Physical Assessment

M-A-K-I-N-G I-T

- Use these Skills…. In this order
  - Inspection
  - Palpation
  - Percussion
  - Auscultation

- Inspection – using sense of sight
  - You are always inspecting
  - Good lighting
  - Expose the body part
  - Compare findings to opposite side
  - Don’t hurry

- Palpation – using sense of touch
  - Warm hands!
  - Short fingernails
  - Gentle approach
  - Temperature best with dorsum of hand
  - Texture, size and pulsation with finger pads
  - Palm for vibrations

- Turgor – by grasping skin
  - Percussion – tapping the body
    (using the sense of hearing)
  - Involves striking body with fingertips
  - Used to evaluate size, borders, discover fluid in cavities
  - Evaluate density of underlying structures

- Auscultation – listening to sounds
  - (using the sense of hearing)
  - Done last with the exception of the abdominal exam
  - First learn normal
  - Need good hearing
  - Quiet environment
  - Good stethoscope
  - Always listen to naked skin - not on top of clothes
  - You may close your eyes

M-A-K-I-N-G I-T

Mentation / Neurological Assessment

- Talk to your patient and assess for “alertness”
  - Awake - Opens eyes
  - Alert - Responds immediately to his name
  - Confused - Responds inappropriately
  - Lethargic
    - Drowsy and inattentive. Dozes off easily but arousable
  - Coma – no response

- Level of Consciousness or Orientation
  - Person
    - “What is your name?”
  - Place
    - “Tell me where you are.”
  - Time
    - “What day is it? “What is the date?”
    - “Who is the president?”
Purpose
- “Why are you here?”

Mini Mental Status Exam
- Take out page 59 from module
- Used to detect the level of intellectual impairment

Motor function
- Can he move his extremities?
- Can he grasp hands firmly and equally?
- Strength of plantar flexion against your hand.
- Do facial muscles move symmetrically?
- Balance and gait

Pupil Assessment
- Pupil size (1 – 9 mm)  2 – 6 is normal
- Round
- Equal in size
- Responsive to light (brisk, sluggish)
- Accommodate
- PERRLA
- May be obscured by a cataract
  - Lens appears opaque, whitish, bluish or gray colored. (In addition ask about visual acuity)
- Pupil Sizes

A Airway / Respiratory Assessment
- Overall appearance – Breathing comfortably?
- Are respirations easy or labored?
- Fast or slow?
- Shallow or deep?
- Complaint of air hunger or SOB?
- Chest move symmetrically?
- Are retractions present?
- Use of accessory muscles?
- Nasal flaring?
- Equal expansion?
- Tracheal deviations?
- Color
  - Flushed, pink, pale, ashen, dusky, cyanotic, jaundiced
  - Mucous Membranes or conjunctiva in dark skinned individuals
  - Nail beds
- Cough
  - Frequency
  - Dry or productive?
  - Sputum color – (yellow, green, brown…)
  - Amount and consistency
- Breath Sounds / Normal
  - Listen anteriorly and posteriorly
  - Instruct patient what to do
  - Patient with SOB, confused or in coma will not be able to follow your directions
  - Anterior Auscultation
    - Supine at least 30 degrees
    - Clothing off – skin to skin!
    - Instruct patient to take breaths which are deeper than normal and exhale through an open mouth.
    - No voice sounds!
    - Use diaphragm - warm it!
o Posterior Auscultation
   o Sitting up
   o Hands placed on opposite shoulders will separate scapula
   o If patient cannot sit up – roll to side to listen
o “Auscultation of Normal Breath Sounds”
   o NURS103Y01
   o CD ROM to assist you in mastery of this skill
   o Takes about one hour
   o Do in next couple of weeks so you can practice in N150 clinical
o Breath Sounds / Abnormal
   o Rales or Crackles
     - Non continuous
     - Produced by moisture
     - Sounds like fizzing of carbonated beverage
     - Sounds like rolling a lock of hair between fingers near your ear
     - Usually heard on inspiration
     - Character may change with coughing
   o Rhonchi and Wheezes
     - Continuous
     - Produced by air flow across narrowed passages
     - Secretions
     - Mucosal swelling
     - Tumors
     - Sounds may be high pitched and musical sounding
     - Sounds may be low pitched and sonorous
     - May be on inspiration and expiration but are more prominent on expiration
     - Character may change with coughing
     - Rales may be present with rhonchi and wheezes

K Cardiovascular Assessment
o Cardiovascular Anatomy Review
   o Blood flow through the heart
   o IVC / SVC
o Apical pulse
o Heart sounds
   o S1 – Lub
     o Closing of the AV valves (tricuspid and mitral or bicuspid)
   o S2 – Dub
     o Closing of the pulmonic and aortic valves (semilunar)
   o Blood pressure
   o PMI (Fifth Intercostal space / Midclavicular line)
     o Apex of heart is touching the chest wall
   o Radial and pedal pulses
     o Rate
       o Regularity (regular or irregular)
     o Strength
       o Strong, weak, thready, bounding
       o Equality (compare left to right)
       o (When checking pedal pulse – if nonpalpable move up the leg to the popliteal and or femoral pulse)
   o Capillary refill – squeeze to illicit blanching
     o Blanching should last no longer than 3 seconds
   o Color of extremities
     o Warmth of extremities
- Touch simultaneously with both hands
- Look for redness or sores especially on the lower extremities of immobile patients

- Chest pain?
- Homan’s sign – pain in calf with dorsiflexion
- Peripheral edema
  - 1+ up to ¼ inch
  - 2+ ¼ to ½ inch
  - 3+ ½ to 1 inch
  - 4+ greater than 1 inch
- Jugular venous distention (with HOB elevated 45 degrees, look for distention of the internal jugular vein)

IN  Integument Assessment
- Pressure sores – look at bony prominences
- Skin turgor – pinch up skin on forearm or chest
- Redness – look for local inflammation
- Moisture –
  - Diaphoresis
  - Dry
  - Moist
- Incision – assess for healing and signs of infection
- Bruises and rashes / itching
- Lesions – describe size, shape and color
- Overall skin temperature
  - Cool
  - Warm
  - Hot

G  Gastrointestinal / Genitourinary Assessment
- Oral cavity
  - Moistness
  - Loose teeth
  - Thrush – Candida Albicans
  - Sores
  - Mucous membranes
- Oral hygiene
- Gag / swallow reflex
- Assessment of the Abdomen
  - First **inspect** the abdomen for contour, distention, peristalsis and pulsations
    - Abdominal Contour
      - Normal
      - Distended
  - Then **auscultate** …
    - Bowel sounds
      - Illeum has bowel sounds continuously, stomach does not
      - Listen **up to 5 minutes** to hear bowel sounds if necessary
      - Bowel sounds – 4 quadrants
        - Divide the abdomen into 4 quadrants dividing through the umbilicus
    - Bowel Movements
      - When was your last bowel movement?
- Palpate abdomen
  - Soft
  - Full
  - Firm
  - Tense
- Abdominal pain?
  - Point to where it hurts.
- Diarrhea?
- Incontinence?
- Nausea?
- Vomiting?
- Weight – loss or gain?
- Gastrointestinal / Genitourinary Assessment
  - Urine
    - Color
      - Light yellow to amber colored is normal
      - Cloudy is abnormal
    - Amount
      - Intake and Output
      - Foley?
      - Difficulty or pain when urinating?
      - Incontinence?
      - Menses? LMP?

I Invasive Line Assessment
- Intravenous line
  - Patent Line?
  - Right fluid hanging?
  - Right rate?
  - Insertion site
  - Erythema?
  - Pain?
  - Edema or swelling?
  - Infiltration? (How does the arm with the IV compare in size to the other arm without the IV?)
  - Infection?
- A/V Shunt or Fistula
  - Provides access to artery and vein for patient receiving hemodialysis
  - Assess for patency by checking for bruit and thrill
    - If shunt or fistula is not patent call MD right away
    - Bruit – Auscultate over graft to hear flow of blood
    - Thrill – Palpate over graft to feel flow of blood
- T Tubes and Drains Assessment
  - O2?
  - NGT?
  - Suction tubes – Yankaur tube for sputum?
  - Ostomy bag?
  - Gastrostomy tube?
  - Rectal tube?
  - Drainage systems
    - Jackson Pratt (JP), Hemovac, Davol
    - Character and amount of drainage
      - Serous, Sanguenous, Serosanguenous, Purulent
  - Dressings
    - Dry and intact, soiled?
Sample questions

- Which quadrant would the nurse auscultate to hear gastric sounds?
  - LUQ
  - RUQ
  - RLQ
  - LLQ

- Sample question
  - Which lobe would the nurse most likely hear rales?
  - R upper lobe
  - L upper lobe
  - R middle lobe
  - R lower lobe

- Sample question
  - Bronchovesicular breath sounds are normal at which site?
  - Over the alveoli
  - Over the trachea
  - Between the scapula
  - Laterally, at the 6th intercostal space

- Sample question
  - The purpose of the mini mental status exam is to
    - Assess ability to speak coherently
    - Assess level of orientation
    - Assess level of intellectual impairment
    - Assess level of consciousness

- Sample question
  - Capillary refill time of four seconds indicates:
    - Normal arterial perfusion
    - Normal venous perfusion
    - Abnormal arterial perfusion
    - Abnormal venous perfusion

- Sample question
  - The purpose of a skin turgor assessment is to:
    - Assess for level of peripheral edema
    - Assess for jugular venous distention
    - Assess for signs of dehydration
    - Assess the color of the extremities

- Sample question
  - To assess for perfusion through a arterio/venous fistula the nurse will:
    - Auscultate over the fistula to hear the thrill
    - Auscultate over the fistula to hear the bruit
    - Palpate over the fistula to feel the bruit
    - Call the physician if there is impaired perfusion