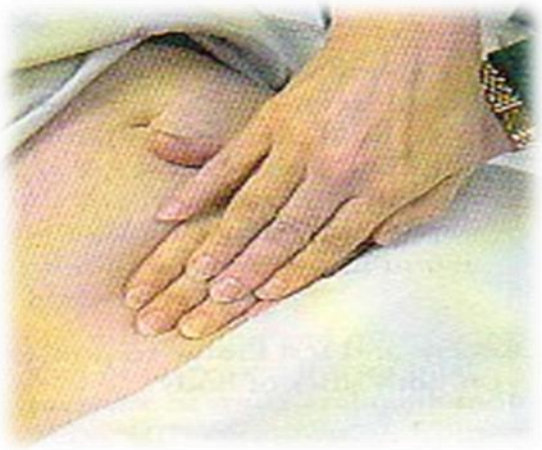
- Explain procedure to patient
- Ask patient to undress and drape him / her appropriately
- Make sure the room is warm, quit , and adequately light
- Ensure patient privacy
- Wash hands

C- Conduct general survey

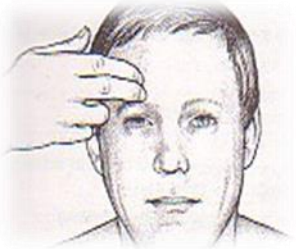
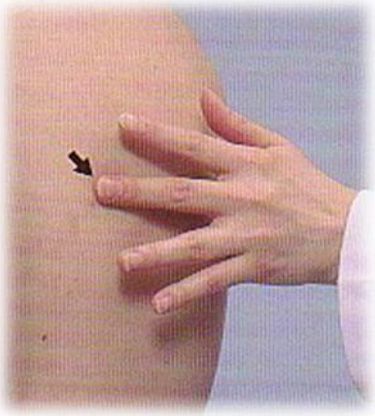
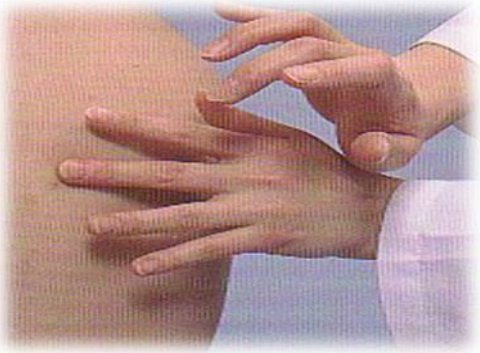
D- Procedural steps of Physical Examination Techniques:

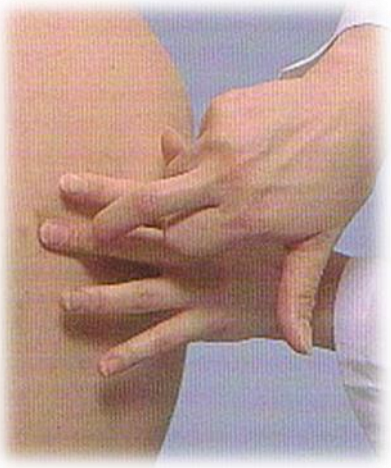
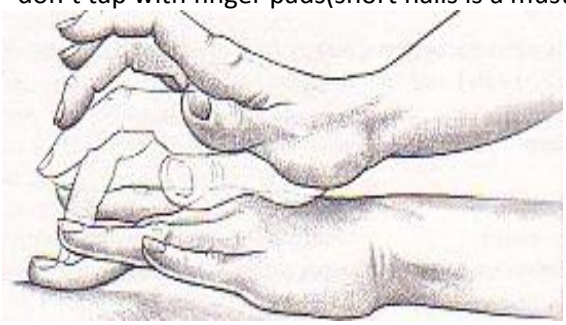
1-Inspection:	
Technique	**Rational**
1-Inspection starts at the initial patient encounter	1-Inspection is the main skill employed in general survey
2-Expose area to be inspected, sufficiently.	2- Allows the area to be totally seen
	
3- Adjust lightning (or use penlight) as needed	3-Allows all areas' details to be observed.
4-Use vision and smell senses to observe client	4Helps elicit highly sensitive clues about client
5- Note key landmarks while inspecting the entire body areas	5-Ensures accurate descriptions of findings

6-Inspect client following body system review	
7-Inspect for: Color, odor, sounds, shapes, texture, size, location, movement, odor, and symmetry.	
2-Palpation	
Technique	**Rational**
1-**Inform patient** to expect occasional discomfort.	1-Pressure causes organs discomfort
2-Ask patient to report pain	2- Assess for tenderness.
3-**Warm hands** by kneading them together	3- Cold touch causes stiffening and restricts palpation.
4-**Wear gloves** if palpating mucous membrane or other areas involving body fluids	4-Prevents infection.
5-Keep **tender areas last**.	5-Tenderness radiates to surrounding organs causing acute pain ;which aggravates the patient and reduces his / her cooperation
6-Keep **observing patients' face**through out the palpation.	6-Allows detection of sings of pain.
7- Apply just **enough pressure** to assess the tissue beneath one or both hands, then release pressure and gently move to the next area.	7-Prevents excessive pain or rupture of internal organs.
8-**Move hands systematically**	8-Ensures covering the entire area to be assessed
Start with lightpalpation	Light palpation detects surface characteristics and accustom patient to being touched.
1-Hold the pads of 2-3 fingers together	1-Provide fine tactile discrimination of superficial organs.
2-Press gently on the skin to a depth of 1-2 cm (use lightest touch possible)	2-Deeper pressure blunts examiner fine tactile sensitivity
3-palpate for; texture, swelling, pulsation, lumps Tenderness, temperature , moist, elasticity.	
	
deeppalpation	Deep palpation is employed to assess deep structures

1-Instruct patient to relax	1-Muscle tension interfere with performance and result of palpation
2-Use finger tips to press skin down 4-5 cm with firm deep pressure	
3-May place one hand on top of the palpating hand	3-Controls and guides hand movement 
4- Palpate for skin texture ,swelling ,pulsation ,lump position ,shape, consistency, mass, size , tenderness, mobility, vibrations	

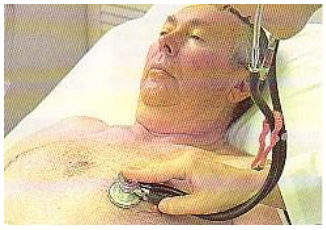
<u>3- Percussion</u>	
Technique	**Rational**
<u>Direct Percussion</u>	Direct percussionelicits tenderness and sounds of small body tissues(sinuses, child thorax)
1-Instruct patient to tell which areas are painful during test	1-to assess for tenderness (pain is a subjective data).
2-Use one or two fingers	2-It facilitate percussion of small body areas
3-tap finger pads directly on body part	3-gives the direct response of small tissue under percussion
4-percuss for sound, tenderness	

	
<u>Indirect percussion</u>	Indirect percussionis performedto map ,elicit pain & reflexes ,signals density of organ, and detects superficial mass
1-Press and hyperextend the distal part and joint of middle finger of nondominant hand firmly on the body part to be assessed 	1-This finger work as a mediating device to receive the taps(pleximeter)
2-Keep the rest of the nondominant hand off the body surface	2-Other fingers touching the surface will damp the sound
3-Bring the dominant hand wrist over the nondominant hand wrist	
4-Flex the dominant hand wrist	4-This keeps the movement at the wrist (not at finger, elbow ,or shoulder)
5-Place the dominant hand forearm close to surface to be perccused	
6-Keep dominant hand wrist and forearm as relaxed as possible 	6-This provides the lightest touch capable of producing a clear sound

7-With relaxed wrist motion; use the tip of flexed middle finger of dominant hand(plexor) to tap just beneath the distal joint of the middle finger of nondominant hand *perpendicularly (90 degrees angle) *directly *quickly 	7-This provides the strongest strike where the greatest pressure is exerted on the surface to be perccused. *don't tap with finger pads(short nails is a must) 
8-Lift the tip of middle finger of dominant hand rapidly between strikes	8-Avoids dampening the vibrations
9-Move nondominant hand to cover the entire area to be percussed	
10-Keep consistent degree of firmness exerted by the hyper extended finger while moving from area to area	10-Different degrees of firmness cause the sound to vary
11-Listen for sounds': **Amplitude**: Loudness or intensity of the sound, it ranges from loud, medium loud, soft, to very soft. **Quality**: type of note that describes the density of the organ that ranges from hollow, fluid, partially dense, to dense	

4-Auscultation

Technique	Rational
1-Determine which side of stethoscope to use • diaphragm • bell	**1-Diaphragm** detects high-pitched sounds (breath, bowel) **Bell** detects low-pitched sounds (heart, vessels)
2-Eliminate extraneous sounds by *remove clothes *wet body hair *avoid rubbing head of stethoscope against body surface	2-The function of stethoscope is to block extraneous sounds and concentrate body sounds, it DOES NOT magnify sounds.
3-Disinfect stethoscope *head between patients;& *earpiece if you use other persons' stethoscope	3-Eliminates possible vector infection
4-Warm the stethoscope with your hand	4-Cold stethoscope causes involuntary muscle contractions that draws out other sounds

5-Slope the earpiece in ears such that they face towards nose	5-This directs sounds towards the ear canals
6-Place the head of stethoscope on body area to be assessed	
*if using diaphragm: hold it **firmly** enough against the patient's skin to leave a slight ring afterward 	To block extraneous sounds 
*if using bell :hold it **lightly** against the skin enough to form a seal	Holding the bell too firmly causes the skin to act as a diaphragm which obliterates low-pitched sounds
7- May close eyes and listen	7-It helps focusing attention
Listen and identify the sound's: **Intensity**: strength **Pitch**: loudness of the peak **Duration**: length that each sound cycle lingers	

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NURSING DEPT. — Performance checklist

Physical Examination Technique

The student nurse should be able to:

Performance criteria	**Competency level**						
Technique	**Trial 1**			**Trial 2**			**Comment**
	Done correctly (2)	**Done with assistance (1)**	**Not done (0)**	**Done correctly (2)**	**Done with assistance (1)**	**Not done (0)**	
Preparation:							
Conduct general survey							
Review interview note							
Explain procedure							
Position and **drape** patient correctly							
Ensure adequate **light**							
Explain procedure to patient							
Wash hands							
Put the patient in sitting **position**							
Expose body part to be examined and **Drape** patient appropriately							
Compare findings of any side of body to the other							
Follow the **IPPAsequence**							
Inspection							
Expose body area to be examined sufficiently							
Inspect for :color ,odor ,sounds ,shapes ,texture ,size , location ,movement ,symmetry							
Palpation							
Inform client to expect occasional discomfort							
Ask client to report pain							
Warm hands							
Keep eyes on patients face							
Cover entire area to be assessed systematically							
Keep tender areas last							
Start with light palpation							
Light palpation							
Hold the tips of 2-3 fingers together							
Press gently on the skin to a depth of 1-2 cm							
Use dorsal part of hand to assess temperature							
Palpate for: texture, swelling, pulsation ,lumps ,tenderness ,temperature ,moist ,elasticity							

Deep Palpation							
Instruct patient to relax							
Press down 4-5 cm with the finger tips of both hands							
Place one hand on top of other if needed							
Direct Percussion							
Instruct patient to tell which areas are painful during test							
Use one or two fingers							
Tap finger pads directly on body part							
Percuss for :Sound ,Tenderness							
Indirect percussion							
Press and hyperextend the distal part and joint of middle finger of nondominant hand firmly on the body part to be assessed							
Keep the rest of the nondominant hand off the body surface							
Bring the dominant hand wrist over the nondominant hand wrist							
Flex the dominant hand wrist							
Place the dominant hand forearm close to surface to be percussed							
Use the tip of flex middle finger of dominant hand to tap beneath the distal joint of the middle finger of nondominant hand *perpendicularly *directly *quickly							
Lift the tip of middle finger of dominant hand rapidly between strikes							
Move nondominant hand to cover the entire area to be percussed							
Keep consistent degree of firmness exerted by the hyper extended finger while moving from area to area							
Listen for sounds': Amplitude , Quality							
Auscultation							
Disinfect stethoscope							
Eliminate extraneous sounds							
Warm the stethoscope with hand							
Slope the earpiece in ears facing towards nose							

Place the **head** of stethoscope on body area to be assessed using **diaphragm**: hold it **firmly** enough against the patient's skin to leave a slight ring afterward							
Place the **head** of stethoscope on body area to be assessed using **bell** :hold it **lightly** against the skin enough to form a seal							
Listen and identify the sound's Intensity ,Pitch ,Duration							