

Nursing Assessment

1. Part of Nursing Process
2. Nurses use physical assessment skills to:
 - a) Develop (obtain baseline data) and expand the data base from which subsequent phases of the nursing process can evolve.
 - b) To identify and manage a variety of patient problems (actual and potential)
 - c) Evaluate the effectiveness of nursing care
 - d) Enhance the nurse-patient relationship
 - e) Make clinical judgments

Gathering Data

Subjective data - Said by the client (S)
 Objective data - Observed by the nurse (O)
 Documents: SOAP/IE

Assessment Techniques: The order of techniques is as follows (A-D) except for the abdomen where you inspect then auscultate

A. Inspection - critical observation

1. Take time to "observe" with eyes, ears, nose (all senses)
2. Use good lighting
3. Look at color, shape, symmetry, position
4. Odors from skin, breath, wound
5. Develop and use nursing instincts
6. Inspection is done alone and in combination with other assessment techniques

B. Palpation - light and deep touch

1. Back of hand (dorsal aspect) to assess skin temperature
2. Fingers to assess texture, moisture, areas of tenderness
3. Assess size, shape, and consistency of lesions

C. Percussion - sounds produced by striking body surface

1. Produces different notes depending on underlying mass (dull, resonant, flat, tympani)
2. Used to determine size and shape of underlying structures by establishing their borders and indicates if tissue is air-filled, fluid-filled, or solid

D. Auscultation - listening to sounds produced by the body

1. Direct auscultation – sounds are audible without stethoscope
2. Indirect auscultation – uses stethoscope
3. Know how to use stethoscope properly (practice)
4. Fine-tune your ears to pick up subtle changes (practice)

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Adapted from the Kentucky Public Health Practice Reference, 2008 and Jarvis, C., (2012), *Physical examination & health assessment*, 6th Edn, Elsevier, St. Louis MO.
 by Wright State University on May 29, 2012 for the NLN Assessment Exam for Credit by Exam Test Out

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5. Describe sound characteristics (frequency, pitch intensity, duration, quality) (practice)
6. Flat diaphragm picks up high-pitched respiratory sounds best
7. Bell picks up low pitched sounds such as heart murmurs
8. Practice using BOTH diaphragms

General Assessment

A general survey is an overall review or first impression a nurse has of a person's well being. This is done head to toe, or cephalo-caudal, lateral to lateral, proximal to distal, and front to back. General surveying is visual observation and encompasses the following.

Appearance	appears to be reported age; sexual development appropriate; alert & oriented; facial features symmetric; no signs of acute distress
Body structure/mobility	weight and height within normal range (refer to Centers for Disease Control and Prevention (CDC) Body Mass Index (BMI) [adult] or BMI-for-age and gender forms [children]); body parts equal bilaterally; stands erect; sits comfortably; gait is coordinated; walk is smooth and well balanced; full mobility of joints
Behavior	maintains eye contact with appropriate expressions; comfortable and cooperative; speech clear; clothing appropriate to climate; looks clean and fit; appears clean and well-groomed

Deviations from what would generally be considered to be normal or expected should be documented and may require further evaluation or action, including a

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**Anat Prior, Tamar Degani, Zofia
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