SYNDICATE OF HOSPITALS IN LEBANON

PATIENT ASSESSMENT

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I. Introduction

Performing an accurate physical assessment and being able to differentiate normal from abnormal findings is one of the most important roles for today's health care practitioner.

If an accurate physical assessment cannot be performed, whether for baseline data or when the patient's condition changes, then the patient is not receiving the level of competent care that should be given.

II. Objective

The purpose of this presentation is to provide the nurse with the basic information to enhance existing assessment skills and to learn the way it can be applied to the clinical setting.

III. Facts about Patient Physical Assessment (PPA)

Patient Physical Assessment is an organized systemic process of collecting objective data based upon a health history and head-to-toe or general systems examination. A physical assessment should be adjusted to the patient, based on his needs.

IV. Purposes of PPA

A comprehensive patient assessment yields both subjective and objective findings.

- Subjective findings are obtained from the health history and body systems review.

Subjective data are apparent only to the person affected and can be described or verified only by that person. Pain, itching, and worrying are examples of subjective data.

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- Objective findings are collected from the physical examination.

Objective data are detectable by an observer or can be tested by using an accepted standard. A blood pressure reading, discoloration of the skin, and seeing the patient in the act of crying are examples of objective data.

V. General guidelines in preparing the patient for PA

The nurse should :

- Review the chart prior to performing the assessment. Note the patient's name, age, address, race, and occupation. This will provide the nurse with an idea of the patient's lifestyle and will avoid asking repetitive questions.

- Establish a Positive Nurse/Patient Rapport , Greet the patient in a friendly, non-threatening manner, by using "Mr.", "Mrs.", or similar. This relationship will decrease the stress the patient may have in anticipation of what is about to be done to him.

- Explain the Purpose for the Physical Assessment. The purpose of the nursing assessment is to gather information about the patient's health so that the nurse can plan individualized care for that patient.

- Obtain an Informed, Verbal Consent for the Assessment. The chief source of data is usually the patient unless the patient is too ill, too young, or too confused to communicate clearly. Patients often appreciate detailed concern for their problems and may even enjoy the attention they receive.

- Ensure Confidentiality of All Data. If possible, choose a private place where others cannot overhear or see the patient. Explain what information is needed and how it will be used.

- Provide Privacy From Unnecessary Exposure. Assure as much privacy as possible by using drapes appropriately and closing doors.

- Communicate Special Instructions to the Patient. The nurse should inform the patient of what she / he intend to do and how he can help.

V. Basic Techniques used in performing PPA

- Inspection

A method of systematic observation. Inspection should begin with general observation of the patient progressing to specific body areas.

- Palpation

Examination by touch is called palpation. The nurses feels for texture, size, consistency, and location of body parts.

- Percussion

Tapping of the body lightly but sharply to determine consistency of tissues and/or organs through vibration and areas of tenderness.

- Auscultation

Process of listening for sounds over body cavities to determine presence and quality of heart, lung, and bowel sounds.

VII. Components of PPA

A. Assessment of General Health history

During this step of assessment the nurse interviews the patient to obtain a history, so that the nursing care plan may be patterned to meet the patient's individual needs.

- Chief complaint

The nurse records the chief complaint as a brief statement of whatever is troubling the patient and the duration of time the problem has existed. The chief complaint is the signs and symptoms causing the patient to seek medical attention.

- Past medical & surgical history

This provides background for understanding the patient as a whole and his present illness. It includes childhood illnesses, immunizations, allergies, hospitalizations and serious illnesses, accidents and injuries, medications, and habits.

- Family health history.

This enhances the nurse understanding of the environment in which the patient lives. Obtaining this information identifies genetic problems, communicable diseases, environmental problems, and interpersonal relationships. Specific inquiry should be made regarding the general state of health of parents, grandparents, siblings, spouse, and children.

- Vital signs

The patient's vital signs are part of the objective data that helps to better define the patient's condition and helps the nurse in planning care.

- Hints

The nurse should :

- ✓ Communicate with the patient at eye level
- ✓ State the name, & status and the purpose of the interview
- ✓ Assess the patient's comfort and ability to participate in the interview during the introduction
- ✓ Terminate the interview when the needed data are obtained, or the patient cannot provide more information.

B . Assessment by systems

- Integumentary
- Neurologic
- Respiratory
- Circulatory
- Musculoskeletal

- Nutrition
- Elimination
- Endocrine / Reproductive
- Self care ability
- Risk of pressure sore / falls

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