



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
<b>1-Biographical Data</b> 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
<b>2-Reason for Seeking Care</b> 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.
<b>3-Present Illness</b> To obtain a chronological (time) narrative of the chief complaint of an ill person. Final Summary <u>include eight critical characteristics:</u> <b>1. Location, Region, radiation</b>  <b>2. Character or quality</b>  <b>These are descriptive terms</b> <b>Burning, sharp, dull, aching, gnawing, throbbing, shooting</b>  <b>3. Quantity or severity</b>          <b>4. Timing</b>  <b>Onset, Duration, Frequency</b>	? 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"  ? 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?  ? Attempt to quantify the sign or symptom such as "profuse blood flow soaking five pads per hour"  ? 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

	<p>☐ Did it resolve completely and reappear days or weeks later?</p>
5. Setting	<p>☐ Where the person or what was the person doing when the symptom started?</p> <p>☐ What brings it on?</p>
6. Aggravating or Relieving Factors	<p>☐ What makes the pain worse? Is it aggravated by weather, activity, food, medication, standing, bending, fatigue, time of day, season, etc?</p> <p>☐ What relieves it? (e.g., rest, medication, ice pack)</p> <p>☐ What is the effect of any treatment?</p> <p>☐ What have you tried?</p> <p>☐ What seems to help?</p>
7. Associated Factors	<p>☐ Is this primary symptom associated with others? (e.g., urinary burning)</p> <p>☐ Review this body system now rather than wait.</p>
8. Patient's Perception	<p>☐ Find out the meaning of the symptom by asking how it affects daily activities.</p> <p>“What do you think it means”?</p> <p>☐ This is important as this alerts you to potential anxiety.</p>
<b>PQRSTU – mnemonic that will help remember all the points.</b> <b>P – Provocative or palliative</b> <b>Q – Quality or quantity</b> <b>R – Region or radiation</b> <b>S- Severity Scale</b> <b>T – Timing</b> <b>U – Understand Patient's Perception</b>	<p>☐ What brings it on?</p> <p>☐ How does it look, feel, sound?</p> <p>☐ Where is it? Does it spread anywhere?</p> <p>☐ How bad is it? (Scale 1-10) is it getting better or the same?</p> <p>☐ Onset – exactly when did it occur?</p> <p>Duration – how long did it last?</p> <p>☐ Frequency – how often does it occur?</p> <p>☐ What do you think it means?</p>
<b>4-Past Health</b>	

Past health events may have residual effect on the current health state	
<b>-Childhood illnesses</b>	☐ Mumps, measles, rubella, chicken pox, pertussis. Ask about serious illness that may have sequelae at later life. (rheumatic fever, scarlet fever, and poliomyelitis)
<b>-Accidents or injuries</b> <b>Serious or chronic illnesses</b>	☐ Auto accidents, fractures, penetrating wounds, head injury (especially associated with unconsciousness), and burns. ☐ Diabetes, hypertension, heart disease, sickle-cell anemia, cancer, seizure disorder.
<b>-Hospitalizations</b>	☐ Cause, name of hospital. How the condition was treated, how long the person was hospitalized, and the name of the physician.
<b>-Operations</b>	☐ Type of surgery, date, name of the surgeon, and how the person recovered.
<b>-Obstetric history</b>	☐ Number of pregnancies (gravida) number of deliveries, (full term), (pre-term), abortions, and number of children living.
<b>-Immunizations</b>	☐ Measles, mumps-rubella, polio, diphtheria-pertussis-tetanus, hepatitis B, etc.
<b>-Last examination date</b>	☐ Physical, dental, vision, hearing, EKG, chest X-ray examinations.
<b>Allergies</b>	☐ 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)
<b>Current medication</b>	☐ Ask about vitamins, birth control pills, aspirin, antacids, prescription and over the counter medications.

<b>5-Family History</b> 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
<b>6-Personal / Social History</b> <b>To develop an understanding of the patient as an individual and as a family member</b>	☐ Cultural and religious traditions ☐ Geographic location City vs. town ☐ Be sensitive to cultural value of privacy ☐ Males may answer for females

# Exercise

Miss Fatema is a 40 years old female, came to the hospital complaining of abdominal pain in the right upper quadrant of abdomen, radiating to the back and left shoulder, The patient describe feeling of pain as colicky in nature and rating of pain is 8 , also its provoke after having a fried foods or fatty food and pain is relived by vomiting. During the pain attack cannot able to go to the bathroom.

**Now describe the patient chief compliant, following the PQRSTU mnemonic.**

<u>P</u>	<u>Q</u>	<u>R</u>	<u>S</u>	<u>I</u>	<u>U</u>

# 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 ☐ severe 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

## 9- Review of body systems:

### 1-Integumentary Systems:

- ☐ Rashes ☐ lumps ☐ Itching ☐ Dryness ☐ Color changes  
☐ Changes in hair or nails ☐ other .....

### 2-Head and neck:

#### **Head:**

- ☐ Headache ☐ injury ☐ dizziness ☐ other .....

**Eyes:**

☐ Glasses ☐ Contact lenses ☐ Pain ☐ Redness ☐ Blurred vision ☐ Double vision

☐ Glaucoma ☐ Cataract ☐ other .....

**Ears:**

☐ Tinnitus ☐ Pain ☐ Discharge ☐ Hearing aids

**Nose and sinuses:**

☐ Discharge ☐ Itching ☐ Bleeding ☐ other .....

**Mouth and throat:**

☐ Bleeding gums ☐ Denture ☐ Dryness ☐ Sore tongue ☐ Sore throat

**Neck:**

☐ lumps ☐ Swollen glands ☐ pain ☐ stiffens ☐ other .....

**3-Breasts:**

☐ Lumps ☐ Pain ☐ Nipple discharge ☐ Self-examination practice ☐ other  
.....

**4-Respiratory System:**

☐ Cough ☐ Sputum ☐ Hemoptysis ☐ Dyspnea ☐ Wheezing ☐ Asthma ☐  
Bronchitis ☐ Tuberculosis ☐ other .....

**5-Cardiovascular System:**

☐ Increased B.P ☐ Murmurs ☐ Chest pain ☐ Palpitation ☐ Edema ☐ other  
.....

**6-Gastrointestinal System:**

☐ Nausea ☐ vomiting ☐ Heart burn ☐ Hematemesis ☐ Dysphagia ☐  
Constipation

☐ Diarrhea ☐ Distention ☐ Pain ☐ other .....

**7-Urinary System:**

- ☐ Polyuria. ☐ Nocturia. ☐ Dysuria. ☐ Hematuria. ☐ urgency. ☐ hesitancy.
- ☐ Incontinence. ☐ stone. ☐ dribbling

**8-Musculoskeletal System:**

- ☐ Pain in joint or muscles. ☐ Stiffness. ☐ Arthritis. ☐ Limitation of motion.
- ☐ Gout. ☐ Others (describe):

**9-Neurological System:**

- ☐ Seizure. ☐ Weakness. ☐ Paralysis. ☐ Numbness. ☐ Tremors or other involuntary movements.
- ☐ Others (describe):

**NURSES NOTES:** -----  
-----  
-----  
-----

**Name/Signature-----Date----**

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**Adult Health assessment NUR 225**  
**Performance Checklist**  
**History Taking**

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

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

Checklist performance	Student Performance						
Data collection 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)	
A-Introduction phase of interview							
1-prepare the physical environment							
2- greet client and introduce self							
3-call client by name							
4-arrange comfortable equal status seating at eye level							
5-put client in a comfortable position							
6-establish verbal contact with client by stating the reason for interview							
7-assess the client for: a-posture							

14-avoid nonproductive interview behaviors.							
<b>c. Closure phase:</b>							
15.summarize collected data							
16.provide conclusion of interview							
17.offer client chance for final addition							
18.thank the client							
20.explain the next step (physical examination)							
21-document all data (biographic data, chief complaint, medical history, surgical history, psychosocial history, activities of daily living, Review of body systems) following structured format correctly.							

# Quick Quiz

- 1- The health history is:
  - a. A way of wasting time in the morning
  - b. One of the most important components of a physical assessment
  - c. Only carried out by the doctor
  - d. Only to be taken by the admitting nurse
  
2. One difficulty in obtaining a good history in Saudi Arabia is:
  - a. The patient asking too many questions
  - b. The language barrier
  - c. It takes up too much time of the nurse
  - d. The doctors
  
3. Data for the health history can be
  - a. Obtained from looking only at the old notes
  - b. Obtained from the doctors when they do their assessment
  - c. Obtained over a period of time
  - d. Obtained at the point of admission
  
- 4- Health history obtained which type of data:
  - a. Primary data
  - b. Secondary data
  - c. Subjective data
  - d. Objective data
  
- 5- A client reveals that her mother and father both had sensitive skin and developed many skin allergies. This information would come under which one of the following categories:
  - a. Family history
  - b. Present history
  - c. Past medical history
  - d. Lifestyle history



## 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 :** ☐ even color ☐ intact ☐ Pallor ☐ cyanosis  
☐ jaundice ☐ lesions-----
- 5-Facial features:** ☐ symmetric with movement ☐ . Immobile  
☐ mask like ☐ asymmetric ☐ drooping.
- 6-signs of acute 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


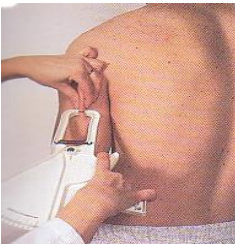
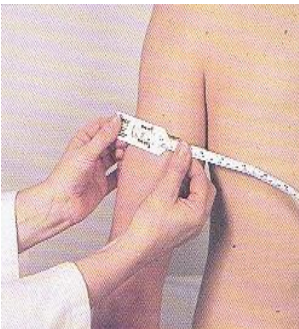
- 1-Facial expression:** ☐ normal ☐ Flat ☐ depressed ☐ angry  
☐ sad ☐ anxious
- 2-Mood and affect: the person appears** ☐ comfortable ☐ cooperative  
☐ Hostile ☐ distrustful ☐ suspicious ☐ crying
- 3-Speech:** ☐ normal ☐ Dysarthria ☐ dysphagia ☐ monotone ☐ garbled  
☐ talks few words ☐ Constant talking.
- 4-Dress:** ☐ appropriate ☐ inappropriate
- 5-Personal hygiene:** ☐ appropriate ☐ inappropriate

**General Survey****The student nurse should be able to:**

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

## Nutrition Screening Patient Interview Form

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

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

## **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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**Application of Health Assessment**

**NUR 225**

**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							
<b>A. Triceps skin fold thickness (TSF )</b>							
<b>B. Mid upper arm circumference(MAC)</b>							
<b>c.Body Mass Index (BMI)</b>							
*Document finding following designated Format.							

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

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## Application of Health Assessment

NUR 225

### 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:


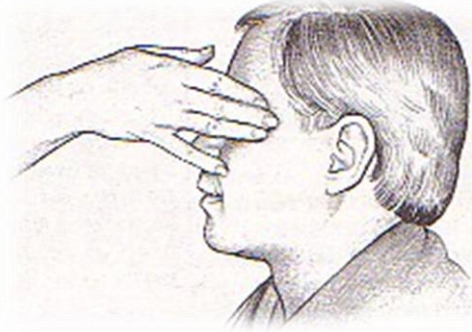
- Explain procedure to patient
- Ask patient to undress and drape him / her appropriately
- Make sure the room is warm, quit , and adequately light
- Ensure patient privacy
- Wash hands



C- Conduct general survey

D- Procedural steps of Physical Examination Techniques:

<b>1-<u>Inspection</u>:</b>	
<b>Technique</b>	<b>Rational</b>
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
4-Helps 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.	
<b><u>2-Palpation</u></b>	
Technique	Rational
1- <b>Inform patient</b> to expect occasional discomfort.	1-Pressure causes organs discomfort
2-Ask patient to report pain	2- Assess for tenderness.
3- <b>Warm hands</b> by kneading them together	3- Cold touch causes stiffening and restricts palpation.
4- <b>Wear gloves</b> if palpating mucous membrane or other areas involving body fluids	4-Prevents infection.
5-Keep <b>tender areas last</b> .	5-Tenderness radiates to surrounding organs causing acute pain ;which aggravates the patient and reduces his / her cooperation
6-Keep <b>observing patients' face</b> through out the palpation.	6-Allows detection of sings of pain.
7- Apply just <b>enough pressure</b> 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- <b>Move hands systematically</b>	8-Ensures covering the entire area to be assessed
<b><u>Start with light palpation</u></b>	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.	
	
<b><u>deeppalpation</u></b>	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	

<b><u>3- Percussion</u></b>	
<b>Technique</b>	<b>Rational</b>
<b><u>Direct Percussion</u></b>	Direct percussion elicits 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 facilitates 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	



### **Indirect percussion**

Indirect percussion is performed to 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 works 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 percussed

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 percussed.

\*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 <ul style="list-style-type: none"> <li>• diaphragm</li> <li>• bell</li> </ul>	<b>1-Diaphragm</b> detects high-pitched sounds (breath, bowel) <b>Bell</b> detects low-pitched sounds (heart, vessels)
2-Eliminate extraneous sounds by <ul style="list-style-type: none"> <li>*remove clothes</li> <li>*wet body hair</li> <li>*avoid rubbing head of stethoscope against body surface</li> </ul>	2-The function of stethoscope is to block extraneous sounds and concentrate body sounds, it DOES NOT magnify sounds.
3-Disinfect stethoscope <ul style="list-style-type: none"> <li>*head between patients;&amp;</li> <li>*earpiece if you use other persons' stethoscope</li> </ul>	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 <b>firmly</b> enough against the patient's skin to leave a slight ring afterward 	To block extraneous sounds 
*if using bell :hold it <b>lightly</b> 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
<b>Listen and identify the sound's:</b> <u><b>Intensity:</b></u> strength <u><b>Pitch:</b></u> loudness of the peak <u><b>Duration:</b></u> length that each sound cycle lingers	

**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)	
<b>Preparation:</b>							
<b>Conduct</b> general survey							
<b>Review</b> interview note							
<b>Explain</b> procedure							
<b>Position</b> and <b>drape</b> patient correctly							
Ensure adequate <b>light</b>							
<b>Explain</b> procedure to patient							
<b>Wash</b> hands							
Put the patient in sitting <b>position</b>							
<b>Expose</b> body part to be examined and <b>Drape</b> patient appropriately							
<b>Compare</b> findings of any side of body to the other							
Follow the <b>IPPA</b> sequence							
<b>Inspection</b>							
Expose body area to be examined sufficiently							
Inspect for :color ,odor ,sounds ,shapes ,texture ,size , location ,movement ,symmetry							
<b>Palpation</b>							
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							
<b>Light palpation</b>							
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							

<b>Deep Palpation</b>							
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							
<b>Direct Percussion</b>							
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							
<b>Indirect percussion</b>							
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 <b>head</b> of stethoscope on body area to be assessed using <b>diaphragm</b> : hold it <b>firmly</b> enough against the patient's skin to leave a slight ring afterward							
Place the <b>head</b> of stethoscope on body area to be assessed using <b>bell</b> :hold it <b>lightly</b> against the skin enough to form a seal							
Listen and identify the sound's Intensity ,Pitch ,Duration							



# Quick Quiz

Choose the correct answer for each of the following questions:

1. Physical examination should be conducted systematically, means that it is
  - a. Right to left examination
  - b. Head to toe examination
  - c. Left to right examination
  - d. Toe to head examination
  
2. All examination techniques may involve the use of equipment EXCEPT:
  - a. inspection
  - b. palpation
  - c. percussion
  - d. Auscultation
  
3. The sequence of the four examination techniques is.
  - a. Inspection, percussion, palpation, auscultation
  - b. Inspection, palpation, percussion, auscultation
  - c. Auscultation, palpation, percussion, inspection
  - d. percussion, palpation, auscultation , inspection
  
4. Tender areas examination should be kept till end of examination during:
  - a. Inspection
  - b. Palpation
  - c. Percussion
  - d. Auscultation
  
5. The diaphragm of the stethoscope is used to auscultate :
  - a. High –pitched sound
  - b. Low \_pitched sound
  - c. Medium\_pitched sound
  - d. No –pitched sound
  
6. In percussion technique the nondominant hand should be kept :
  - a. off the body surface
  - b. directly on the body surface
  - c. perpendicular to the body surface
  - d. All the above
  
7. During palpation the examiners eyes should be focused on:
  - a. The clients face
  - b. .Body part being palpated
  - c. The examiners hands
  - d. None of the above